

Witness Name: SABRINA TAYLOR-HALL

Statement No: WITN0088001

Dated: 21 November 2025

## THE NOTTINGHAM INQUIRY

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### FIRST WITNESS STATEMENT OF SABRINA TAYLOR-HALL

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I, Sabrina Taylor-Hall, will say as follows: -

#### **INTRODUCTION**

1. My name is Sabrina Taylor-Hall, Chief Executive Officer at Healthwatch Nottingham and Nottinghamshire. I joined the organisation in April 2022. I hold a BA in Psychology and an MA in Community and Youth Work with Anthropology. I am currently Chief Executive Officer at Healthwatch Nottingham and Nottinghamshire, where I have also served as Head of Operations over the past three years.
2. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 16<sup>th</sup> June 2025 (the "Request").

#### **BACKGROUND**

3. I have been asked to set out by way of background, the role of Healthwatch Nottingham and Nottinghamshire in respect of the provision of mental health services in Nottingham in the period 2019 – 13 June 2023.
  
4. Healthwatch Nottingham and Healthwatch Nottinghamshire was established pursuant to the Health and Social Care Act 2012, which mandated the creation of local Healthwatch bodies across all local authorities England. It commenced as two separate entities in 2013 as the independent statutory body responsible for representing the views and experiences of patients, service users, carers, and the wider public in relation to health and social care services within Nottingham and Nottinghamshire. The separate entities merged in 2018 and become a stand alone charity '*Healthwatch Nottingham and Nottinghamshire*' registered charity number 1159968.
  
5. The primary statutory functions of Healthwatch Nottingham and Nottinghamshire are as follows:
  - To obtain the views of individuals about their needs for, and experiences of, local health and social care services;
  - To make those views known to those responsible for commissioning, delivering, and regulating such services;
  - To make reports and recommendations about how services could or should be improved;
  - To provide advice and information to the public about accessing health and social care services and exercising choice;

- To escalate matters of concern relating to the quality and safety of services to relevant oversight bodies.
6. Healthwatch Nottingham and Nottinghamshire also have a legal power to visit health and social care services and see them in action. This power to *'Enter and View'* services offers a way for Healthwatch Nottingham and Nottinghamshire to meet some of its statutory functions and allows us to identify what is working well with services and where they could be improved.
  7. The Department of Health and Social Care fund our work. They give money to local councils so they can commission an effective local Healthwatch (Nottingham and Nottinghamshire) service. Healthwatch Nottingham and Nottinghamshire operates independently of both the council and the organisations it scrutinises. Its purpose is to ensure that the voices of service users — particularly those who are seldom heard — are taken into account in the planning, delivery, and improvement of services.
  8. Healthwatch Nottingham and Nottinghamshire forms part of a wider statutory network coordinated by Healthwatch England, a non-departmental public body established under the same legislation. Healthwatch England provides leadership, guidance, and national oversight, and acts as a conduit for the escalation of local issues that have national significance or require intervention at the policy level.

9. There exists a formal statutory relationship with the Care Quality Commission (CQC). Healthwatch Nottingham and Nottinghamshire shares intelligence with the CQC to inform its regulatory and inspection functions and contributes to risk assessments where local intelligence indicates potential breaches in the quality or safety of care provision.
  
10. Locally, Healthwatch Nottingham and Nottinghamshire engages directly and routinely with NHS bodies, integrated care systems, social care providers, and commissioners. Through formal consultation, representation on strategic boards, and the provision of evidence-based reports and recommendations, it seeks to ensure that services are responsive to public needs and accountable to the communities they serve.

#### **MENTAL HEALTH CARE IN NOTTINGHAM**

11. Healthwatch Nottingham and Nottinghamshire is not a monitoring body, we do not monitor quality and patient experience in psychiatric care services as this is not within our remit. We do, however, gather data and intelligence about people's experiences of health and care, including experience of care within mental health services and share this intelligence where necessary and appropriate via reports, presentations and at system meetings and events.
  
12. Our organisation utilises a range of methods to gather and convey views of mental health patients, including surveys, structured interviews, outreach sessions, and partnership working with community groups. We also provide information and sign posting for individuals who contact us via our website and phonenumber. All data and intelligence gathered are subject to internal analysis and

are shared in the form of thematic reports or formal intelligence briefings with statutory and regulatory bodies, including Healthwatch England, the CQC, and local service providers.

13. In January 2024, we published our report entitled '*Specialist Mental Health Services: The Experiences of People Living with Severe Mental Illness*' [CQCM0016521]. This report was the product of extensive engagement with 367 individuals who had direct experience of severe mental illness and had interacted with specialist mental health services across the City and County. The engagement methods employed included online and paper-based surveys, focus groups (delivered in partnership with local voluntary and community sector organisations), and one-to-one interviews conducted over an eight month period. The report identified systemic issues relating to access, referral pathways, communication, crisis provision, and the role of non-statutory support. Eight key recommendations were made, including the need for early intervention, person-centred care plans, improved referral processes, holistic approaches to support, and improved crisis response mechanisms. This report was formally shared with commissioners, providers, the local Integrated Care Board, and the CQC.

14. In addition, mental health has remained a stated priority in our organisation's strategic planning and public engagement. In our 2022–23 annual report we listed Mental Health as one of our top three priorities [WITN0088006]. In our 2023–24 Annual Report, Healthwatch Nottingham and Nottinghamshire

documented concerns raised by members of the public in relation to mental health services [WITN0088007].

15. Healthwatch Nottingham and Nottinghamshire haven't escalated any concerns relating to mental health services in Nottingham specifically to HWE or CQC (or any other body) as it is not within our remit to escalate individual cases. We do, however, share intelligence on an ongoing basis with HWE, which contains all topics, including Mental Health.

16. Healthwatch Nottingham and Nottinghamshire has received a number of complaints and concerns from patients and members of the public regarding mental health services in Nottingham, particularly within the city area. These concerns have been raised thematically over the course of routine engagement with Nottinghamshire Healthcare Foundation Trust and system partners as we are unable to raise individual complaints or act as personal advocates.

17. The nature of the concerns can be grouped into four thematic areas. First, issues were raised about treatment quality, including poor clinical decision-making, lack of accountability in specialist programmes, and inadequate therapeutic approaches for neurodivergent individuals. Second, access to services was a recurring concern, with reports of premature discharge, and unclear referral pathways. Third, serious incidents were reported, including an assault by a staff member at Highbury Hospital and historical concerns around unsafe discharge and confidentiality breaches. Finally, concerns were raised about service delivery and safeguarding, particularly in relation to inattentive remote therapy

sessions and failures in responding appropriately to disclosures of historic abuse.

18. The overall sentiment of these reports is one of distress, frustration, and a perceived lack of appropriate, safe, and accessible mental health care. These concerns have been documented, reported to relevant bodies (including Notts Healthcare Trust and Nottingham and Nottinghamshire ICB), and in some instances escalated for further investigation in accordance with our Adult Safeguarding Policy.

19. Healthwatch Nottingham and Nottinghamshire produced several reports and recommendations relating to mental health services in Nottingham prior to 13 June 2023.

20. These include: '*Young People's Mental Health and Wellbeing*' – June 2016 (Healthwatch Nottingham) [WITN0088008]. This engagement project gathered insights from over 300 young people aged 14-25, focusing on their experiences seeking mental health support. It highlighted barriers faced by Black Minority Ethnic and LGBTQ+ youth, including stigma, lack of awareness, and inconsistent access to services. Key learnings included the need for culturally competent and inclusive services, the importance of early intervention and youth-friendly communication. Recommendations informed local youth mental health strategies.

21. In August 2016, Healthwatch Nottinghamshire published *'Experiences and Views on Seeking Support During a Mental Health Crisis'* [WITN0088009]. Engagement with 269 individuals and survey responses from 484 people revealed significant challenges in accessing crisis support. Target groups included carers, veterans, students, homeless individuals, and Black Minority Ethnic communities. Key learnings found that crisis services were often inaccessible or poorly understood and discharge processes lacked continuity. Recommendations fed into the Nottinghamshire Crisis Concordat action plan, prompting service reviews and improved signposting.

22. Finally, in June 2019, Healthwatch Nottingham and Nottinghamshire undertook an *'Enter and View'* visit to Rampton Hospital in partnership with the CQC. This statutory visit focused on patient experience within a high-security mental health setting. Observations included ward environment, staff interaction, and patient dignity. Key learnings from this visit highlighted areas for improvement in communication and therapeutic engagement [WITN0088010].

23. Across all reports, Healthwatch Nottingham and Nottinghamshire consistently highlighted gaps in access, communication, and service coordination. These reports also demonstrate Healthwatch Nottingham and Nottinghamshire's sustained engagement with mental health service users and its role in shaping local service improvements.

**VALDO CALOCANE**

24. Healthwatch Nottingham and Nottinghamshire had no interactions with the Nottinghamshire Healthcare Foundation Trust regarding the events on 13 June 2023

25. The circumstances leading to Healthwatch Nottingham and Nottinghamshire producing a report on mental health services in Nottingham in 2023 is as follows: In early 2022, Healthwatch Nottingham and Nottinghamshire was approached by the Nottinghamshire Healthcare NHS Foundation Trust to undertake an independent engagement project focusing on the experiences of people accessing mental health services within Nottingham. The purpose of the project was to gather detailed insights into the lived experiences of individuals accessing secondary and specialist mental health services across Nottingham and Nottinghamshire, with a particular focus on service quality, access, and outcomes [HWNN0000007].

26. This request was initiated following a meeting held on 3 February 2022 between representatives of Nottinghamshire Healthcare Foundation Trust and the Programme and Insights Manager at Healthwatch Nottingham and Nottinghamshire.

27. Subsequent to that meeting, Healthwatch provided initial costings and methodological recommendations. On 17 February 2022, Healthwatch advised Nottinghamshire Healthcare Foundation Trust on data saturation and proposed limiting the number of in-depth one-to-one interviews to 30, rather than the initially suggested 50. A range of engagement methods was proposed, including a public

survey, focus groups, and interviews, to capture both breadth and depth of experience [WITN0088011].

28. Costings were formally submitted in March 2022, with two options presented and the following month, Nottinghamshire Healthcare Foundation Trust confirmed its agreement to proceed with the project. Healthwatch then issued a draft one-page agreement and outlined a clear project timeline, proposing to launch the general population survey on **1 June 2022**, complete all data collection by **30 September 2022**, and deliver the final report by **31 December 2022**.

29. A Project Initiation Document (PID) [HWNN0000008] and initiation meeting were scheduled to finalise the scope, content of participant information materials, and mechanisms for referrals and progress reporting. The formal commissioning of the project was completed in mid-2022, and data collection was carried out as planned throughout summer and autumn of that year.

30. There was, however, a significant delay in publication which arose primarily due to the scale and complexity of the Information Governance (IG) requirements imposed by Nottinghamshire Healthcare Foundation Trust, which necessitated a subsequent renegotiation of the contract to reflect the additional work and extended timeline. The IG requirements placed a disproportionate burden on our small organisation, which lacks a dedicated IG department.

31. The interim report was shared with Nottinghamshire Healthcare Foundation Trust in early 2023 [WITN0088012] [WITN0088002]. The final report, was

completed in November 2023 and was published in January 2024 [CQCM0016521]. It was informed by extensive engagement with service users and stakeholders and aimed to inform Nottinghamshire Healthcare Foundation Trust 's transformation plans for local mental health services.

32. The information was gathered using a mixed-methods approach to ensure both the breadth and depth of service user feedback and was conducted over an eight-month period.

33. The methods included an open public survey, promoted via Healthwatch networks and voluntary sector partners, yielding 367 responses. Four focus groups, delivered in collaboration with community-based mental health organisations including Recovery College, Turning Point, and Bipolar Lift. Sixteen one-to-one in-depth interviews with service users who had recent experience of accessing specialist mental health services and we also collected feedback in the form of a case study .

34. Participants represented a diverse range of demographics, health conditions, and service interactions. The data collected included both quantitative (structured survey responses) and qualitative (free-text comments, interview transcripts) information.

35. The report concluded that while some individuals did report positive experiences, these were in the minority. The majority of participants reported significant barriers in accessing timely and appropriate mental health support.

Recurring themes included long waiting times, fragmented referral pathways, and inconsistent care, with individuals often feeling dismissed or deemed “too complex” for treatment—particularly those with dual diagnoses or trauma histories. Crisis services were frequently described as inadequate, while neurodivergent individuals found mainstream therapies ill-suited to their needs. Trust in the system was low, and many participants expressed feelings of abandonment, dismissal, or dehumanisation. Participants consistently called for more holistic, person-centred care that addressed social and physical wellbeing alongside mental health. Voluntary and community organisations were widely praised for their responsiveness, often stepping in where statutory services fell short

36. The report made eight specific recommendations for service improvement, including:

- **Streamlining referral pathways** and ensuring timely access to support.
- **Enhancing communication** and continuity of care.
- **Embedding trauma-informed and person-centred approaches.**
- **Improving crisis care pathways.**
- **Ensuring therapies are adapted for neurodivergent individuals.**
- **Investing in early intervention and prevention.**
- **Recognising and resourcing the role of the voluntary sector.**
- **Using diverse engagement methods** to ensure underrepresented voices are captured.

37. The findings were formally shared with Nottinghamshire Healthcare NHS Foundation Trust, the Nottingham and Nottinghamshire Integrated Care Board, and the Care Quality Commission in autumn 2023 [HWNN0000014]. The report was intended to directly inform Nottinghamshire Healthcare Foundation Trust's mental health transformation work.

38. A series of steps have been taken to ensure the recommendations have been acknowledged and acted upon by Nottinghamshire Healthcare Foundation Trust and system partners. On 20 October 2023, a formal meeting was held between Healthwatch Nottingham and Nottinghamshire and Trust colleagues to discuss the draft Serious Mental Illness (SMI) report. The discussion included concerns about tone, representation of feedback, and the need for actionable recommendations [HWNN0000002].

39. Between 23 October and 3 November 2023, a structured exchange of emails took place. Healthwatch Nottingham and Nottinghamshire requested written feedback specifically on the recommendations. Nottinghamshire Healthcare Foundation Trust responded with clarifications and updates on service developments [HWNN0000011].

40. On 18 November 2024, Healthwatch Nottingham and Nottinghamshire formally requested further written feedback from Nottinghamshire Healthcare Foundation Trust on the actions taken in response to the SMI report recommendations [HWNN0000003]. This is approximately one year after publication of the report and allows time for implementation to occur. This request included a pre-

populated form seeking evidence of impact. Nottinghamshire Healthcare Foundation Trust responded with a detailed summary of service improvements aligned to the recommendations

41. On 26 April 2024, a further meeting was held in which Healthwatch Nottingham and Nottinghamshire directly asked Nottinghamshire Healthcare Foundation Trust for assurance that its recommendations would be embedded within the wider implementation plan. Healthwatch Nottingham and Nottinghamshire also sought confirmation that its recommendations would not be lost within the broader set of 17 Section 48 recommendations, which are being reported directly to the Secretary of State [HWNN0000009].

## **RECCOMENDATIONS**

42. In reviewing the Independent Mental Health Homicide Review report, it confirms that VC was repeatedly failed by mental health services and that there were missed opportunities to involve his family meaningfully in care planning and risk management decisions. I would therefore make the following recommendations for the Chair to consider:

- **Embed Lived Experience in Governance and Oversight**
- The review underscores the need for personalised risk assessments and joint discharge planning involving families and community teams. It would be pertinent to require statutory services to co-produce safeguarding and risk management policies that are embedded in practice with individuals who have lived experience of serious mental illness, including families affected by homicide. This ensures that policies reflect real-world complexity and emotional impact.

- **Family Voice and Engagement Protocols**

- It's clear from the review that family concerns were not adequately acted upon. Introduce formal mechanisms for families to raise concerns, with guaranteed follow-up, documentation, and escalation routes. Services should be required to demonstrate how family input has shaped decisions and outcomes.

- **Strengthen Patient Voice in Service Design**

- The report calls for improvements in assertive community treatment and engagement policies. It is therefore important to ensure that service redesigns—especially in crisis care and forensic mental health—are informed by structured patient feedback, gathered through trusted intermediaries like Healthwatch. This includes regular thematic reviews and public reporting of how feedback has influenced change.

- **Fund Independent Advocacy and Navigation Support**

- The review notes that VC disengaged from services without sufficient follow-up. Provide dedicated funding for independent advocates to support patients and families navigating complex systems, particularly when concerns are dismissed or labelled “too complex.”

- **Establish a National Co-Production Framework**

- Given the review's emphasis on multi-agency working and personalised care a national framework should be developed that sets minimum standards for co-production and multi-agency collaboration in mental health and safeguarding. This should include expectations for shared decision-making, transparent communication, and joint accountability across health, police, social care, and voluntary sectors. Healthwatch, as an independent champion

of public voice, should be resourced to gather and report on people's experiences of these partnerships—ensuring that lived experience informs both local practice and national policy. Healthwatch's independent insight can help identify where collaboration is working well and where it is falling short, supporting continuous improvement and public accountability.

43. There are several improvements that could be made locally and nationally to multi agency working to increase effectiveness in preventing similar outcomes in the future. Primarily, I think it's important to recognise and resource the voluntary sector as equal partners in Mental Health Systems. Voluntary and community organisations—including Healthwatch Nottingham and Nottinghamshire—play a vital role in supporting good mental health through trusted relationships, holistic care, and early intervention. Evidence from the Centre for Mental Health shows that local alliances led by voluntary groups improve access and outcomes, especially for marginalised communities. Yet these organisations are often excluded from strategic planning or forced to compete for short-term contracts. National and local systems must embed voluntary sector partners into multi-agency structures, provide sustainable funding, and ensure their insights shape service design and delivery. This includes formalising their role within safeguarding boards, crisis response planning, and subgroup structures—where their input has already proven more efficient and comprehensive.

### **Statement of Truth**

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false

statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **GRO-B**

Dated: 21.11.25

**Index to First Witness Statement of Sabrina Taylor-Hall**

No.	Inquiry URN	Document Description
1.	CQCM0016521	Report dated 21 November 2023, Healthwatch Nottingham and Nottinghamshire – Re: Specialist Mental Health Services: The Experiences of People Living with Severe Mental Illness.
2.	WITN0088006	Healthwatch Nottingham and Nottinghamshire Annual Report 2022–23
3.	WITN0088007	Healthwatch Nottingham and Nottinghamshire Annual Report 2023–24
4.	WITN0088008	Report - <i>Young People's Mental Health and Wellbeing</i> – June 2016
5.	WITN0088009	Report - <i>'Experiences and Views on Seeking Support During a Mental Health Crisis'</i> - August 2016
6.	WITN0088010	<i>Report - re 'Enter and View'</i> visit to Rampton Hospital in partnership with the CQC
7.	HWNN0000007	Healthwatch Nottingham and Nottinghamshire – Evidence Collection Request form
8.	WITN0088011	Email dated 17 February 2022 from Healthwatch Nottingham and Nottinghamshire to the Nottingham Healthcare Foundation Trust
9.	HWNN0000008	Healthwatch Nottingham and Nottinghamshire Project Initiation Document PID dated 9 November 2022

10.	WITN0088012	Correspondence sharing the interim report with the Nottingham Healthcare Foundation Trust in early 2023
11.	WITN0088002	Report dated 21 March 2023, Healthwatch Nottingham and Nottinghamshire – Re: Specialist Mental Health Services: Interim Report March 2023
12.	CQCM0016521	Report dated 21 November 2023, Healthwatch Nottingham and Nottinghamshire – Re: Specialist Mental Health Services: The Experiences of People Living with Severe Mental Illness
13.	HWNN0000014	Email dated 29 September 2023 from Kinsi Clarke, Healthwatch Nottingham and Nottinghamshire to Louise Randle Nottinghamshire Healthcare Foundation Trust and others re “ <i>SMI Draft Report</i> ”
14.	HWNN0000002	Email dated 23 October 2023 from Kinsi Clarke, Healthwatch Nottingham and Nottinghamshire to Louise Randle Nottinghamshire Healthcare Foundation Trust and others re “ <i>Follow on from Meeting on Friday</i> ”
15.	HWNN0000011	Email chain dated 23 October 2023 – 3 November 2023 between Kinsi Clarke, Healthwatch Nottingham and Nottinghamshire and Louise Randle, Nottinghamshire Healthcare Foundation Trust and others – re “ <i>SMI Report - Actions for next steps</i> ”
16.	HWNN0000003	Email chain dated 18 – 19 November 2023 between Asra Ahmad Healthwatch Nottingham and Nottinghamshire and Sally Carrier Nottinghamshire Healthcare Foundation Trust and others re “ <i>SMI Recommendations</i> ”
17.	HWNN0000009	Minutes of meeting on 26 April 2024 between Healthwatch Nottingham and Nottinghamshire and Sally Carrier Nottinghamshire Healthcare Foundation Trust