Wednesday, 3 June 2026

(1.49 pm)

THE CHAIR: Yes, Mr Carr.

MR CARR: Yes, Chair, may I call please, Chris Dzikiti.

THE CHAIR: Yes.

CHRIS DZIKITI (sworn)

Questioned by MR CARR

THE CHAIR: Yes.

MR CARR: You have prepared three statements for this Inquiry, haven't you --

A. That's correct.

Q. -- dated 18 December 2025, 13 April 2026 and 18 May 2026?

A. That's correct.

Q. Are those statements true to your best knowledge and belief?

A. Yes.

Q. I'm going to summarise quickly your professional background. It's right, isn't it, you're currently the Interim Chief Inspector of Mental Health --

A. *(The witness nodded)*.

Q. -- and the Executive Director for operations at the CQC?

A. That's correct.

Q. Previously you've been Director of Mental Health at the CQC, Interim Chief Inspector of Healthcare, and Interim

Executive Director for Operations, and Executive Lead for Mental Health?

A. That's correct.

Q. By profession you're a mental health nurse?

A. Yes.

Q. Your previous roles prior to the CQC have involved managing mental health services in London and working for a commissioning team at NHS England?

A. Yes.

Q. In your first statement, you set out in detail the background and role of the CQC as an organisation.

A. Yes.

Q. You explain that the CQC is the independent regulator of health and social care in England?

A. That's correct.

Q. It has the power to take civil or criminal enforcement action where regulatory healthcare standards are not met?

A. That's correct.

Q. You explain in your statement that there are currently no enforcement powers against local authorities?

A. That's correct.

Q. But there's an ability to notify the Secretary of State --

A. Yeah.

Q. -- where there are concerns.

A. That's correct.

Q. The way in which the CQC carries out regulatory activity is through monitoring and inspection?

A. That's correct.

Q. Monitoring can involve meetings with the care provider?

A. *(The witness nodded)*.

Q. So external meetings?

A. Yes.

Q. Internal meetings within the CQC?

A. *(The witness nodded)*.

Q. And then obtaining and considering data?

A. That's correct.

Q. That can involve incident reports --

A. *Yes*.

Q. -- and other statistics. Then, significantly, there are inspections which lead to inspection reports.

A. Yes.

Q. The Inquiry has already considered a number of CQC inspection reports and then in respect of the Mental Health Act, there's a duty on the CQC, under that Act, to monitor how powers under the Act are used?

A. That's correct.

Q. So the CQC carries out Mental Health Act visits?

A. Yes.

Q. Looking at how those powers are being exercised?

A. That's correct.

Q. Then of particular relevance to the Inquiry, pursuant to Section 48 of the Health and Social Care Act, the CQC has a power and in fact it is a duty, where a Secretary of State requests it --

A. Yeah.

Q. -- to carry out a special review or investigation into the provision of NHS care.

A. That's correct.

Q. Following the attacks in Nottingham, the CQC was required to complete a review into the circumstances of that attack?

A. *(The witness nodded)*.

Q. Now, in your first statement, paragraph 200 -- yes, paragraph 200, page 68 of your first statement, you explain that the CQC was required to complete the Review in three months, and that was a shorter than usual 12-month period the CQC would have for this sort of investigation?

A. Yeah, that's correct.

Q. So you termed it a rapid review?

A. That's correct.

Q. But part two, because there were two reports published, weren't there, there was a part 1 and part 2?

A. Yes.
Q. Part 2, which focuses on issues relevant to VC and the various benchmarking cases, that was published slightly later, wasn't it, than part 1, that was published in August 2024?
A. Yeah, that was correct because when we had been commissioned by the Secretary of State to complete the reports, we were also conscious that the timelines we had been given were tight and we needed more time and we also had spoken to the bereaved families who helped with or in the sense of actually helping us to think about the time we needed to complete that report. So we requested the Secretary of State to consider us being given more time to complete that part of the Review.
Q. So more time was given, but you were aware, and you've set this out in your report, that Theemis had been consulted --
A. Yeah.
Q. -- and instructed by NHS England to carry out a more comprehensive investigation than the CQC were carrying out?
A. Yeah.
Q. The work being carried out by the CQC was working within limitations, wasn't it?
A. That's correct.

Q. We'll look at part 2 of the report in a moment, we'll deal with that first, which considers the care provided to VC, but identifying some of those limitations with it being a swifter report, it was essentially, wasn't it, for part 2, anyway, a desktop review? It was based on looking at medical records?
A. Yes.
Q. It didn't involve the CQC talking to staff from the Trust?
A. No, it didn't include, but we were also able to speak to staff in terms of our regulatory work in terms of some of the inspections, we were using that information intelligence, we --
Q. You had a relationship with the Trust --
A. Yeah, yeah. The Trust yeah --
Q. -- because you inspected them.
A. When inspecting them, yes.
Q. But in terms of digging down into what happened in VC's case --
A. No --
Q. -- this wasn't the sort of investigation --
A. No, it wasn't.
Q. -- where you would go and speak to the -- those treating VC?
A. Yeah, it wasn't.

Q. It was focused very much on the records and the approach by the Trust.
A. Yes.
Q. So you weren't looking at inter-agency working with police --
A. No.
Q. -- and the local authority.

Now, your statement deals with the methodology for the report and the Inquiry has already heard evidence from Dr Dracass and Dr Ahmed, and the two community mental health nurses as well who were instructed to carry out analysis for the purposes of the report.

If we can look at the part 2 report. It's CQCM0016518. And I want to go, please, straight to the conclusions, the summary. It's page 4. And the first bullet point, just under the heading "Our review found":

"If the decision had been made to treat VC under section 3 of the Mental Health Act [...] during his fourth admission to hospital, further options would have been available for his care and treatment in the community."

And the further options that are being described there, it's essentially a CTO, isn't it?
A. Yeah, it was a CTO and possibly depot medication as well.

Q. Well, a CTO with --
A. Yeah, yeah.
Q. -- with a condition of a --
A. Yeah.
Q. -- depot medication. And if we look at the rationale for that conclusion, we see it at page 33 of this document, please, and it's -- oh you're just there. It's page 33. Top paragraph. Yes. And this sets out the rationale, doesn't it --
A. Yeah.
Q. -- for the conclusion we just looked at:

"By this point, VC was known to have a diagnosis of paranoid schizophrenia [...] non-compliant [...] in the community ..."

And it said:

"Given this information, it could be considered a missed opportunity not to detain him under section 3."

And it explains the additional powers that there are with Section 3.

Is it the view of the CQC that the fourth admission should have been on the basis of Section 3 rather than Section 2 for the reasons given here?
A. Yeah, that's correct.
Q. If we go back to page 4 of this document, please, and again looking at the next summarised conclusion:

"... a series of errors, omissions and missed judgements ...

"Key among [those] were:

"the decision to discharge VC back to his GP in September 2022

"inconsistent approaches to risk assessment ...

"poor care planning and engagement ..."

And again, if we look at the detail, so it's in respect of risk assessment, page 17 of this document. And if we look in the middle of the page, we can see -- well, we can see from the second paragraph on the screen, eight risk assessments were found and assessed by the CQC. Completed for each admission and updated at other times.

And the conclusion here is that:

"... risk assessments minimised or omitted key details including:

"refusing medication

"ongoing and persistent symptoms of psychosis

"levels of violence ...

"escalation of violence ..."

The paragraph that follows finds that:

"The risk assessments didn't provide suitable analysis of the risks ... identify the factors that might reduce [the] ... risk of violence, how [it] ...

would be managed. ... did not outline the seriousness and the immediate threat of the risks and known issues that would increase his risks, or provide a written outline of the scenarios where the risk of violence would escalate and who may be put at risk."

Given all of those findings, is it fair to say that these are failures which are being identified which are pretty fundamental when it comes to conducting the risk assessment?

A. Yeah, I mean that was our conclusion: that these were serious failures from the review we did of VC's medical records. These were serious.

Q. Because a risk assessment that doesn't deal with all the things being identified here is no real risk assessment at all, is it?

A. Because I suppose the risk assessment gives you the basis of putting a risk management plan in place.

Q. And then at page 18, over the page it identifies, second paragraph on that page, the absence of "an updated risk summary or review" prior to discharge. And it's described here as "a missed opportunity", but again is it fair to say that that is a fundamental failure in the management of risk?

A. Yes, that was our conclusion, because then it would then inform the decision you make in terms of discharge.

Q. So where the report describes "a series of errors, omissions and misjudgements", and it's obviously considering an awful lot of information here --

A. *(The witness nodded)*.

Q. -- but certainly, so far as what we've just looked at with risk assessments, you'd agree that those are fundamental failures in managing and assessing risk?

A. Yes, I would agree.

Q. From the benchmarking cases -- and we've heard evidence on that, I'm not going to go through them -- but is it also fair to say that the problems identified and highlighted in VC's case were not, at this Trust, isolated to his case?

A. No, they were not.

Q. For part 1 of the report, which was a -- or the first report, rather, as part of the Section 48 report, that looked at standards at the Trust more generally, didn't it?

A. Yes.

Q. But it also identified a number of matters of concern at the Trust which were also relevant to VC's case?

A. Yeah.

Q. Issues with demand for services and problems with staffing --

A. Yeah.

Q. -- problems with leadership.

Is it also fair to say that themes identified in part 2 specific to VC identified in part 1 more generally at the Trust, that those were similar to the very same themes that the CQC were identifying at earlier inspections?

A. Yes.

Q. Now, just to explain the process of inspections, you set out, it's paragraph 61 of your first statement, which is on page 17, you've set out the five key questions that the CQC consider when carrying out an inspection. So that's safety, effectiveness, caring, responsive, well led?

A. Yeah.

Q. But ultimately, what a healthcare provider is being assessed against are the fundamental standards, aren't they?

A. Yes, that's correct.

Q. Then helpfully they're set out, it's paragraph 50 of your statement, page 14, they're set out there and it's the various bullet points.

Now, we can see Regulation 12 is "Safe care and treatment", isn't it?

A. Yes.

Q. So that's going to be one of the most important --

A. Important one, it is.
Q. -- standards.
Now, considering the issues relevant to this Inquiry and in particular the issue of considering, assessing, managing risk of harm to the public, which one of these standards, if any, do you think would be engaged or might be engaged where there were deficits in the treatment or care being provided by a healthcare provider which created a risk of harm to the public or increased the risk of harm to the public?
A. I mean, you can take, for example, you know, Regulation 12, which is "Safe care and treatment". And then, when you look at the five key areas we look at, for example, is the service, providing self-care, one, is it responsive to the needs of the patient and also is it effective?
So one could argue to say, you know, the treatment, for example, in this case, VC was receiving, one, was not responsive to his needs, and secondly, it wasn't effective to support him when he had left hospital or when he was in community.
So one can argue that "Safe care and treatment" was not available.
The other regulation we can look --
Q. Just on that before -- and I do want to hear what you

say about other regulations -- but on Regulation 12, "Safe care and treatment," so the terms of Regulation 12 itself refers to care and treatment being provided in a safe way for service users, doesn't it?
A. That's correct.
Q. Now, I think your answer is suggesting well, actually when considering if treatment is being provided in a safe way for service users, that might be expanded to consider safety or the risk of harm to others.
A. Because when you provide safe care and treatment to someone, and like the questions we've got, like I say, is it responsive to the needs of the person, is it effective? The hope is part of safe care and treatment it's not just medication, it's also including things like risk management, because it's part of treatment and supporting someone's care.
Q. So do you say that is something that is known to the CQC and known to the CQC inspectors, so when they're out carrying out an inspection, one of the, as it were, standards they're considering is: well, what are the implications of the level of treatment for the wider public?
A. I'd want to believe so because when we look at services, and I was going to clearly cover under, for example, good governance on Regulation 17, we're talking about

risk assessment and risk management.
When you complete a risk assessment, you would hope that people identify that there is risk to self, there is risk to others, and risk to others might mean to the patients -- the other patients on the unit, it might mean staff, it might mean also members of the public, poses risk to others. And if you identify those needs in a risk assessment, you then expect an organisation to have a risk management plan which addresses those risks which have been identified in the assessment.
Q. So one of the things we've seen in inspections is that CQC inspectors are looking at risk assessments and considering how a healthcare provider undertakes those?
A. Yes.
Q. That deals with Regulation 12. Do you think risk of harm to the public, do you think it's engaged by any of the other regulations, or do you think Regulation 12 is the main --
A. I think Regulation 17 was good governance. It is about good governance. Do you have systems in place, for example. When things happen within an organisation where there are some instances, is the organisation learning those, from those instances? Is there an opportunity to share what's coming out from those instances across the organisation?

And as part of the Section 48, there were some issues, in terms of, you know, the leadership, how they looked at what was happening within the organisation, and whether it was a learning organisation in terms of learning from what was already happening within the organisation.
So you can look at good governance as another area to think about, actually, around things like risk assessments. What are you learning from it? You know, what information is shared by the leadership team to think about what's happening within a service?
Q. If you look at some of the inspections that were carried out of the Trust, if we deal first with the 2019 inspection, CQCM0016473. And so this is an inspection, isn't it, of the Trust in its entirety?
A. Yes.
Q. We can see "Requires improvement" is the overall rating.
A. Yes.
Q. With "Requires improvement", also for "safe" services, "responsive" and "well-led"? And this represents a reduction, doesn't it, from the previous inspection where the overall rating had been good?
A. Yeah.
Q. But specifically in respect of acute wards, if we go forward, please, to page 22 of this document, where we

see "Inadequate" at the top of the page there, that's the overall rating for acute wards, isn't it?
A. Yeah, that's correct.
Q. And the downward arrow, that's indicating that that's, again, a reduction in rating from the previous occasion.
And that's in circumstances where if we look further down the page, the paragraph that starts:
"At the last comprehensive inspection in November 2017, we rated the acute wards for adults of working age in psychiatric intensive care units as requires improvement overall."
And so what this appears to be saying is the 2017 report, the Trust was told: well, your acute ward for adults of working age needs improvement. And then two years later, you've come back and, rather than improving it's actually deteriorated.
A. Yeah.
Q. How typical is it for a -- for that to occur? For a Trust to be inspected and told "You need to improve", and you go back and actually they've got worse?
A. It is possible that some --
Q. It's obviously possible under -- *(overspeaking)* --
A. Yeah, yeah.
Q. How common is that?
A. It is common. It is common in terms of actually, you

know, your expectations is every time we go into services you want to see improvement, because that's good for people in those services.
Q. And especially where you flag that there's a problem --
A. Yeah, yeah --
Q. -- this "Requires improvement".
A. -- improvement. And we also expect to see an action plan being put in place to address the concerns we've identified.
So there is an expectation that actually you would hope that a service would then rectify those gaps, they might, you know, which we've identified and hoping that the action plan will help that service to improve.
Q. And so, is it a particular cause for concern, then, whenever a Trust is rated "inadequate", that that's going to be a cause for concern, isn't it?
A. Yeah.
Q. But where the rating of "inadequate" follows a previous rating of "Requires improvement", so it's not fallen from "good" to "inadequate", not from "Requires improvement" to "inadequate", is that a particular cause of concern?
A. It is a cause of concern, because that means the service is deteriorating further or there is a question about the leadership as well, in terms of what has happened

within the leadership, in terms of the work that needs to be taken forward to improve the service or the organisation.
Q. And then page 25 of this document, please, considering the safety of services on this ward, the fourth bullet point on the page dealing with risk assessments, and it identifies there, so on the basis of looking at 36 care records -- and that's because there's a sample, isn't there?
A. Yeah.
Q. So when the inspectors go they obviously can't look at every single --
A. No.
Q. -- patient record.
So 36 have been looked at and no risk assessment in five, and in a further seven the risk management plan was incomplete.
So straight away you can see --
A. Yeah.
Q. -- there are issues there with risk assessment.
And that's a point we see echoed, isn't it --
A. Yeah.
Q. -- in the Section 48 report?
A. Yeah, that's correct.
Q. But at this time, we see at page 29, the

"Community-based mental health services of adults of working age", that was rated good, wasn't it?
A. Yes.
Q. If we go forward, please, to the next document, CQCM0016475, now this is the focused inspection from July 2020 published September 2020, and this was looking just at acute wards for adults of working age in Psychiatric Intensive Care. So that's the one we just looked at --
A. Yeah.
Q. -- that was previously rated "inadequate".
Just looking at the first page, we can see that overall rating for the service appears to have gone from "Inadequate" to "Requires improvement"; is that right?
A. Yeah, that's correct.
Q. That's an "Improvement" overall. But the subcategory, so "safe", "caring", "well-led", remain the same, and is that because this is a focused inspection, so those categories aren't, as it were, re-rated?
A. Yeah, that's correct.
Q. Now, improvements are noted in this report. If we look, please, at page 7 of this document, and under the heading "Assessment of patient risk", we can see there, we've got this sample, again, of looking at cases looking at risk assessments, and 11 cases have been

looked into, 11 risk assessments, and there's an improvement compared to the previous inspection. It describes:

"All patients had a core risk assessment which was a comprehensive risk profile and also individual risk assessments where specific risks were identified which were reviewed regularly."

So it's an improvement on the previous inspection where the inspectors looked and in some cases there was no risk assessment at all --

A. *(The witness nodded)*.

Q. -- or a risk assessment wasn't fully completed?

A. That's correct.

Q. Here, you have risk assessments which appear to be completed fully?

A. Yes.

Q. By that -- and we've looked at risk assessments in the Inquiry -- but by that, it means you flick through the various pages, the boxes, and there's text in those boxes?

A. Yeah.

Q. Obviously, the difficulty for the inspectors is they're not going to be able to identify, are they, from that dip sample information that's missing? They can look and see where the text boxes have been filled out.

A. Yeah.

Q. But without carrying out the kind of deep dive, the deep analysis, the sort of deeper analysis that was carried out for the Section 48 report, an inspector is not going to be able to work out whether information is missing or misstated from a risk assessment?

A. Yeah, but what you'd hope is, when you look at the sampling, for example, those 11 risk assessments, is, you know, was the need identified, right? That this is the need for someone, these are the issues for someone, for example, violence and aggression, right? So if the need is identified, right, what's the objective, what's the goal? It should be documented in those notes.

Then, finally, what are the actions being taken by the team to support that individual? So you would expect that to happen.

On top of that, our inspectors as well, when we do inspections, we also have specialist advisors. These are people who are in current practice and so, for example, if we are going to a Psychiatric Intensive Care Unit to assess or inspect, we would take a specialist advisor who is currently working in a Psychiatric Intensive Care because we want to make sure we're clear about the context, we're clear about current practice and best practice.

Q. Yes, and that makes sense. The question, the signposting is simply this: when the inspectors go, they're there for a limited amount of time?

A. That's correct.

Q. There's only so much they can do?

A. Yeah, that's correct.

Q. There's the dip samples, to get an indication --

A. Yeah.

Q. -- of how a Trust is carrying out risk assessments, and clearly, where a Trust is just not completing a risk assessment or it's only being half done, really easy for inspectors to say well, their risk assessments were rubbish.

A. Yes.

Q. When a risk assessment has all the text boxes filled in, it's going to take much more work, isn't it, to spot or identify whether key important bits of information have been missing or have been properly stated?

A. *(The witness nodded)*.

Q. Something that's going to be difficult for inspectors to do?

A. That's fair.

Q. Then if we can just deal, please, with page 9, and one of the issues that's identified there. So it's -- yes, under the heading "Track record on safety" but going

four paragraphs down, where it deals with staff being aware of their roles and responsibilities for reporting incidents and were able to describe the incident reporting procedure.

Now, this focus report followed a visit in July 2020, and you will be aware, I suspect, from the background to VC's case that he had obviously had a first Mental Health Act assessment --

A. Yes.

Q. -- which had not led to him being admitted, and when he returned at home, there was the incident involving his neighbour who jumped from the first-floor window in fear of him, and suffered a spinal injury necessitating spinal surgery.

Now, is that, in your view, something that a healthcare provider ought to be reporting to the CQC? Is it a notifiable incident?

A. It is. It is a notifiable incident.

Q. It is?

A. Yeah, it is.

Q. So it should be reported?

A. Yeah.

Q. Violence more generally, where a patient who is under the care of secondary mental health care, and they are violent, and that includes violence away from the

hospital, violence in the community, and that is violence which is or which is believed to be the result of their mental illness, is that something that you think ought to be reported to the CQC as a matter of course?

A. I would expect that, and also to add during this time as well, we had relationship managers who were sort of a single point of contact for providers, and there were regular engagement meetings between the CQC and the provider, and you would expect during the conversations in those meetings, if there were those serious incidents to be discussed in those meetings.

Q. And there are formal notification procedures --

A. Yeah.

Q. -- to the CQC as well --

A. That's correct.

Q. -- aren't they? And what I'm trying to establish is whether violence that occurs in the community but is linked to a mental health condition of a patient, whether that should be reported.

A. Yes.

Q. Because if it's violence on a member of staff in hospital for instance, you'd expect that to be reported.

A. Yes, that's correct.

Q. There's clarity about that.

A. Yeah.

Q. If it's patient-on-patient in a hospital, you'd expect that to be reported as clarity.

A. Yeah.

Q. If it's a mental health patient in the community, do you consider that healthcare providers do appreciate that they ought to be reporting that to the CQC?

A. I would want to believe so, because we would expect them to. So I would want to believe so. But I can't speak in general terms about all the providers, but there would be an expectation to do so.

Q. Now, some of the issues that we have spoken about and which are identified in both CQC reports, they are, as you've explained, not isolated to VC's case, were more widespread at the Trust, were picked up in earlier inspections. But some of the issues also reflect national issues, don't they, more widespread issues --

A. Yeah.

Q. -- in mental health? So if we look please at CQCM0016517. It's the first report. And we'll look at some of the points being identified in there. Page 21.

"Referrals and waiting times for community services". It's the bottom paragraph on the page, the report is identifying that's an issue at the Trust but also an issue nationally.

A. That's correct.

Q. Then page 27, "access to inpatient beds", second paragraph under that heading, again identifying that there are national problems with that.

A. Yes.

Q. And then the third statement, most recent statement that you provided to the Inquiry, that's dealing, isn't it, with the wider picture --

A. Yeah.

Q. -- of regulating mental health providers. Here, the paragraph you're looking at, is looking at the Mental Health Act annual report. CQC also does the State of Care Report, but what are -- particularly with your background as a mental health nurse, what do you consider are the biggest challenges for mental health care in this country?

A. Yeah, I say, I mean I've been in mental health services, I qualified in 2002, and I have worked in most services. I've worked in Psychiatric Intensive Care, I've worked in Assertive Outreach teams, in Psychiatric Liaison Service, and over time, I think there has been a demand for inpatient mental health services, and nationally I think we continue to see an increase on that demand. And I think that the pandemic didn't help as well because that increase keeps on going since the pandemic

as well.

I think the other issue we have raised on several occasions around workforce or staffing, the limited number of mental health nurses, for example. And also part of my job I did before going to CQC was retention programme, a National Retention Programme, which was to support the whole of the NHS workforce.

And after the pandemic we saw people retiring and we saw people making decisions. So people who were experienced mental health nurses found themselves retiring early as well, so workforce is a big, big challenge. And obviously the change of --

Q. It's going to compound the increased demand.

A. Yeah, the demand, and obviously the changes of, you know, when I qualified, for example, as a mental health nurse, we used to work with four mental health nurses in a service. I think if you go around now it's either one or two, sometimes, in some services.

So that workforce issue is a big one, and obviously the change of services, like I know we have spoken a lot about Assertive Outreach teams, for example, supporting the community. Because I worked for those services. It's now different because those services are no longer available.

Q. So issues with staff?

A. Yeah.
Q. Not able to hire staff, staff leaving. Increased demand. Lack of beds.
A. Yeah.
Q. And you describe all of those are putting a strain on mental health services.
A. That's correct.
Q. You, in your third statement, you refer to, or you produce a spreadsheet setting out ratings for Trusts who provide community-based mental health services and it's right to say, isn't it, "Requires improvement" is not an unusual or infrequent rating?
A. No, it's not.
Q. So is it fair to say that up and down the country, there are difficulties and shortcomings in meeting the regulatory standards that you're inspecting against?
A. That's correct.
Q. Now I've spoken -- I've asked you a lot of questions about the Trust. You also regulate private providers of healthcare.
A. That's correct.
Q. In particular, a private hospital that was involved in VC's care, Priory Arnold, was where he spent part of his third admission.

Now, we have looked at the inspection reports

already in the Inquiry, and there are a series, aren't there, of inspection reports which find that hospital to be "inadequate" --
A. *(The witness nodded).*
Q. -- in multiple domains --
A. *(The witness nodded).*
Q. -- time and again.
A. That's correct.
Q. Very serious concerns being raised as to its safety?
A. *(The witness nodded).*
Q. They were in special measures at the time of VC's admission there?
A. *(The witness nodded).*
Q. Now, part of the special measure was that they needed CQC approval before taking on new patients?
A. That's correct.
Q. The documents dealing with that have been provided to the Inquiry, but what's, as it were, the purpose of that approval process? So in what circumstances would the CQC say to the Priory: "Well, no, we've received the referral documents, you can't take this patient"?
A. We would want to understand the acuity levels, for example, just before a new admission is taking place. So we'd want to understand what is happening and we'd want to understand the staffing levels. For example,

their rota, to understand they've got enough staff to support another person coming into that service.

So all those areas, we'd be looking at those areas, that's why we'd put a condition like that into a service.
Q. A special measure essentially is the CQC is not satisfied --
A. Yeah.
Q. -- that the hospital can make decisions for itself --
A. Yeah.
Q. -- as to whether it can safely admit somebody?
A. Yeah, that's correct.
Q. Now, where you have a hospital such as the Priory which is being found to be "inadequate" time and time again, what are the powers available to you? What can you do if you're inspecting, you're going back, it's "inadequate", it's "inadequate"; is there anything more that can be done? At what stage do you take further steps?
A. Yeah, I mean, so, I mean, consistently, if a service continues to be "inadequate", and we -- we've got other ways to try and enforce improvement. For example, we can issue warnings notices and ask for an action plan to be put in place. We can go back to check on that warning notice in terms of whether there's been any

improvement.

We can also give providers, if we get to a position where there's no improvement, we can give a provider a notice of proposal in terms of proposing we're going to look at the conditions we might put in that provider, like limiting admissions, or we might be deciding a proposal around withdrawing registration, for example.

Then we can give them again what is called a Notice of Decision, of our decision, to say what are we going to do, and it might get to a place where we speak to NHS England to require that that service is no longer being commissioned. But then it's the decision for commissioners to make that decision to move patients from that service.
Q. On the issue of commissioning and decisions by commissioners, the Inquiry has heard a lot of evidence, it's heard evidence about the reduction in the number of beds and how decisions by commissioners shape. For instance, a type of EIP service that the Trust provided, you've spoken about reduction in staff numbers.

The CQC doesn't inspect, does it, commissioners?
A. No, we don't.
Q. But commissioning decisions have a really huge impact, don't they, on the type of care that a Trust can provide?

A. They do. They do. I worked in a commissioning service, so I appreciate that. So they do. And I suppose we would get, I think, to some of the recommendations we put in my statement, where I think one of those recommendations is to ask to have an opportunity to look at commissioning as part of the work we're doing, because it plays a big part on -- in terms of services.

MR CARR: Thank you very much. I don't have any further questions for you. We do have your statement, it will be uploaded and we do have the recommendations as set out there.

For me, those are all my questions, thank you.

THE CHAIR: Yes, thank you.

Yes, Ms Patrick.

Questioned by MS PATRICK

MS PATRICK: Good afternoon, Mr Dzikiti. My name is Angela Patrick. I ask questions on behalf of the bereaved families.

I have two issues I want to talk about. The first is about reporting issues up to the CQC and the second is looking a little bit more generally at engagement by the CQC with issues of public safety.

A. Yes.

Q. On the first point, can we look at one document, please. It's WITN0380054.

This is a document the Inquiry is quite familiar with, it's an email from John Brewin, who was the Chief Executive, to other members of the Executive Team and management at the Trust, raised in October 2021.

Now, if you can have a look at that while I return to the questions, you can see some very serious language there, talking about a discussion having been had with staff, the ward managers at lunchtime, it's very sobering at times, harrowing conversation about their concerns, professional, committed, passionate.

Now, the language is very stark: "harrowing", "sobering", "not safe". We see reference to "despondency". "Threatened with closure".

"... if [the] CQC arrived we would be threatened with closure ..."

These are significant concerns being expressed from the staff within the Trust at a time when the CQC had themselves raised concerns that safety and good governance required improvement, aren't they?

A. Correct.

Q. Have you been able, and can you assist the Inquiry, with whether these concerns at this time in October 2021 were escalated up to the CQC by Trust Management?

A. I can't recall exactly the specific issues here being reported to CQC by the management, but like I said

earlier, I would expect part of the regular contact on a monthly basis between CQC and the management of the organisation, you would expect --

Q. I imagine there would be records of correspondence that could be checked.

A. Yeah.

Q. You would know if, for example --

A. Yeah.

Q. -- the day after this email had been sent, there was a message sent to the CQC saying, "We have got some ward staff who are really worried"?

A. I can't say I've seen such, but I'm more than happy to look at that and bring back a response to the Inquiry, if that's acceptable, Chair.

Q. But these -- are these the kind of significant concerns about patient safety, something you'd expect a Trust to notify the CQC about?

A. Yeah, I would, I would. Our expectation is, you know, during this time, especially where we had a relationship manager who worked closely with the Trust, our expectation as an organisation is, you know, leadership to be transparent and to talk about these issues in those relationship management meetings because that would then inform a better way of working with the organisation.

Q. And those kind of management meetings, there will be contemporaneous records kept --

A. Yes --

Q. You'd be able to check them --

A. Yes.

Q. -- and perhaps assist the Inquiry on whether, at this time, these kinds of serious concerns were escalated up to the CQC?

A. Yeah, I would be able to do so.

Q. Thank you. Now, the second topic I want to look at in more general terms, Mr Carr has asked you a number of questions this afternoon about previous engagement between the CQC and the Trust before June 2023. Just to be absolutely frank, there had been concerns raised about a number of matters, but including about risk assessment?

A. That's correct.

Q. About good governance?

A. That's correct.

Q. And about learning from previous incidents?

A. That's correct.

Q. And where you agreed this morning that "Requires improvement", that rating, it's not infrequent, you agree.

A. Yeah.

Q. The fact that it's not infrequent doesn't matter that the actions which the CQC identifies as "must" actions or "should" actions for a Trust, they're not insignificant, are they?
A. No.
Q. They ought to be taken seriously by a Trust and acted upon?
A. Yes, that's correct.
Q. Now, just to be really frank, does the fact that concerns had been raised time and again by the CQC prior to the events of June 2023, does that indicate that there are real limitations in the ability of the CQC and its regulatory work to actually secure real change?
A. I can see it's a fair challenge, I can see it's a fair challenge. But if I look at our engagement with the Trust, and we have used all the powers we've been given, in terms of going in and inspecting, and I think it's one of the organisations we've gone in more often, because of our concerns in terms of the intelligence we gather, and we have issued some warning notices to them to try to get accelerated improvement, hence the reason of issuing those warning notices to those services, and we will continue to monitor those services and continue to raise any issues we believe needs to be addressed.
But also, there is room for us, you know, we work,

you know, and spend time talking to other organisations, for example NHS England, because the driver for improvement, especially in that Trust, it's something which is led by other stakeholders like NHS England, because they are the ones who put an improvement team into the organisation.
So yes, a part of our role as a regulator is to assess and inspect those services and to raise concerns when we see them about the other stakeholders who have got a mandate to help in terms of improvement.
Q. Again, staying pre- June 2023, separately, and Mr Carr has taken you back to that this morning, we've heard about the admission of VC to Priory Arnold.
A. Yeah.
Q. And we've heard that that admission only happened after contact with the CQC. Has the CQC conducted any internal reflection on that correspondence with the CQC prior to VC's admission to Priory Arnold while it was rated "inadequate"?
A. Yeah, obviously on hindsight you look and think: could something else have happened? But that point is you're looking at the acuity levels, like I said, you're looking at the organisation thinking about, actually, how are they performing at this point in time. In terms of acuity levels, do they have enough staff in their

service to support someone in that service. And if those things are in place then you're continuously monitoring that service as well.
As you can see, that service we went in I think three times again over that period because we wanted to keep monitoring that service.
Q. It's a slightly different question. Maybe if I frame it slightly differently. We understand the CQC obviously has this continuing role --
A. Yes.
Q. -- in looking at the service and how it's performing at any point in time. At that point in time, in September 2021, the CQC had a lot of information about Priory Arnold --
A. Yeah.
Q. -- and had rated it "inadequate".
A. Yeah.
Q. They were contacted prior to VC's admission. That exchange is the question I'm asking about.
A. Yeah.
Q. In relation to that involvement by the CQC as an organisation, has there been any reflection within the organisation about its role in that admission?
A. I would need to double check that.
Q. Thank you.

Now the Inquiry has also heard the approach to the least restrictive principle in practice.
A. Yes.
Q. Now this is something which is actively considered by the CQC in its inspections, isn't it?
A. That's correct.
Q. And in fact sometimes Trusts are praised for their approach to least restrictive practice, aren't they?
A. That's correct.
Q. Is there a possibility, a possibility, in that approach that there needs to be a greater reflection on how least restrictive is interpreted when looking at circumstances where there is a known and historic risk to third parties?
A. I think we are quite clear, I mean least restrictive doesn't negate the idea that actually you still need to do, but it's in context, isn't it, it's least restrictive in context of, you know, you've carried out a risk assessment. You understand the needs of that individual, and you're making a decision about how best you can support that person.
Yes, least restrictive, it doesn't mean least restrictive is you don't do your risk assessment or your risk management, or you consider the risks that person poses. Least restrictive means, you know, you've taken

everything into consideration and you're making a decision where best someone is supported.
Q. In the context of this Inquiry, where obviously that language has appeared time and again, and time and again we've seen evidence on difficulties in the approach to risk and risk assessment.
A. Yeah.
Q. Has there been any reflection within the CQC about ensuring that when that language is used, it's understood that that context is critical?
A. It is. I mean, if I talk from a point of being a Chief Inspector for Mental Health and conversations, I would expect the team to understand is it's least restrictive from the sense of supporting someone, right, but it doesn't mean you can say, for example, complete a risk assessment and the risk assessment tells you the risks that person presents is high, and they need to be in hospital. You decide we will move that person from a service, because it's least strategic alternative. It's based on other factors being considered and I think most clinicians, you'd expect any clinician who has read on least restrictive to understand that.
Q. If we can just look a bit again at language. In questions that Mr Carr asked you this morning *(sic)* you've obviously identified your understanding that

Regulations 12 and 17 obviously incorporate an element of considering how a provider approaches risk to third parties, and to public safety.
Now, those Regulations cover the whole of the spectrum of the CQC's work, don't they?
A. They do.
Q. Would it be helpful to have a clear indication, whether in Regulation 12 or elsewhere, that, when considering safety, the CQC must consider the management of risk, which a patient may pose to others and to public safety?
A. Obviously, for the sake of the Inquiry to just explain like those regulations are given to us by the Parliament, but your point, in terms of whether they will need to review and consider that, I think yes, that's for the Parliament to consider. But I would see how helpful that would because it makes it clearer. But that's not a decision for CQC because those regulations are given to us by Parliament. But I do agree with your point you're making.
Q. Thank you. Separately, could specific guidance, whether in statute or in Regulations, or even in the guidance issued by CQC on the approach to inspection in a mental health setting incorporate specific directions, or guidance, to ensure that attention is paid to the management of known risk to third parties and to the

public safety as part of inspection processes as a routine when conducting that work in a mental health setting?
A. I've worked in mental health services for a long time, and everyone agrees that there is always a risk assessment to consider a risk to others, right. And as a clinician, risk to others is quite clear: you're looking at risk to other patients, to staff, to others, to people, to the public in the community.
So when you carry out an assessment before someone leaves the ward, for example, to go on Section 17 leave, you are considering risk to others, to the public. So I would expect clinicians -- I worked as a clinician myself, I would continuously look at risk to others and risk to public safety because every clinician is expected to consider risk to public safety.
Q. Thank you. You've been in this field for years and you'd expect clinicians to know this. It's clear in your mind. Is there, in your experience, any benefit in revisiting how the guidance works to ensure it's spelled out in terms?
A. You know, there is always room to improve. There is always room to improve. It's never enough. You know, we, as a society, have to continue working, and it's something I can take back because I'm also conscious

that, you know, in terms of public safety it's not clearly articulated in CQC, because it sits with, for example, professional regulators like GMC and NMC. But it's something I'm willing to take back to the organisation to reflect on as well.
MS PATRICK: Thank you. No further questions.
THE CHAIR: Thank you. Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon. I ask questions on behalf of the survivors.
Just picking up on regulations that the CQC are responsible for, I just want to deal with the topic of the Duty of Candour and Regulation 20 because obviously that plainly is a general obligation on trust that the CQC have responsibility for; would you agree?
A. Yes, that's correct.
Q. Thank you. So it's really picking up the theme of the notifiable safety incident you've been asked about relating to Feven, the May 2020 incident. I just want to look at the notes that Dr Dracass and Dr Ahmed completed which then fed into the Review --
A. Okay.
Q. -- and how the Review dealt with that incident, please.
A. Okay.
Q. Can we start, please, just by looking at the notes that

were shared that fed into the report, please. Please can we display CQCM0016210. That's CQCM0016210, page 7. Thank you. So these are the notes that are understood were provided from Dr Dracass and Dr Ahmed that then resulted ultimately in the rapid review.

A. Yes.

Q. We can see that they had identified:

"No evidence that the decision not to detain on 24/5/2020 and subsequent arrested, with harm caused to person in flat (due to jumping from window in fear) [led] to a datix related to the outcome or any learning."

So would you agree that they were flagging that as a significant factor?

A. Yes, that's correct.

Q. Right. Then, if we can please just look at part 1 of the report, because we don't see, either in part 1 or part 2, that that significant issue which, would you agree, that engages Regulation 20 was picked up as a particular aspect of the Review of VC's case?

A. That's correct, and I would want to believe they -- when we did the review and we commented around how risk was managed within the Trust and how VC's risk was recorded, there were gaps in some of that work when we looked at it, as a sort of summary of what we saw in terms of risk

management. There were definitely concerns around risk management and risk assessment.

Q. But obviously the fact that the CQC with the obligation to enforce Regulation 20 but also Trust obligations to Datix incident, would you agree, was a lost opportunity from the CQC Review in both part 1 and part 2?

A. Yes, something -- it's fair point. It is fair point. Because our expectation on Duty of Candour is we expect providers to be transparent and open when -- especially when things go wrong, that's an expectation as part of that Duty of Candour regulation.

Q. When harm events are caused?

A. Yes.

Q. I think the first principle of that is, first of all, the obligation to make an apology.

A. Yes, that's correct.

Q. So, as of 2026, no apology has still been provided to Feven, but would you agree that the CQC had an opportunity to flag this significantly in the rapid review, which would have been that the CQC had a role to play to ensure that Feven received the most timely investigation and apology for this incident?

A. Yeah, that's fair enough.

Q. So can we then please look at part 1. CQCM0016517. Just to orientate the report, please. If we can then

please go to page 53 because there's no evidence that the CQC specifically sought the answer to the -- from the Trust as to why they hadn't, on 24 May 2020, Datix incident it, or at some time thereafter, and so we can see there the culture of reporting and learning is dealt with, but if we look in the bottom paragraph, please. Bottom paragraph, thank you.

So from reporting and learning from patient safety incidents, the CQC set a date range for the review of the NRLS data of 1 February 2023 to 31 January 2024, which was for the CQC to assess how well the Trust had monitored and learnt from patient safety incidents.

So would you agree that in the knowledge, that was flagged from Dr Dracass and Dr Ahmed, of a very significant, significant harm event that this was too limited a window that the CQC should have been looking at?

A. Yes.

Q. That at the very least it should have started with a review of the data from 24 May 2020?

A. Yeah.

Q. You agree?

A. That's correct, yeah.

Q. Thank you. Then if we go over the page, please, a further significant theme from that data was

identified, if we look at paragraph 3:

"Of these 13,766 incidents, 96% were no or low-harm incidents. Most incidents were related to adult mental health, forensic mental health, and community nursing specialties. Community mental health, early intervention and crisis services had reported 1,499 of these incidents."

And again, you were asked questions by Mr Carr about whether there was sufficient knowledge in the Crisis Team, and obviously VC was under the Crisis Team.

A. Yeah.

Q. But would you agree, also, that by limiting it in the way it was, that, actually, there was a very specific issue about the Crisis Team's failure to Datix the incident, the May 2020 incident?

A. Yes, there were concerns about Crisis Teams including that, correct.

Q. But again, that doesn't seem to have been picked up, again we've got:

"The high rate of no or low harm incidents across the trust may suggest that staff and leaders are not recording the severity of incidents appropriately. When incidents are reported as minimal or no harm, it is less likely that they will be reviewed by senior leaders and that there will be learning from these incidents. This

increases risk to patients and staff. We will then review this data in further detail in line with [the Trust's] risk reporting procedure ..."

So, again, a really significant 96% which, would you agree, suggests that an under-reporting, to essentially keeping it internal to the Trust, the Review of these incidents, rather than the escalation process when there's a higher level of harm caused; would you agree?

A. It's a fair point.

Q. But even more significant, from what the Feven incident had identified, was not just under-recording of the harm, but a complete failure of the Trust to Datix incident it then would have resulted in the most detailed scrutiny of a serious harm incident; would you agree?

A. That's correct.

Q. This report failed to pick up and audit any other harm incidents where the Trust had not incident reported it in accordance with its obligations; would you agree?

A. That's correct.

Q. Then, please, if we go over the page, concerning information, even absent the consideration of the Feven incident is recorded:

"Feedback from staff, along with evidence of poor quality internal investigations and lack of engagement

with the inquest process, suggest that the trust did not have a learning culture. For example, our review of coroner reports highlighted concerns with the serious incident investigation process or reports, inaccurate or false information, the trust's failure to identify key concerns, and witness statements that the HM Coroner 'found difficult to reconcile with the chronology of events'."

So again, would you agree, really quite significant concerns around how the trusts were approaching incident reporting and investigation?

A. That's correct, yeah. As documented, yeah, that's correct.

Q. Again, just to pick up on -- I'm obviously grateful for the candid way you've accepted the failure of the CQC to pick up on this theme, but would you agree, set against this bad back-story as recorded here, that we've had evidence this morning about problems with the culture and the culture of lack of candour and defensiveness of trusts. Would you agree that if the CQC themselves, and internal investigation reports like this, are not challenging trusts on very significant issues, factually rooted in the investigation of VC, then the CQC themselves are failing in their regulatory obligations to ensure that culture of candour in Trusts? If you

don't hold them accountable, then, again, it's part of the regulatory regime that should be there to call Trusts to account when they fail to comply with candour; would you agree?

A. I would not fully agree to say, you know, CQC has got a culture of not, for example, practising candour or holding organisations when they fail on that Regulation 20, because previously we have at least, you know, prosecuted seven organisations in terms of duty of candour, so I wouldn't say we don't recognise. I do appreciate your points you're making, and there's room to improve, but I wouldn't get to the conclusion that it's not something which is not our priority.

Q. So up until -- had the CQC asked the Trust, then, and investigated why they didn't Datix incident the Feven serious harm incident with an individual with a fractured back?

A. Yeah, that's something I will take back with me.

Q. Can we then just follow through the theme, please, in the second part of the report. CQCM0016518. Again this is just to highlight how again the absence of addressing this very significant issue. So essentially a patient, first episode, it would seem, of psychosis where again a very serious harm event was caused.

We look at page 12, please. In the chronology

summary there is no reference in the CQC's timeline to the fact that between the first incident and the re-arrest, that that harm event had occurred; would you agree.

A. Yes, and I might have to come back to the Inquiry, because we also had a timeline we were given to operate on, in terms of when to look at and when to finish in terms of the Review.

Q. But in terms of what happened to Feven, significantly, VC went home following a Mental Health Act Assessment under the care of the Crisis Team; the issue that had caused the re-arrest was the harm incident. So would you agree that there's no reference to it there.

A. No, I can't see it here, no.

Q. Then if we go to page 20, please. And if we look, please, at the bottom paragraph. It references:

"... the [Crisis] Team can be seen to have been appropriate and following Mental Health Act ... Code of Practice guidelines to provide person-centred care that offers the least restrictive intervention."

But then goes on:

"However, the fact that he was re-arrested so quickly after leaving custody from his first arrest raises questions about the quality of the initial mental health assessment and the assessment of risk that took

place. VC had presented with a clear description of psychosis with paranoid delusions, which he had acted on."

Over the page, please. So no reference to Feven there --

A. Yeah.

Q. -- and the harm. Then:

"Following his second arrest, a Mental Health Act assessment was carried out that led to VC being detained in hospital under section 2 ..."

And then the Section 2 reference there.

And:

"On his first admission to hospital, it was known from the Mental Health Act assessment that [he] was psychotic. However, no psychological assessment or interventions related to psychoeducation ..."

So again, no reference there to the notifiable safety incident that you have referenced.

A. Yeah.

Q. Would you agree that again, when it's the CQC's obligation to enforce Regulation 20, the complete absence, even in this factual timeline where there had been a notifiable safety incident was a significant failing in this review report?

A. Yeah, it's not -- it wasn't included in this passage(?)

which was, yeah, a shortfall on our part.

Q. Just finally, sorry, just so we understand the process in light some of the evidence we heard this morning from NHS England, please can we just look at your paragraph 33, please, of your first statement WITN0091001. I hope that's the right reference. Paragraph 33. Thank you.

If we could move forward, it's just context you give from paragraph 33. I'm very grateful. Thank you.

This is where you're dealing with notifications about death, and obviously we know there's been some wider homicide reviews linked that had occurred pre-the incident with VC.

If we look then, just following it down, at what you say at paragraph 35, that:

"The notifications to NHSE via NRLS are shared with [the CQC] under a data sharing agreement and are incorporated into our intelligence and monitoring."

So can I ask you, has the CQC tracked to check that the Trust, in respect of the earlier incidents before VC's attack where there had been a homicide, that they had followed the appropriate reporting through the NRLS as it was, and that found its way to the NHS?

A. I would need to look at that, because the information doesn't directly come to the CQC.

Q. I appreciate that.

A. It goes to NHSE and then NHSE then sends that information, so I wouldn't want to mislead the Inquiry and answer that. I would need to take that back.

Q. But would you agree, the question was asked this morning of the NHS witness, and I think she wasn't involved at that time, but is that something that that can be audited, to check that that necessary auditing of those incidents did follow that correct route and that therefore that correct data was then shared with the CQC?

A. I would need to take that back because, yeah, it's something that's done by NHS England so I would want to take that back.

MS CARTWRIGHT: Thank you very much.

THE WITNESS: Yeah, thank you.

THE CHAIR: Yes, Ms Heaven.

Questioned by MS HEAVEN

MS HEAVEN: Good afternoon. Just some short questions on behalf of VC's family, and it's on communication with families and carers.

We don't need to turn it up but it's your witness statement paragraph 220. So the issue of families and carers and communication came up in the part 1 report and the part 2 report, didn't it?

A. Yeah, it did.

Q. Just in terms of the part 1, so that obviously is looking at a number and cluster of cases, and this is 220, the feedback from families and carers indicated that:

"The quality of care planning, risk assessment and involvement of patients and their families and carers was inconsistent ..."

A. That's correct.

Q. So this was indicative, wasn't it, of a systemic failure?

A. *(The witness nodded)*.

Q. It wasn't a one-off, it was happening in lots of cases; is that fair?

A. That's correct.

Q. Then in the part 2 review, the CQC spoke to VC's family and they told the CQC that they did not feel engaged by VC's care team. And is it right that when the CQC then investigated this concern more broadly, they were critical of some aspects of the communication with VC's family, and I think in particular at the point of discharge in September 2022; is that fair?

A. That's correct.

Q. As a result, we know the CQC made a recommendation to the Trust to improve this aspect of communication with

families and carers?
A. That's correct.
Q. Now, the Theemis Report was also critical of aspects of the Trust's engagement with VC's family. They highlighted the lack of co-produced care plans with the family around safety planning. They also talk about scenario planning, to help support VC and his family, for example, there was no Crisis Support Plan particularly in September 2022 when VC was discharged. Presumably the CQC would agree with that finding from Theemis?
A. Yeah, that's correct.
Q. Just moving on, then, to what the Trust says they were doing about this. So this is before 2023. The Inquiry has heard from Julie Attfield that the Trust realised in 2021 and 2022 that they had become distant from carers and families and that they had work to do, and that it became a trust quality priority to make improvements, and there was a reference to care and support workers being employed.

Did the CQC investigate the actions that the Trust had taken in 2021-2022 to make improvements on communication with families?
A. I would have to check that, I would have to double check that. Because there has been a lot of regulator

activities with the Trust, so many inspections we have done, so I would need to really look at that and come back, if that's okay.
Q. I'll move on, then. In terms of another Theemis recommendation, they also made a recommendation, and it's page 28 internally of their report for the record, they were critical about the use of Triangle of Care, which is a concept that you're probably familiar with that's been talked about in the Inquiry?
A. *(The witness nodded)*.
Q. They said the Trust should develop processes in line with national guidance to support effective family engagement using the Triangle of Care and this should inform decisions on care treatment and the management of safety and risks.

Now, this doesn't feature in the CQC Report, but presumably the CQC would agree with that recommendation from Theemis.
A. Yeah, but it is -- yeah, it is critical in terms of supporting people.
Q. Triangle of Care is a very old concept, isn't it?
A. Yeah, yeah.
MS HEAVEN: Thank you very much, those are my questions.
THE CHAIR: Yes, any questions? Yes.

Thank you.

Questioned by THE CHAIR

THE CHAIR: Yes, just a couple. We heard this morning, I think from Jessica Sokolov, about in a sense a fragmentation of oversight and review of Trusts' performance. Do you think there is any difficulty in ways of dealing with it that you get certain responsibilities, NHS England have other responsibilities, and you don't always get the same information?
A. From my experience, I believe there is. We are quite clear about what we do at CQC, in terms of regulation or inspections and assessments of services. But we also have opportunities to speak to NHS England. So when we -- there are serious concerns, we can have those conversations with NHS England.

That's why I was saying earlier on, I think, you know, for me, I believe NHS England are there to support with the improvement because they've got opportunities of going in and working with organisations.

So I think, in terms of sharing of information, I think where there is a need to share information, I've not encountered any challenges in terms of sharing of information.

I think we are quite clear in terms of the information that's needed to be shared.

THE CHAIR: Thank you. Just, finally, you've said that you'll come back about a number of issues.
A. Yes.
THE CHAIR: If you can do that, that would be very helpful. Thank you.
THE WITNESS: Thank you.
THE CHAIR: Right, we'll take a break now until 3.25.
(3.10 pm)

(A short break)

(3.25 pm)
MR WESTON: Chair, I call Amanda Sullivan.
THE CHAIR: Yes.

AMANDA JEAN SULLIVAN (affirmed)

Questioned by MR WESTON

MR WESTON: Mrs Sullivan, you've prepared a statement dated 3 December 2025 for the Inquiry.
A. Correct, yes.
Q. And that statement is true to the best of your knowledge and belief?
A. Yes, it is.
Q. You are the Chief Executive Officer and Accountable Officer of NHS Nottingham and Nottinghamshire Integrated Care Board?
A. I am.
Q. You've been in that role since the ICB was incepted on

1 1 July 2022?
2 **A.** That's correct.
3 **Q.** Prior to that, you held the like role, Chief Executive
4 and Accountable Officer of the predecessor, Clinical
5 Commissioning Group?
6 **A.** I did, yes.
7 **Q.** You held that role in the CCG since April of 2020?
8 **A.** That's correct.
9 **Q.** Integrated Care Boards, they're a statutory body which
10 bring together NHS organisations and partners to improve
11 population health?
12 **A.** Yes.
13 **Q.** And to establish shared priorities within the local NHS?
14 **A.** Yes, that's part of their role, yes.
15 **Q.** ICBs replaced Clinical Commissioning Groups, CCGs, as
16 the local statutory bodies in July 2022. That was
17 a nationwide change, wasn't it?
18 **A.** That's correct, yes.
19 **Q.** ICBs have responsibility also for planning to meet local
20 health needs?
21 **A.** Yes.
22 **Q.** Including mental health needs?
23 **A.** Yes.
24 **Q.** Allocating resources?
25 **A.** Yes.

1 **Q.** Ensuring services are joined up?
2 **A.** Yes.
3 **Q.** And overseeing delivery?
4 **A.** And, sorry?
5 **Q.** Overseeing delivery?
6 **A.** Yes. We monitor the services that we have commissioned,
7 yes.
8 **Q.** You don't regulate the trusts?
9 **A.** No.
10 **Q.** But you hold the trusts to account in terms of their
11 service delivery?
12 **A.** Yes, we do. Within the contractual arrangements that we
13 have, yes.
14 **Q.** The predecessor CCG, that also was required to ensure
15 physical and mental healthcare needs of the population
16 in the area?
17 **A.** Yes.
18 **Q.** It purchased healthcare services and managed NHS budgets
19 for those areas?
20 **A.** Yes.
21 **Q.** CCGs, like ICBs, were also required to hold Trusts to
22 account in terms of service delivery?
23 **A.** Yes, within the remits of the contracts that we hold
24 with the providers, yes.
25 **Q.** Can I take you, please, to RLIT0000065. We see here the

1 National Service Act 2006, Section 14Z34:
2 "Duty as to improvement in quality of services."
3 It says:
4 "Each integrated care boarding must exercise its
5 functions with a view to securing continuous improvement
6 in the quality of services provided to individuals for
7 or in connection with the prevention, diagnosis or
8 treatment of illness.
9 "In discharging its duty under subsection (1) an
10 integrated care boarding must, in particular, act with
11 a view to securing continuous improvement in the
12 outcomes that are achieved from the provision of the
13 services.
14 Then at subsection (3) it says:
15 "The outcomes relevant for the purposes of
16 subsection (2) include, in particular, outcomes which
17 show --
18 "the effectiveness of the services;
19 "the safety of the services; and
20 "the quality of the experiences undergone by
21 patients."
22 Do you see that there?
23 **A.** Yes.
24 **Q.** "Safety of the services", that would include safety of
25 the patients?

1 **A.** Yes.
2 **Q.** And also safety of the public?
3 **A.** Yes.
4 **Q.** The CCG that existed before the ICB, that would also
5 have a duty to provide like, in a likewise way, safe
6 services?
7 **A.** Yes. To commission and oversee, not to actually provide
8 services. We don't actually provide services.
9 **Q.** To secure the safe services?
10 **A.** To secure them, yeah.
11 **Q.** Both an ICB and a CCG, they're governed by a board,
12 aren't they?
13 **A.** Yes, the CCG was governed by a governing body which was
14 made up of constituent member practices, and the ICB is
15 overseen by its own board, yes.
16 **Q.** In relation to the ICB, please, the Integrated Care
17 Board, there is a requirement, isn't there, to have
18 someone with mental health experience on that board?
19 **A.** There is.
20 **Q.** Where does that requirement come from?
21 **A.** It comes from the legislation that brought into
22 existence Integrated Care Boards and also their
23 associated integrated care systems, which is the
24 collaborative partnership arrangement, and it required
25 ICBs to have somebody on the board with -- who would

represent the sector in terms of what the needs of the population are.

Q. We've heard from Professor Lade Smith that there's going to be quite a lot of reform and ICBs are going to have a new enhanced role in the structure, is the suggestion that's there. Would there still be a requirement, as far as you're aware, to have mental health experience on the board?

A. At the moment, it does look as though that will be the case.

Q. It does look like it?

A. At the moment. It's still going through its legislative processes, so we will have to wait for that, but at the moment it does look like that will remain the case, and we -- I would completely support that. I think it's very necessary.

Q. Going back in time before July 2022, did the Clinical Commissioning Groups, did they need to have someone with mental health experience on that governing body that you've mentioned?

A. No. We did -- we did, though, believe it was important, and we had clinical advisors who were able to help us with the commissioning of mental health services, but it wasn't a requirement that we had somebody with that expertise on the governing body of the CCG.

Q. I want to focus on the period leading up to the Nottingham attacks in June of 2023, please, if I may. I want to ask you questions in your role as the Chief Executive and Accountable Officer of both the CCG up to July of 2022, and the ICB thereafter.

A. Yeah.

Q. It's right that an independent review report was prepared by Theemis that reached a number of conclusions as to the work done by the ICB prior to the attacks?

A. Yes.

Q. You and the ICB accept the findings of the Theemis Report?

A. Yes, we do.

Q. Can I take you to that report, please. It's NHNB0018966. It's right that this report makes a number of criticisms of the ICB.

A. It does.

Q. I want to pick out some of the key themes from the report. I want to do it topic by topic, if I may. Can I start with governance and oversight by the -- so governance at the ICB and oversight by it. Can I please take you to page 239. So at the very bottom of the page, please, it said:

"Several interviewees [and this is the section about the ICB] told the independent investigation ..."

And there were a number of individuals from the ICBs were interviewed as part of the Theemis investigation; that's right, isn't it?

A. That's correct.

Q. "Several interviewees told the independent investigation that it was identified in early 2023 that the System Quality Group meeting needed to be strengthened."

The System Quality Group was responsible for ensuring -- can I just ask you about that: the System Quality Group was responsible for ensuring that quality was embedded in the system; is that right?

A. Yes, the System Quality Group was a new group that was formed in light of the ICB requirements to convene the system and take a more -- it blurred the boundaries between the commissioners and the providers and local authorities, so that the ICB was the convener of a more system-orientated approach.

So we retained, if you like, the commissioning statutory quality committee within the -- that essentially carried on from the ICB to the -- from the CCG to the ICB, but there was a new requirement to have a System Quality Group, which linked to the policy changes, and it was very much about more of a system view and system oversight and shared ownership of quality issues, and the System Quality Group was

therefore in its infancy, and it did need to be strengthened.

Just in terms of some additional context as well, from -- we were preparing to become an ICB, and establish the ICB and the ICS up until '22, but from 2020, from March 2020, that was in the context of we were in the national pandemic and we were -- the way that we exercised our commissioning and contracting arrangements was determined nationally because it was part of a major incident.

So there was -- so for two years we had no contractual arrangements with the Trust, and then following that it was a much more lighter touch year. So in the -- I think that's very important context for what's in this report because the System Quality Group was new and in addition to, if you like, the more traditional ICB or CCG commissioning internal governance; this was about system ownership.

So I think it is true, and we accept the report completely, but it's just some important context around that statement.

Q. I think in your statement you say that in terms of Covid things were back to normal in about mid-2021.

A. No, the national -- we had some groups in place then, but we were still under a national mandate. In fact it

varied between level 4, which is nationally mandated, to level 3, between March 2020 and May 23, in terms of the level of national requirement because obviously there was a national effort required to deal with the pandemic.

But I think the 2021 piece is relevant in terms of some of the groups that were operating, that originally we stepped down a lot of governance because face-to-face contact was not really felt to be safe. Once there was the vaccine early in '21 and people were more vaccinated, it was felt to be more safe to resume some of that governance. So I think that's what that statement refers to about '21.

Q. Can I take you over the page, please. It says there:

"Comment:

"The approach to identification and management of risk at that time did not adopt recognised practices to ensure controls are considered and evaluated for their effectiveness. As described earlier, groups referred to as 'Quality' do not infer management of risk as required to understand safety."

Can I take you over the page once more. Second paragraph there at the top:

"Whilst the role of understanding quality of the services they provide sits with the Trust, an

interviewee from the ICB told the investigation that there was an overreliance on the Trust informing the, ICB of concerns and then the ICB seeking assurance from the Trust that steps had been taken to improve areas of concern rather than the ICB seeking to assure themselves."

And that's a finding that you agree with?

A. I did, yeah, yes.

Q. Further down the page, in the box, it says:

"Finding

"There were limitations with the assurance and oversight arrangements at the Integrated Care Board in 2023. The arrangements were not formalised or robust to provide the opportunity to fully identify signals of issues with safety and risk. Nor were the governance arrangements mature enough to triangulate intelligence with partner organisations."

In terms of robust oversight, that starts at the top, doesn't it, in terms of the Board?

A. Sorry?

Q. In terms of robust oversight, that starts at the very top of the ICB, doesn't it, of the Board?

A. Of course, yeah.

Q. You told us that the Board had a requirement to have someone with mental health experience on it?

A. Yes.

Q. In 2022 and 2023, the person with mental health experience that represented that side of things was the CEO of the Nottinghamshire Healthcare NHS Trust; is that correct?

A. That is correct. He was the representative fulfilling that role. We did also have a Non-Executive Director and we had a Clinical Advisor, completely separate to that, but who helped us with our commissioning oversight.

The inclusion of a provider Chief Executive on the ICB board was very much in line with normal practice then, and we also had other partner members, again, it was a requirement, who were Chief Executives of other providers as well. So that is the case, and that was standard practice at the time.

Q. The Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board, that was a board that was responsible for transformation of mental health services in the area?

A. *(The witness nodded)*.

Q. That Board was led by the Nottinghamshire Healthcare NHS Trust, wasn't it?

A. It was, and again that was very much in keeping with the philosophy and the policy of having an Integrated Care

System, the ICS, that came into being at the same time as the ICB and the notion of distributed leadership across the health and care system. So again, that was very consistent.

What we did was make sure that that stayed in its lane in terms of being a partnership development group and it didn't cross into either assurance or the core commissioning responsibilities, and we made sure that there was clear blue water between that and any commissioning decisions that would have been taken to avoid conflicts of interest. But the role of the Chief Executive of the Mental Health Trust as having a leadership role in the system was again standard at that time, and remains so in the legislation until it changes.

Q. So advantages in terms of working together, collaboration?

A. Yes.

Q. But in terms of oversight --

A. Yes.

Q. -- this can create, even though it's standard, it can create potential conflicts or blind spots, can't it?

A. In terms of oversight, we would make sure that we kept that, as I say, kept that as a distinct process. That group was more of a partnership development group,

strategic development. It wasn't in any way conflicting in terms of interests or the oversight.

But I take your point, I think it's a point well made, and it's an ambiguity within the policy that we have tried to manage very carefully over the years.

Q. The Theemis Report was concerned that some of the oversight problems may have been attributable to the change --

A. Yes.

Q. -- from the CCG to the ICB.

A. Yeah.

Q. But in your statement you don't agree with that, do you? You don't quite agree with that?

A. I think the change was a contributory factor, in that we -- the way that we went about exercising our duties was different. It had to be much more collaborative. It linked to the integrated care system. As I say, there was a deliberate blurring of boundaries between commissioning and provision in order to try and get more of an integrated care approach and make the best collective use of resources within, you know, within the allocations that we had.

So that was the policy environment at the time. I think it contributed. Also, it meant that we were going through organisational change, as we moved. But

I think the most -- in terms of how we operated, we literally -- the CCGs in Nottinghamshire merged on the 1st April 2020 and within two weeks we'd completely changed our operating model to operate within the pandemic and to coordinate the pandemic response. So I think the operating model changes were partly policy driven and they were partly due to the pandemic in the early 2020s.

Q. Can I take you please to WITN0223001, page 48.

Just picking up on that point, this is where you deal with the changeover from the ICB, the CCG to the ICB, and you touch upon the level of scrutiny. And you say:

"On 1 July 2022, the ICB was legally established. The organisational transition from the CCG to the ICB did not impact on the level of scrutiny placed on NHFT, as the CCG completed a thorough due diligence and handover process."

So your evidence there is that the transformation was not a relevant factor for the level of scrutiny on the Trust.

A. No, can I explain that a little bit? So the reason for that is because, as I said, we kept an internal Quality Committee, and there was a very structured handover and handover report between the issues that we were

considering and overseeing in the CCG, and that was as part of the due diligence process, with the change in the organisational form, there was a handover to the new Quality Committee around the -- so that's kind of what sits behind that statement.

Q. Okay, but you're saying there in your statement that it didn't impact the level of scrutiny on the Trust.

A. No. That in and of itself didn't, no.

Q. So if there were problems in terms of scrutiny of the Trust and oversight, they pre-dated July of 2022, didn't they?

A. I think there were varying levels of concern, as you'll know from our submission and from the evidence, during the time kind of from 2019 through to 2023, there were varying levels of concern about the Trust and varying different issues, some of which appeared to sort of get resolved and then other things happened.

So overall -- and in 2022 we did have the Trust on an enhanced surveillance which was a kind of a recognised classification of how much scrutiny, quality scrutiny, the Trust required. So I think we did -- we were very careful to make sure that that continued.

Clearly, I think some of the observations in the Theemis Report around the level of some of the scrutiny

and the triangulation of that, I think we have learnt more from that and we've developed more metrics which can tell us more about the safety of the services at the frontline than we had at the time. At the time we had more metrics in some of the sectors than in the mental health sector. That wasn't uncommon and what we've done, particularly with the SafeNow dashboard, is to make sure we have a clearer oversight and clearer metrics around the issues that are sadly being investigated in this Inquiry.

But -- so I think that's really at the heart of some of those statements.

Q. Can I pick up on another theme from the Theemis Report, please, and that's the issue of safe mental health community teams.

A. Yeah.

Q. Can I take you NHNB0018966, page 236. Towards the bottom of the page, six lines from the bottom it says:

"ICB interviewees describe their perception that the focus on specialist services impacted on the level of attention paid to other services such as the community mental health teams. An interviewee described that seeing local community mental health teams as a core function has been missing."

Can I then take you to 243, please. Towards the

bottom of the page:

"An interviewee from the ICB discussed the April 2023 Quality Improvement Group meeting. Their sense was the Trust was telling them lots of things but were not assuring the ICB that they had a grip on the full range of services that needed to be deemed as safe."

Then if I can take you, please, to 246, at the bottom there it says the:

"Finding

"Evidence suggests that at all levels of the regional healthcare system, there was a level of knowledge about the challenges faced by the Trust. Despite this knowledge, the risk remained for Trust frontline staff to manage."

So just picking up on the themes from Theemis about the deprioritisation of community mental healthcare and this issue about risk being left to staff, did you have an opportunity to hear yesterday the evidence of Dr Vidyah Adamson?

A. Yeah.

Q. She was the Strategic Clinical Lead for Early Intervention in Psychosis at the Trust from January 2020 to late 2021.

Can I take you to one of the documents that she

referred to which she told us was within the sight of the CCG at the time. It's NHFT0020008. So this is a document headed:

"Nottinghamshire Early Intervention in Psychosis Service: Workforce Configurations Option Paper".

Dr Adamson told us that this was a report that was provided to the board and provided to the Clinical Commissioning Group. You'll see that it says:

"The purpose of the paper [is to identify] the current workforce model and the associated financial envelope available for the Nottinghamshire Early Intervention in Psychosis ... service ..."

It says:

"[It] does not support the Mental Health Long-term Plan ... Requirement ..."

Can I take you, please, to page 3. Towards the bottom of the page, it talks about "Care Coordinator Caseload Ratios". It says:

"National guidance stipulates that a 15:1 service user to care coordinator ratio is required to achieve compliance with both the timely access standard and the effective treatment standards for an EIP services which only serves individuals experiencing a first episode of psychosis."

Can I then take you over the page to see the

information that was provided to the CCG. We can see on the right-hand side of that column that the patient ratio at a number of different teams, including the Nottingham City team, were around, many of them almost approaching twice the recommended caseload there, Nottingham City at 27:1 caseload.

You were the Chief Executive Officer -- Chief Executive and Accountable Officer of the Nottinghamshire and the Nottinghamshire CCG at this time. Were you aware of this problem and what did you do?

A. So could you just tell me the date of this paper?

Q. Yes, of course: August 2020.

A. Okay. Thank you. Could I respond, because you've referred to a number of different points --

Q. Please.

A. -- as we've gone through, so can I respond to those?

So in terms of the focus on community services, I think we did have some concerns that the -- and I think this is what is meant in the comments in the Theemis review --

Q. Well, those aren't your comments, are they? They're comments of others.

A. They're not, but I think at the time we were aware that the Trust had a very broad range of services. Some were nationally the Rampton, which is nationally highly

specialised and commissioned. There were a lot of regionally commissioned specialised services and then the local services that we commissioned, which was around 40% of the income for the Trust. We did sometimes feel, as local commissioners, that some of the issues at Rampton and some of the specialised services were very much in the sight of the Board and taking up quite a lot of Board attention. Quite rightly so, they're extremely important services, but I think that is what that is trying to convey.

I think we did feel as the local commissioners that sometimes the very broad range and geography of services that the Trust provided did mean that we needed to keep a very sharp focus on the local services.

In terms of the Early Intervention in Psychosis, I don't recall the specific paper, but I do recall the issues, and around that time, it was when Early Intervention in Psychosis was really very much being developed, as I recall it, and there were some NICE standards that were launched which included a number of domains, including things like the activity, the workforce, and we did a lot of work with the Trust.

Following this paper, I think this would have been a position at that time. Since that time we've done a lot of work to make sure that the EIP standards and the

NICE standards are achieved, and they are, and some of that was around access into the service within two weeks and working with this service even when a full diagnosis hadn't been made.

So we did make sure that the Trust achieved the NICE compliance in relation to EIP, around that time. That probably would have been --

Q. When did that happen?

A. It would have been -- it probably would have started in earnest around this time and then kind of up to 2021, 2022, 2023.

Q. Can I take you forward in the chronology to March 2021, please. NHFT0020001, page 1. This is another document from Dr Adamson dated March of 2021, as I've said. Can I take you to page 4, please. A slide there at the top about "Challenging Service Related Issues".

Then if you look at the notes further down in terms of what was being said by Dr Adamson at this presentation, second paragraph:

"I think it's fair to say that the EIP service in Notts Healthcare was really struggling -- the dedicated service ... had been there was disbanded in 2017 -- just as the access and waiting times standard was introduced."

So four years since that waiting time standard was

introduced.

"There has been no investment into the service over many years. There were no dedicated EIP staff and clinicians held mixing caseloads. Therefore, it was unclear if any specific EIP work was happening or what the total size was of the EIP caseload was."

So a very concerning picture in March of 2021.

A. I think -- as I say, I think that would have been concurrent with the NICE standards coming out and the work that we did to secure those NICE standards. So I think, you know, this is clearly an accurate picture at a point in time.

Q. Dr Adamson's evidence was that the CCG were aware of the concerns that the EIP team was struggling, failing, at this time; is that right?

A. In 2017?

Q. In 2021.

A. In 2021. Yes, it was very much we were -- it was an area that we were very closely trying to develop and, as I say, we used the NICE framework which was the standard framework to say what would a better functioning service be? And we did invest in that specific service around those years. So that would be consistent with the time that the NICE standards we were implementing, so yeah.

Q. Another area of community mental health care that we've heard quite a lot of evidence about in this Inquiry is as regards Assertive Outreach.

A. Yes.

Q. The CCG commissioned the Trust to provide dedicated Assertive Outreach teams until 2019, but then stopped the Assertive Outreach teams and amalgamated them with local NHS Trusts.

We've had local mental health teams. We've heard evidence from Julie Attfield, Trust Executive Director of Mental Health, that this was a significant loss to the Trust. We've heard also, in fairness, that many Trusts stopped having dedicated teams in this period.

But that wasn't universal, was it? The evidence is that from a near universal coverage, it's about a third by the time we get into the early 2020s. So there was a choice to be made in terms of commissioning Assertive Outreach; do you agree?

A. There was a choice, and the preference that was expressed by the Trust at that time was very strongly that the national evidence didn't support that overall and it was their clinical view, their view that actually it would be better to amalgamate the Assertive Outreach Team with the community teams, so -- and because that appeared to be the national direction of travel we

agreed with that and it came out of the contract as a specific requirement, as a separate team in 2019, as you say. But it was very driven by the clinical and policy environment at the time rather than the CCG leading that viewpoint.

Q. When the CCG agreed or in fact chose to stop the commissioning, because that was its responsibility, was there any impact assessment done locally on how that would impact actual patients or those that are hard to reach? Was any kind of analysis done, in terms of the local population, which is the duty of the CCG?

A. Yes, well we would have taken into account the sort of policy at the time and followed that as a guidance, and the intention was very much that the team -- it wasn't that people with the most complex needs would not get that care; it was more about the teams integrating so that there was more spectrum and a more integrated pathway. So that was the intention around that.

But as I say, that was something that we responded to, because that was the national direction of travel. It wasn't something that we initiated. But, as I say, we didn't -- obviously now with hindsight we know that that has had consequences. At the time, it was felt to be advantageous to the population because it would join up those pathways of care more.

Q. Can I look at another theme from the Theemis Report, please, and that's risk assessment and risk management. If we can go back to the Theemis Report please NHNB0018966 page 240.

There's a comment there about:

"Management of risk did not recognise that the safety was included in it."

I've already taken the Inquiry to that particular part.

Can I take you to 242, please.

A. Sorry, can I just make a point of clarification on that?

Q. Please.

A. So I think in the Theemis Report the implication is that quality is only about the experience of care. We very much took the view that was in the legislation you took me to at the beginning that quality includes safety, effectiveness, and experience. And we've always built that into our quality assurance mechanisms. That has always been there.

So I think the investigators felt that we'd taken a partial view of quality and we weren't really considering safety, but it was inherent within the mechanisms.

Clearly, it sadly wasn't able to prevent what's happened, but it was -- that was true, but just to say

that safety was in our consideration as well as quality in a broader sense.

Q. Can I take you to 242, please. The bottom paragraph there:

"In relation to safe care, one of the Trust's patient safety priorities for 2023/24 was to improve clinical risk assessment, management, and safety planning in support of reducing suicide and self-harm. There were a number of actions documented but under assurance it is documented that the ICB had 'limited assurance' in this area."

So it had limited assurance in terms of clinical risk assessment; is that correct?

A. It did, and that was particularly in relation to the CQC findings around that time and we were monitoring the Trust's action plan in relation to the CQC finding, and there had been some incidents around this. So -- and we thought some improvements had been made, but we weren't fully assured that they were fully embedded and likely to stick. So that's why we came up with that conclusion.

Q. 248, please. The "Finding" of the report is that:

"The processes in place for oversight and assurance did not provide a systematic approach to risk management."

You've mentioned the CQC report from 2019. That identified clinical risk assessment as a mandatory area for improvement. That was then reviewed in September 2020.

Can I take you, please, to NHNB0004170. This is a CCG document, as I say, dated 24 September 2020. Can I take you to page 6, please.

"Quality of services -- safety".

"Robust risk assessments for management of known risks ...

"Buddy programme to be rolled out across all areas and audit of compliance undertaken."

It says:

"CCG Support required

"Nil identified."

Was there any discussion at this time as regards whether the risk assessment policy at the Trust was appropriate and fit for purpose?

A. Yes, there was and this is specifically around Adult Mental Health and in relation to, as I say, some of the incidents. And yeah, the Trust had said that a buddy programme would be a good way of -- and we agreed -- in terms of getting a sort of fresh eyes on how the risk assessments were conducted. And so I think the "nil identified" bit for "CCG Support" was the fact that that

was in the Trust's gift to complete that action. It was clearly outstanding at that time and escalated through our committee structure.

Q. But my question was about the policy. Was the Trust policy discussed? Was it concerned as to whether it was up to best practice?

A. Yes, that would have been part of the discussion.

Q. We've heard evidence that at this stage the risk assessment policy was out of date.

A. Yeah.

Q. Now if this was out of date and you discussed it, that would have been identified at this stage, wouldn't it?

A. Yeah, I think we would have -- we would have discussed the approach that was taken and whether that was rooted within the policy in the Trust, and we might not have looked at the exact document but we would have checked that the approach that the Trust was taking was appropriate. And clearly there were shortcomings there.

Q. If that had been identified, you -- something would have been done about it in 2020, wouldn't it? And the inference is that you weren't aware of what the policy was or that it was out of date.

A. Yeah, I think that is an inference. I think -- yeah, I think we would have checked what the practice was, possibly not the actual policy, but the approach would

have been very much in the quality assurance processes.
Q. In your statement, I won't take you to it now, but you talk about that in 2020 you were concerned that the Trust had a higher level of serious incidents --
A. Yes.
Q. -- than other --
A. Yes.
Q. -- than other providers in the area; is that correct?
A. Yes.
Q. How did you find that information out?
A. They reported through on a system through to the commissioner, so we could see -- at the time that they're reported, we look at them and then we oversee the subsequent investigations, and we actually sign them off. And sometimes we don't sign them off; we send them back to the Trust and say, "We think you need to look at this again" or other things.

So that's how we would have known the number. It was a system that was used at that time. It's a standard system across the NHS.
Q. In the wake of that, there were, in the following years, a number of concerning incidents --
A. Yes.
Q. -- touched upon with Dr Sokolov this morning.
A. Yes.

Q. There was a homicide --
A. Yes.
Q. Two potentially attempted homicides that occurred in the year before the Nottingham attacks.

Were you aware of those three incidents?
A. We were and we were particularly -- we will have seen the escalations through the serious incident route. Also, there is also a separate governance, if you like, that's multi-agency, the statutory governance, whether it's the Community Safety Partnership or safeguarding boards that involve the police and other agencies.

We would also be part of those multi-agency processes, and sometimes the governance for oversight of those investigations, like a domestic homicide review, for example, would be through that multi-agency route and we would monitor the health or the Trust-specific actions that contribute to that.
Q. So in terms of these three serious incidents, you were aware at or around the time of them. We've heard evidence from the Trust that there was a long delay in learning --
A. Yeah.
Q. -- in relation to two of those cases.
A. Yeah.
Q. It was thought that they needed to wait for a police

investigation and so the learning was not --
A. Yeah.
Q. -- obtained for a number of years. Those are delays that were accepted by the Board to be serious governance failures.

Now you were aware of these particular incidents. Did you ask about when the learning would be available in relation to them?
A. Yes, we would have, because if a serious incident is reported, there's two stages of it. There's kind of an immediate review to see what, if there's any immediate actions that need to be taken and we would have made sure that happened.

Then, as you say, sometimes the longer-term investigations and understanding in more depth what's happened can take longer and sometimes if there are a number of different -- if there's a criminal proceeding happened, for example, then agencies would work together to agree the sequence of events around that, but we would expect that initial steps that needed to be put in place would be put in place from those events.
Q. The evidence we've had is the learning -- the substantive learning took years.
A. Yes, and sometimes, yes --

Q. And there's a concern, it's accepted, particularly by those that sat on the Board, that they shouldn't have waited for the police investigation.

Did you ever communicate, given that you were aware of this, did you say to the Trust "We need to learn sooner about this and don't wait for the police investigation"?
A. Whether it was specific to the police investigation, we were concerned about the length of time it was taking to complete investigations more generally. We clearly are very respectful of criminal proceedings and wouldn't want to compromise those in any way.

But in terms of the learning and the amount of time it was taking to complete investigations into serious incidents, we were escalating that. So about that specific case, we'd need you know, there would be some specifics there.

But in answer to your question, we would -- we were raising concerns about the timeliness of investigations and the thoroughness of them and whether they were fully embedded or, because things recurred. So that suggests that things had perhaps been done in the short term but not really embedded and then they recur. So yes, there was a theme about learning.
Q. The Trust, a number of witnesses, have accepted that

this was a serious governance failure, this was a serious governance failure that the ICB was aware of. It was a failure of the ICB not to ensure that these investigations were expedited?

A. We were very challenging about the timescales for the investigations. I think we used the levers that we had and we did escalate our concerns to the regulators as well, which is part of our duty. If we are the eyes and ears on the ground, we obviously need to maintain a constructive working relationship with the Trust, we need to get to the bottom of things, but also we do escalate concerns and -- *(overspeaking)* --

Q. When was that escalation to the regulator, please?

A. So --

Q. About these three incidents.

A. That would have been part of an escalation about serious incidents, and we would have --

Q. When was that?

A. Well, we have an ongoing dialogue with NHS England and the CQC. That varied in its format and things over the time of this time, because the governance of it changes.

Q. When did you tell the CQC about these three cases and the concerns you had about the delays -- *(overspeaking)* -- when was that?

A. The timeliness? So it would have been a more general

concern that was expressed. As I say, if there were criminal proceedings, we would have respected that, we would have accepted immediate -- *(overspeaking)* --

Q. Was it before or after June 2023?

A. Before.

Q. When?

A. Well ... well, we would have had ongoing -- we had ongoing forums with the regulators there, so these things would have been on the agendas at regular forums, as they were emerging. Soon after --

Q. -- *(overspeaking)* -- if those escalations were made, I'm sure there will be evidence that can be produced by the ICB of that.

A. There would be meeting forums and things where they were discussed, yeah, yeah, and escalation routes.

We did do a more formal escalation in 2023 when there were a number of different concerns emerging and it looked like the breadth of concerns within the Trust was more complex and broader than had previously been understood, and I think that's -- I think the timelines that Dr Sokolov said this morning exactly fit the pattern of what we saw as well and the timings of that. So that would be consistent. But there would have been an ongoing dialogue about serious incidents, as, you know, in a more timely fashion.

MR WESTON: Chair, those are my questions.

THE CHAIR: Yes, thank you.

Ms Patrick.

Questioned by MS PATRICK

MS PATRICK: Good afternoon, Ms Sullivan. My name is Angela Patrick, I ask questions on behalf of the bereaved families. I have a few topics.

Just briefly on the questions Mr Weston has been asking you about, you said aware of the incidents in 2023, you said you would have been escalating that, there would have been some specifics, regular forums where it was emerging and you've committed to checking and providing that information to the Inquiry.

A. We can do that for the Inquiry, yes, if --

Q. Just some specifics about that before we move on to the specific topics I want to cover. Would you have expected that to have been escalated up to the Quality Assurance Group?

A. It would have been escalated through quality structures. The Quality Assurance Group was a specific group that we had that was looking at the CQC action plan, and so that was a more -- that was specific to a certain set of actions, but we had the System Quality Group where serious incidents came, and other forums as well. So I can't be -- I can't say it was specifically the

Quality Assurance Group, it might have been another group.

Q. Specific structures aside, would you have had any particular responsibility for the oversight mechanism in the ICB, looking at the response to those kinds of serious incidents?

A. We would have, in terms of the Trust's actions, but we wouldn't have had the full Multi-Agency picture -- *(overspeaking)* --

Q. Multi-agencies aside, within the ICB, would you have had, as an organisation, responsibility for oversight, looking at how the Trust was responding to those kinds of serious incidents?

A. Yes, we would have been one of the bodies doing that, yes.

Q. And specifically within the ICB would you have had a responsibility personally -- as part of the various structures and in the role that you held, would you have had a responsibility for that oversight function?

A. We have a quality, a Director of Nursing and a quality function that would be dealing with the detail of that on a day-to-day basis with the Trust. And then that would be escalated through our committees and Board, in terms of the oversight of that.

Q. Including to you?

A. Well, I'm part of the Board, so yes, yeah.
Q. Indeed. Just moving on, I just want to ask you one specific question about Mr Weston's questions about Dr Adamson's evidence on changes to the EIP model.
Dr Adamson said yesterday, and I think she confirmed that it was in September 2020 that her proposals for the new model went to the CCG and the CCG approved funding proposals for a new model designed to secure an effective ratio within the EIP team.
A. Yeah.
Q. Does that fit with your recollection?
A. It does, and it fits with our earlier conversation about us putting the NICE standards in. So that is consistent.
Q. And if the approved model, that came up to the CCG, was proving difficult to implement or if it was underfunded, would you have expected that to have been escalated back up to the CCG or the ICB in due course?
A. Yes, and it was and I think it did take a little while. It was and it came through our committee structures. It was reported at our Board as well, and we monitored it until such time as it got to that compliance with the NICE standards that I mentioned earlier. So, yes.
Q. And was that something that -- whether it was achieved before June 2023, getting to those standards, that you

continued to monitor. For example --
A. Yes.
Q. -- if it dropped below the standards, should it have been escalated up?
A. Yes, but -- yeah.
Q. Thank you. Now I just want to look to a different topic around public safety and the future of new reforms in the NHS. Can we look in your witness statement, and I'd like to look at the very end at paragraphs 158 and 159, please, if possible?
We see there you say:
"I welcome the new operating model for the NHS, as set out in the Department of Health and Social Care's new ten-year ... plan ..."
And so on. You say:
"... it will be important to ensure that there is clarity of roles and responsibilities between NHS England, ICBs, and NHS providers, and that robust working arrangements between commissioners and regulators continue to be in place.
"Of equal importance will be the enabling of arrangements for local NHS system partnership working to preserve the culture of openness and transparency between ICBs and NHS providers that's been established since ICBs [had been] introduced."

If we could go over the page, please.
"These partnership arrangements have facilitated collaboration across organisational boundaries, with an emphasis on collective responsibilities and mutual accountability across local NHS systems."
Now "facilitated collaboration" and "mutual accountability across local NHS systems". Can you accept that from the perspective of the bereaved families, collaboration and mutual accountability was simply not a feature of the local arrangements in Nottingham prior to June 2023?
A. Yes, I can absolutely see why that would be the thought. My comment about the clarity of roles was because more over the last year there has been a new operating model for the NHS which is linked to the government's 10-year plan.
Q. Can I pause you there. I'm going to ask you a little bit about the future.
A. Okay.
Q. But that part of your statement, the very last part of your statement, immediately above the "Statement of truth", you're saying the existing, old arrangements have facilitated collaboration with an emphasis on collective responsibility and mutual accountability across NHS systems. Do you accept it simply hasn't been

the case?
A. I completely accept that from the families' perspective this would not look, you know, it's not the case. I'm not saying in my statement that that is universally true, but there are some very complex, wicked issues where there are interdependencies across different organisations, not specifically in mental health, I have to be honest, where we have got more -- so for example hospital discharge for physical health we have got --
Q. Can I pause you there -- *(overspeaking)* --
A. So I'm not saying it's complete and all perfect and sorted. I'm just saying it has helped with some aspects, but I completely accept that for the families there is no evidence of that from their perspective.
Q. In plain English, are these two last paragraphs in your witness statement simply a plea for ICBs not to be abolished alongside NHS England?
A. No, not at all.
Q. If so, what does it mean?
A. So -- sorry, could you take me back to the statement you're referring to? And apologies, I do accept it's not very clear and it's a bit jargon-y.
Q. Simply, just what do the last two paragraphs mean, if it's not "Please don't abolish ICBs"?
A. It's not at all that. So when I described the changes

from the CCG to the ICB and the establishment of ICSs, one of the big policy changes around commissioning was, that we needed to operate more collaboratively with the providers and it was a move away from a more distinct commissioner-provider split that was part of the policy, and that led, I think, contributed to some confusion about the respective roles of different organisations within the NHS.

What I'm saying is I think the government announcements around NHS England and the changes to ICBs that are currently going through, aim to put that clarity and that very -- that more separate set of roles back in for commissioners and providers and for the accountability.

So I think to some extent it was undoing what was put in in 2022 in terms of clarity.

Q. Okay.

A. So that's what it is. It's not at all about whether ICBs exist or not.

Q. Can we turn back to page 9 of your witness statement, just while we're on the future. At that page, page 9, I think you have a list of the duties which apply in the --

A. Yes.

Q. -- it may be paragraph 9, I apologise.

A. Yes, I know what -- *(overspeaking)* --

Q. A list of the duties that appear in --

A. Yes, yes.

Q. -- in the NHS Act 2006.

A. Yes, yes.

Q. We can see, I think, you know them, we don't need to bring them up: there's a duty to promote the NHS constitution?

A. Yes.

Q. Duty to be effective and efficient, to improve the quality of services, to reducing inequalities, to promote the involvement of patients -- duty as to patient choice, the duty to obtain appropriate advice, to promote innovation, in respect of research and in respect of education and training, integration and the wider effect of your decisions, and in fact it also includes duties on climate change.

A. *(The witness nodded)*.

Q. None of them include an express duty to promote public safety or to have regard to the risk to public safety, do they?

A. No, that's true.

Q. While we're in this period of change, should there be consideration of an express duty on the ICB, in whatever form it continues, to continue the impact on public

safety on the exercise of its statutory function?

A. Yes, I think that would be -- yeah, I think that would be a progressive and helpful thing and it would focus attention differently. Yes, I agree with that.

MS PATRICK: Thank you. No further questions.

THE CHAIR: Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Ms Sullivan. Can I just return, as Ms Patrick has done, to your final paragraph and I just want to seek further clarification in respect of paragraph 159 at page 57. Thank you.

Now, in paragraph 159, you're referencing that since the establishment of the ICBs and I think you've confirmed it was July 2022 --

A. Yeah.

Q. -- that work:

"... to preserve the culture of openness and transparency between ICBs and NHS providers that has been established since ICBs were introduced."

So you seem to be saying there that from July of 2022, there's been a culture of openness and transparency that existed between the ICB and Nottingham Foundation Trust; is that what you're saying there?

A. I think it's -- what I'm saying is there have been some improvements in it. I wouldn't say they are universal

and not from day one, but I think, I think what I'm referring to there is I think -- and this has been, you know, on my reflection, I think this has been partly the case -- we didn't have the whole picture about the Trust. We obviously have our responsibilities which, you know, clearly I'm accountable for, but we weren't seeing the full picture with the Trust, and so we didn't understand that whole picture. And I think this has come out in previous Inquiries certainly, the Mid Staffs Inquiry around not putting together all of the bits of the jigsaw. We didn't know, for example, what was happening with the offender healthcare contracts because we weren't managing those contacts. There were concerns there. Rampton was obviously a concern.

And I do think, if we are going to be having the safest, best possible services we can, all of the agencies need to be proactively sharing intelligence, and I think through -- my reflection is through different policy environments, different iterations, that has been variable, and when it's at its best I think that is the best for the population: that we all can share that intelligence. So that's really what I'm getting at there.

Q. All right, well would you agree this was a statement you provided on 3 December 2025, but that seems to be

praising a culture of candour from July 2022 rather than saying what you've just said in answer, that essentially --

A. Okay. Apologies -- *(overspeaking)* -- yeah.

Q. -- you were not getting the full picture, which is almost the opposite of a culture of candour and openness?

A. No, it's not; it's more about triangulation. So the culture of openness and transparency, I think, has improved. It's not fully open yet but I think there have been some -- there have been improvements. I think there is more to do on that. And what I'm saying, I think on here, is that I'm really trying to say let's not -- where we are starting to get traction and gain on that, let's not undo that and go backwards. Let's keep going forwards.

Q. So can you identify what the practical things are, then, that have been done to improve the culture of openness and transparency?

A. Yeah, I mean if I'm honest, I think with Nottinghamshire Healthcare Trust, I think the regulatory intervention has been helpful in that respect because it's forced some of that and then it's become more of a way of operating and it's given us, you know, a mandate, other than our contractual relationship, to work with NHS

England on that.

It needs to obviously come from the heart of the organisations. But I do think the fact that we -- with the development of ICSs which were new, and that this whole concept of system working, system sharing, system ownership, it can help to understand where there are complex issues that cross a range of healthcare settings, what the solutions are.

So it is work in progress, that's for sure.

Q. All right. Then just briefly, just see if you can be a bit clearer about your paragraph 156, please. If we scroll back up, please, on to page 57. You say this:

"All the relevant organisations, including the ICB, NHS England, and the CQC, knew about the concerns in relation to [Nottinghamshire Health Foundation Trust], and all such organisations were taking action."

Are you referencing that to be the position before June of 2023?

A. Yes, I think it's subsequent to that that we have worked together more, yeah.

Q. All right, so that is referencing a point in time --

A. Yes.

Q. -- pre-attacks?

A. Yes.

MS CARTWRIGHT: Thank you.

THE CHAIR: Ms Heaven.

Questioned by MS HEAVEN

MS HEAVEN: I ask questions on behalf of VC's family and it's in relation to ICB awareness of concerns being raised by the Coroner.

Can we start with your witness statement, please. It's paragraph 129 and that's page 49. So 129, you explain to the Inquiry that:

"On 23 [*(sic)*] June 2023, a Prevention of Future Deaths Report was issued to [the Trust] and the ICB. The report highlighted two key failings regarding inadequate involvement of families and carers ..."

And certain actions were then raised by the ICB.

Certainly by this stage the ICB were aware, weren't they, that there was a problem within the Trust around communication with families?

A. Yes.

Q. But this was not a new issue, as the Inquiry has heard. The Coroner has been raising this with the Trust, certainly on the documents we've seen, from as early as January 2021 in both a PFD and in general discussions, and the Board were aware.

So just focusing on PFD and the ICB's knowledge. So from 2020 to 2022 was the Quality Improvement Group, and the ICB in general, overseeing coronial PFDs. And just

to put a bit of context on this, we know, for example, there was a PFD at some point in 2021 that raised as a concern liaison with family members.

So were you overseeing this, and indeed were you aware of this PFD?

A. So through our quality assurance routes, where a PFD is issued, we would track to ensure that the Trust completed the actions within the PFD.

My slight hesitation around that is during Covid there were some delays in Coronial cases because of the pandemic, and in 2023, we received -- we became aware that there were quite a number, that the Trust were receiving more PFDs than had previously been the case. They said that was because of the backlog from Covid and, you know, hearings being resumed. But when we escalated our sort of range of concerns in 2023, that was one of them: that there were -- there appeared to be more PFDs than we would normally have, you know, expected, and that didn't indicate a learning environment; if anything, it indicated a deterioration.

So, yeah. But the actions that were being taken in relation to PFDs, we would ensure that they were undertaken.

Q. So there'd be a paper trail in relation to that PFD I've mentioned?

A. We'd need to check the forums, yeah.
Q. I'll move on from PFDs. As I said, the Coroner is raising things like "repeated systemic themes" -- so that's a quote -- in discussions with the quality operating group in the Trust. That's just one example, around use of Triangle of Care, which is the mechanism for engagement of families. That's in 2021.
These general concerns that are being raised with the Trust, were they then being escalated to the ICB?
A. No, there wouldn't be a formal escalation route to the ICB, no, but we would -- themes and things that we became aware of, we would monitor. But there's not a -- the Coroner wouldn't generally -- unless they thought the --
Q. I'm not talking about the Coroner; I'm talking about the Board. We know the Board were aware of these systemic concerns that were being raised by the Coroner that hadn't led to a PFD. Were those matters in 2021 onwards being raised by the Board with the ICB?
A. By the Trust Board with the ICB?
Q. Yes.
A. No, I don't think so.
Q. Was the Board under requirement from the ICB to inform the ICB if these concerns were being raised by the Coroner? So were they under a positive duty to do that?

A. No, there wouldn't have been a specified duty to do that.
Q. So you've been taken to the Theemis criticisms on the over-reliance on the Trust informing the ICB of concerns. Would you agree that it appears this state of affairs also applies to concerns being raised by the Senior Coroner? You were relying on the Trust, and -- *(overspeaking)* --
A. Yes, obviously if it turns into a formal PFD then we would know that. But yes, and we would -- some of that would come through on a serious incident, but I think that is a fair statement.
Q. Okay. ICB information flow to NHS England. We've heard from Jessica Sokolov of NHS England that the ICB had a discretion as to when they escalated coronial concerns to them.
Very briefly, how did this system work, and did the ICB ever tell NHS England about concerns, either in a PFD or otherwise, that were being raised about the Trust's engagement with families and carers?
A. Yes, we did, in 2023. And that was, like I say, after there appeared to be like a stepping down of the coronial hearings, then we were aware that there were a number of PFDs in quite short succession. And so the Trust said that was because, you know, that they were

back from in Covid. But at that point when we saw, you know, a group of them together, we thought this is a deterioration and that was part of our escalation to NHS England in 2023.
Q. Now, we've also heard that improving communications by the Trust with families and carers was the Trust's own quality priority in 2021 to 2022?
A. *(The witness nodded)*.
Q. They identified they had a systemic problem.
A. Yeah.
Q. Did the ICB provide any oversight as to whether or not the Trust was actually meeting their own quality priority on this issue? So before 2023.
A. We would -- so we would comment. Every year we give a quality statement which is part of a formal annual report service, so we would have given a quality statement each year to the Trust.
To be honest, I can't remember exactly whether that continued through Covid or whether it was stepped down, but that would generally be the case and we would comment on the Trust's achievement of their strategy. Any particular themes to our quality assurance routes as well, but --
Q. For example, if the Trust was undertaking to recruit carer support workers to facilitate engagement with

families, that's something that would be checked and audited by the ICB?
A. No, it wouldn't -- we wouldn't audit it --
Q. But you'd check to see if it had actually happened?
A. If that was in an improvement plan that it was a requirement that we were monitoring, then we would monitor that. If it wasn't, we might not be aware of specifics. And also we did some joint engagement with citizens and patients as well, so we would know through those routes what intelligence was coming through, but again, that probably could be more robust going forward.
MS HEAVEN: Thank you, those are my questions.
THE CHAIR: Yes, thank you. Any questions on behalf the ICB?

Questioned by THE CHAIR

THE CHAIR: Ms Sullivan, I just wanted to ask a couple of things. You've stressed in those last two paragraphs you've been taken to in your statement, 158 and 159, the importance of collaboration and openness and transparency.
I think what you've ended up with is an emphasis on collective responsibilities and mutual accountability across the local NHS systems. Isn't it important that, as exercising an element of oversight, that there is

an element of friction?
A. Yeah, absolutely. And that definite --
THE CHAIR: That's not pure collaboration.
A. It's not, I agree. I think where the problems need a collective response, I think that's true, so I think I would differentiate between what the problem is and what the solution is.

If the solution requires a collective response, we all need to get behind it and solve it. If this is about, you know, some fresh eyes, challenge, oversight, I agree, and we do -- I think there is always a friction and a tension in the system, because we do ask, you know, difficult and awkward questions and so that is reflected in our -- and it's a very fine balance we have to tread because we need constructive working relationships, we need to be on the ground and find out what's happening. We don't have regulatory powers of intervention, but the providers know that we will escalate concerns. So there is -- there's always that fine relationship dynamic that we have to tread.

I always say to the teams: be tough on the issues, we can't collude with poor care, but we need to be careful about relationships, because otherwise we become part of the problem, not the solution.

So it is a fine balance, I would agree with you.

And I think if it needs a joint solution, we all need to work together to a shared objective. If it's about maintaining standards and oversight, we need to take a step back, and be a nuisance actually sometimes. Yeah.
THE CHAIR: In that respect, you've referred to your annual report. Do you have in that any sort of declaration or consideration of what's being raised with you in terms of any criticisms of the Trust and how you've dealt with it? A sort of register, if you like, of how you've dealt with, for example, coronial complaints, the PFDs, those sort of things?
A. No, it would be more thematic than that. But again, I think certainly we could -- I think a tighter connection between coronial processes and commissioning processes would be a helpful thing, actually.
THE CHAIR: In order for transparency --
A. Yeah.
THE CHAIR: -- for the Trust to provide you with any, not just PFDs, but any complaints --
A. Yes.
THE CHAIR: -- or recommendations from, say, the Coroner or others?
A. I think that would be -- yeah, I absolutely agree with that, I think, yes.

THE CHAIR: So that's if you continue to exist in your current form?
A. Yeah, I think because at the moment, as I say, it was the PFDs rather than some of the more informal noise around that. So yeah, I do agree with that.
THE CHAIR: Yes, thank you.

Right. Well, we'll finish there and start again tomorrow at 10.00.

(4.40 pm)

(The hearing adjourned until 10.00 am the following day)

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