

Witness Name: Dr Faizal Yusuf Seedat

Statement No: WITN0163055

Dated: 6 July 2026

THE NOTTINGHAM INQUIRY

SECOND WITNESS STATEMENT OF DR FAIZAL SEEDAT

I, Dr Faizal Yousuf Seedat, will say as follows: -

INTRODUCTION

1. This is my second witness statement, which is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 5 June 2026 (the "Request").
2. I am a Consultant Psychiatrist, currently employed by the Nottingham Healthcare NHS Foundation Trust ('NHFT'). Full details of my qualifications, career, and role can be found in my first witness statement dated 3 February 2026 [WITN0163001].
3. This witness statement was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry with my oversight and input, following discussions in writing, by email and by video conference. Where matters are based on my direct knowledge, I say so. Where they are based on information shared with me by others or on my understanding of relevant documentation, I have indicated that accordingly.

BACKGROUND

4. I have been asked to provide information relating to my knowledge of the Trust's Early Intervention in Psychosis ("EIP") service, which was through

my roles as Lead Consultant and Clinical Director for the Adult Mental Health ("AMH") directorate. Both of these roles were carried out in addition to clinical work as a consultant.

5. I was Clinical Director from 2016 until 2022. For the first 3 years I jointly shared the role with Mick O'Driscoll and then from 2019 I shared the role with Michelle Malone, as Mick had taken retirement.
6. As set out in my first witness statement, my role as Clinical Director was alongside my full-time role as an inpatient consultant. Consultant time is split into 10 sessions (40 hours a week) , or "Programmed Activities ("PA", each PA being 4 hours)) per week, of which there is Direct Clinical Care ("DCC") (7.5 sessions for a full time equivalent), which includes all direct clinical patient input such as ward reviews, family liaison, multidisciplinary team discussions etc; Supporting Professional Activities ("SPA")(2.5 sessions for full time equivalent), which covers training, supervision, and other non-clinical professional activities; and on top of the full role consultants may take on Additional Responsibilities ("AR") which are usually formal management or educational roles such as Clinical Director. During my time as Clinical Director, my sessions were as follows:
 - i. January 2019 – January 2020: DCC 6.5PAs, SPA 2.5PAs, AR 4.5PAs (of which 4PAs was for Clinical Director)
 - ii. January 2020 – January 2021: DCC 6.5PAs, SPA 2.5PAs, AR 4.5PAs (of which 4PAs was for Clinical Director)
 - iii. January 2021 – January 2022: DCC 7.5PAs, SPA 2.5PAs, AR 4.5PAs (of which 4PAs was for Clinical Director)
 - iv. January 2022 - 2 August 2022: DCC 7.5PAs, SPA 2.5PAs, AR 4.5PAs (of which 4PAs was for Clinical Director)

7. This meant that I was working approximately a 56-hour week, starting early and finishing late each day. Of this time, 16 hours was for my clinical director role, which was built in with some flexibility with my clinical role, based on need. For the CD role this involved both time for my own development in the role and operational responsibility of the AMH

directorate with the opportunity for some strategic role for the AMH directorate. So, in summary I had 13.5 to 14.5 PAs per week job.

8. I had set days for my clinical work, and I had some set times when I focused predominantly on the CD role. I worked closely with my colleague Michelle Malone who would address any issues whilst I was doing my clinical work and anything that I needed to address I would do so during my Clinical director time. I did my best to make this work. This is not uncommon how consultants work when doing both clinical and management roles. Due to my clinical role, meetings that took place during my set clinical days I would struggle to attend, but I would seek updates from Michelle and review minutes that were relevant.
9. My co-Clinical Director from March 2019 was Michelle Malone, and this was her full-time role. We agreed that she would predominantly focus on the community side of the role, which was the larger remit, whereas I would focus on the inpatient side and senior medical management.
10. As Clinical Director, my time was spent on operational role for the directorate, jointly working with the senior directorate management team, line managing senior medical staff(consultants), fill medical vacancies that arose within the AMH directorate either via recruitment or locum cover (there were always between 6 to 9 vacancies), job planning for consultants, recruitment support (including speaking to potential candidates and trainees who may wish to take up vacancy posts), addressing medical issues (for example where a locum was not performing well, or where there were competency or capability issues with a medics), attending management meetings and at times chairing them and addressing complaints related to senior medics within the directorate.
11. From early 2020, due to the COVID outbreak, a significant focus of my Clinical Director role was devising ways to keep inpatient services safe, and open during the Covid-19 pandemic. This included controlling infections, PPE availability, testing of patients, and establishing dedicated Covid wards to limit spread.

12. With my co-clinical director, Michelle Malone we shared an office, and it was easy to keep each other apprised of developments and issues related to the directorate. We kept each other apprised of the areas which we were focused on and sought solutions for problems raised. We worked well, we got on and through her involvement, I was made aware of the community transformation work which she took a lead on. I was not able to attend a lot of the meetings of the transformation board, and she kept me updated of any developments. If there were any specific medical matters, we would discuss and plan a way forward. I do not recall at any point Michelle raising any issues with regards to medical input in the EIP teams from these meetings.
13. Given the above, it was difficult for me to undertake any kind of strategic role on top of day-to-day operational management. However, I was kept abreast and did seek out information of any strategic developments or decisions via my colleague Michelle, reading minutes, discussions within the SMT directorate meeting.
14. As Clinical Director, I reported to the Associate Medical Director, Dr Hazel Johnson. She was my line manager and did my job planning.
15. As Clinical Director, in addition to the operational duties of ensuring safe services were being delivered within the resources available to us, I attended and at times also chaired some of the directorate management meetings including the senior Management directorate meeting (SMT), AMH consultant forum, the quality and risk directorate meeting and the AMH Programme Board. It is my recollection that when the transformation of community services took momentum, the programme board meeting evolved into the AMH Transformation Board. I was not involved in the decision making around this. There was a cry from the directorate that there were too many meetings, and it was becoming difficult to attend them all. It was also felt that there was duplication and in response to this there was a senior directive to just have the Transformation board meeting which brought the AMH directorate and the senior trust management into one meeting. This fulfilled the needs of the work taking place.

16. As I have explained, the transformation work was mainly handled by my colleague Michelle Malone. I was not able to attend a lot of these as they clashed with my set clinical duties. Michelle, who regularly attended this meeting, updated me on key aspects and developments that arose from these meetings. The meeting had set agenda items which were around finance, subcontracted bed contracts, the transformation work streams including EIP work stream, recruitment, risk log etc.
17. I attended the AMH consultants' forum. This was the AMH directorate senior medical staff meeting. I had a standing slot, clinical director updates, which I used to inform the group of any organizational matters that they needed to be aware of. This also included updates on consultant vacancies, recruitment, staffing gaps, complaints, or other operational matters. There would be an opportunity for the senior medical body to raise any issues or concerns in the areas they worked in. During these meetings the consultant body was informed of the EIP transformation work (the EIP consultants were of course, through their teams, already aware of this) and an email was sent out to all teams, medics and the general manager to update them about EIP transformation [WITN0163066]. My recollection is that there was a general agreement from the EIP consultants that EIP going back to a stand-alone service was supported and welcomed. They understood that the EIP service needed dedicated staff, the required numbers to meet the needs of the patients. It was important that all patients could quickly be allocated care coordinators. The consistent issue raised by the EIP consultants in the meetings and individually was that there were not enough nurses to hold care coordinator roles with increasing demand, and they were pleased when additional funding was agreed to address this. I do not recall during my tenure as clinical director that concerns were raised by medics specifically around lack of medical time to safely deliver the service within EIP.
18. If a consultant raised a concern or flagged a risk at the AMH consultants' forum or directly to the clinical directors, this will be acknowledged and efforts made to address locally within the directorate. The intention would be to first see if this could be addressed by the directorate locally, clinical

directors would lead on this and if not then such concerns will be escalated to the AMH senior management meeting (SMT), at which operational managers, Clinical Directors, and service managers would be present. If it was not able to be addressed there, the matter would be escalated further to the senior trust management team. I would also raise these matters in my one-to-one meetings with the Associate Medical Director (AMD), Dr. Hazel Johnson, to seek guidance on resolving or addressing the concerns raised. There were no matters related to senior medical provision within the EIP service that needed to be escalated during my tenure as clinical director. These one-to-one sessions with the AMD, were open meetings in the sense that we could raise whatever we wished to discuss, whether they were organisational matters, staffing issues, or seeking advice on particular situations and whether any further steps should be taken.

19. The AMH directorate did have daily demand meetings and in addition to that there was also the EIP status monthly report to the AMH programme board where opportunity was there to raise any staffing issues including that related to medics. I was not able to attend the daily demand meetings as they clashed with my clinical work time, but my colleague Michelle Malone did attend them and there was no time when she raised concerns related to lack of senior medical support within the EIP services. There was also a standing item on the Transformation Board meeting, and no issues regarding senior consultant medical cover or availability were raised.
20. It is my recollection that on the whole there was interest from consultant colleagues to take on sessions working with EIP service. They were popular and based on this there were never periods when no consultants were covering these EIP sessions except for short periods whilst plans were being put in place to account for someone retiring or sickness. When sessions were offered that had become available, on the whole they would be quickly taken up. We ensured that the sessions related to EIP were taken on by one clinician working in the respective EIP team with the sector LMHT. For each local mental health team ("LMHT"), the EIP sessions were part of the job plan of one senior consultant. The EIP team would find it easy to relate to one clinician, develop working relationships with the

benefits of team cohesion and consistency. In my view, the sessions or consultant medical time allocated to each sector EIP team was sufficient for the caseload of the team.

21. The situation was very different in the other care pathways within the LMHT.

It was well known to the Board and the Trust that there were vacancy issues with regards to consultant medical staff within the rest of the local mental health teams, with vacancies of around 6 to 9 whole time equivalent in the AMH directorate. This calculated to an approximate vacancy rate of up to 10% to 15%, at any one time within the AMH directorate. The vacancies arose due to a variety of reasons including retirement and people leaving to better jobs with a better work life balance.

22. During my tenure as clinical director, when risks around medical staffing were raised mainly within the LMHT, we as the clinical directors will firstly find ways to address this locally by working with medical staffing and the recruitment team to both secure locums and also attempt to advertise the vacancies with hope of recruiting substantive staff. The concern around challenges around recruitment within AMH were well known to the board and also included on the risk register.

23. During my tenure as clinical director, I do not recall any issues pertaining to the lack of senior consultant medical input within EIP services ever being raised within the directorate SMT, the transformation programme board, the daily demand meetings or within the directorate business meeting.

24. The Lead Consultants reported to the Clinical Director. Their role was to support the Clinical Director in carrying out various tasks, including complaint investigations, job planning for the consultants within their area, and addressing issues arising in the Local Mental Health Teams ("LMHTs"). Lead Consultants did not have a formal line management role over the consultants within their area; the Clinical Director remained the formal line manager for all consultants within the division. However, if consultants had concerns, they would typically raise them through the Lead Consultants, who would in turn escalate them to the Clinical Director. In respect of job planning, I would provide directions to the Lead Consultants as to the

objectives for the service, and they would ensure that those objectives were incorporated into the job plans of the respective clinicians. I would then in turn carry out the job planning for the Lead Consultants themselves. Each Lead Consultant focused on a specific geographic area or portfolio.

25. After my tenure as Clinical Director, my colleague Dr Karthik Thangavelu took over the role jointly with another colleague, Gareth Foote. My colleague Michelle Malone had also taken retirement around the same time I ended my role as clinical director. Dr Thangavelu had previously been a Lead Consultant covering the city teams. I supported him by becoming a Lead Consultant for City South & City East LMHT, which I understand was the area where VC was a patient under the EIP team. I agreed to do the lead consultant to help the clinical director, as despite efforts to recruit someone to the role there was no interest. I agreed to step in to help until someone can be recruited. It was an interim agreement. During the tenure of my role as lead consultant, at no time was I approached, nor was it raised at a job planning meeting that there was not enough medical time to meet the needs of the service they were covering. There was discussion around fluctuating caseloads with a tendency to caseloads increasing but also decreasing, CTO related work etc but the service was safe in terms of medical input. In addition, specifically with regards to the city South LMHT, EIP team, I do not recall any concerns being raised about the lack of senior medical input to the team. The team itself, excluding the medics, would be managed and concerns would be addressed by the team leader, service manager or operational manager, and would not have anything to do with me, as lead consultant.

EIP SERVICE

26. When I took on the role of clinical director at the end of 2016, EIP services were stand-alone service but embedded within community mental health teams. The medical provision was sessional, and there were designated consistent consultants providing medical input to the teams who had developed expertise in providing care to people with psychosis

[WITN0462007]; [WITN0462008]. It was my recollection that during the time of my appointment the trust had also recruited a new senior management team who had an oversight of all directorates within local services. The trust was also requiring making cost improvements and it was my understanding that based on this, decisions were made by this management team for the EIP teams to be integrated within the community teams, there was reduced funding available and there was also a period of vacancy freeze but not for medical recruitment. This was a top-down decision, and I was not involved in this. There was a review undertaken in 2018 of 3 EIP teams serving the north of the county of Nottinghamshire north area (see [WITN0163056]; [WITN0163057] and [WITN0163058]) which evidences the challenges of the EIP service, performance and impact of integrated care.

27. In terms of consultant medical input, this has remained consistent for as long as I have been a consultant working at Nottinghamshire Health Care NHS Foundation Trust since 2007. The provision was on a sessional basis, covering the sector local to the community team, and EIP consultant sessions to each community team were based on caseloads. In all the time I was clinical director, I do not recall any issues being raised that there was insufficient consultant time, the work was undoable and no issues were raised by the service managers of the team expressing concerns around there not being adequate consultant cover to the EIP service. The sessions on the whole were always covered by substantive consultants.
28. Subsequent to the report in 2018 (the Intensive Support Team EIP review) and the need to widen the provision of EIP services to change from the then provision to people between age 18 and 35 years and to now open this from age 14 to 65 and also to that at-risk mental state for psychosis (ARMS).
29. In November 2019, the trust announced the appointment of a new clinical/Manger lead for EIP, Vidyah Adamson who had a psychologist background who started with the trust in January 2020. The intention was that EIP will be a stand-alone service; the nurses will only manage patients on their caseloads who fulfilled the criteria for EIP. In March 2020, the high case load concerns within EIP were raised and this was then included on

the AMH board trust risk register [WITN0163059] that the board and the senior management team had access to. The plan was for the service manager to review the caseloads and ensure all patients met the EIP criteria and if do not meet EIP criteria to consider safe transfer or discharge.

30. Vidyah Adamson was tasked with developing an EIP workforce configuration options paper. On 16th July 2020 at 16:55, Vidyah sent an email to Michelle Malone and I and confirmed our shared understanding of where we were with respect to the EIP transformation work and the significant challenges we were facing. In that email, she approximated how many consultant sessions (PA's) were available and where we need to be if we were to provide a full service. We replied to this by email [WITN0163060] to thank her for the information which was very helpful and the plan will be to gather the current sessions (which we did and collated by our PA in email to the clinical directors [WITN0163061]) we had for EIP services related to consultant medical input and we will also inform the medical body about her findings. This was done via email to the medical body [WITN0163062].
31. In the email from Eileen O'Regan on 2 July 2020 she also raised concerns around staffing within EIP services and that a solution needs to be found in order for the service to be safe to continue to work. A reply was provided by Vidyah Adamson on 3 July 2020 [WITN0462005]. The intended solution was to come up with the options paper.
32. Vidyah Adamson via email shared her first draft of the EIP Workforce Configuration Options Paper [WITN0163063] to the AMH SMT and also to the senior management team, Christopher Ashwell, deputy director and Julie Attfield – executive director of local mental health services. It must be acknowledged that we as clinical directors were not involved in contributing to the contents of this paper nor subsequent versions of the paper other than the insistence of including medical time in the workforce configuration options paper. This was also shared with the AMH consultant body. I replied after reading this paper via email to Vidyah Adamson [WITN0163063] highlighting the importance of senior medical staff within the provision and was surprised that the proposed models did not have any

medic time modelling incorporated. Vidyah replied that simply for ease, medic provision will remain within the current bases and provide EIP as presently. My colleague and I insisted that medical time needed to be included within the proposed workforce configuration for EIP, and this was acknowledged and included in the final paper sent to commissioners by Vidyah. Vidyah shared with Michelle and I the options paper sent to commissioners [WITN0163065] which we as the clinical directors agreed with. In September 2020, Michelle Malone on behalf of the clinical directors and the general manager sent out an update which included EIP to all the teams in AMH and medics about developments around EIP and personality disorder (email from Michelle Malone, dated 10/09/2020 at 10:51 to the personal assistance to action [WITN0163066]).

33. In my interactions with Vidyah Adamson in person or via email, there was no time that I could recollect where she raised a preference about having full-time designated consultants delivering consultant medical input in the EIP teams. In fact, in an email [WITN0163064] she stated that medic provision will remain within the current bases and provide EIP as present.
34. I can confirm that the EIP service model and provision was a standing item on the transformation Board agenda. As stated, my colleague Michelle Malone was more involved with community services and matters relating to the transformation of the EIP service would mainly be raised in the AMH Transformation Board, to which I was not a regular attendee but my colleague Michelle Malone was, and this was within her remit. She did appraise me with any developments and in particular if there were any medic concerns. I do not recall her raising any concerns and in April 2021 she asked in the Programme board if there were any medic concerns and none were raised.
35. I believe that some form of additional funding was agreed for EIP and that, in terms of the response to that funding, Michelle Malone took the lead jointly with the transformation leads for EIP services. I have a vague recollection that there was a discussion about how best to utilize the additional medical time that formed part of that investment, and we were both in agreement that these would be best offered as sessions to the

respect areas where it was needed and to the consultants who were already within those roles to ensure consistency. We did not believe having full-time dedicated EIP consultant was feasible; due to the geography each consultant would need to cover would lead to significant travel time, handling larger caseloads would mean less familiarity, relating to a larger team will mean dilution of working relationships and there were significant challenges around recruitment.

36. I understand that the concept of a "dedicated EIP consultant" referred to having consultants working within the EIP service who did not perform other roles other than senior consultant provision to the EIP service. The plan was to have 2 stand-alone EIP services, EIP south and EIP north. The teams would include a mixture of both city and county areas. The intention would be that the caseloads in either team will be quite similar in numbers and hence the consultant time would be divided into 2, meaning 2.25 WTE (whole time equivalent) for each team bringing the total provision to 4.5 WTE which was based on the options paper funding agreement. The alternative model (which was how EIP operated when embedded within LMHTs) was for the available consultant sessions to be distributed in terms of whole-time equivalents across the LMHT structures, rather than being held by standalone dedicated posts.
37. I am clear that there was never a question of each individual EIP team having its own full-time dedicated consultant, as that would have been unworkable and would not have been a proportionate use of available resources. Based on the calculations that were in existence at the time, my understanding was that the sessions allocated to EIP psychiatry were in line with what was happening nationally. In my time as clinical director or subsequently lead consultant, there were no concerns raised with regards to work not doable, there needed to be changes to the job plan etc with the main issue raised being changing caseloads, at times demand was high and at other times demand would fall. This was a general discussion rather than asking for any specific action.
38. When I was a Lead Consultant for 2 city teams (city south LMHT and city East LMHT) after my clinical director role, one of my roles was to do annual

job planning with consultants in the patch I covered. I carried out job planning for EIP consultants, including Dr. Tuhina Lloyd. If concerns were raised by them during those discussions, I would have documented them in the job plan. Having looked at the job plans there have not been any concerns documented, nor do I recollect about there not being sufficient consultant time for the role. From recollection, I believe Dr Lloyd raised the fact that caseloads had increased and that demand had increased. However, my recollection is that this was not raised as something that required immediate action; rather, it was a matter to be acknowledged and monitored. Any increase in demand at that time was not specific to EIP; demand had increased across all areas. The caseloads were to do with the team. Dr Lloyd did not raise concerns about her workload numbers if they were unmanageable, the inadequacy of her sessions or any aspect of her work. The concerns she raised about team caseloads were well known to the team and the service and operational managers who were monitoring and helping address.

39. In general, from my experience as Clinical Director, EIP was better recruited than conventional LMHTs. During my whole period of being the clinical director, there were never concerns raised around vacancies within the EIP service that could not be addressed. There was never a time when I had to seek a locum or advertise an EIP consultant role to cover EIP consultant time. EIP sessions were popular and highly sought. If there was someone who was retiring, there would be a lot of interest from existing consultants to take on that post and give up sessions within the LMHT. The significant challenges including vacancies that I dealt with were all to do with LMHT work which excluded EIP.
40. From review of the transcript, I believe that she was actually referring to the request of dedicated psychiatrists to the EIP service (which I have covered above) and not psychologists. I do not recall Dr Adamson raising with me any requests around psychology provision or dedicated psychologist within the EIP service. I did not have line management responsibility for psychologists, and I was not involved in psychology recruitment.

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: 6 July 2026

Index to First Witness Statement of Dr Faizel Seedat

No.	Exhibit/ reference number	Document title	Description
1.	WITN0163001	First witness statement of Dr Faizal Yousuf Seedat dated 3 February 2026	First witness statement of Dr Faizal Yousuf Seedat dated 3 February 2026
2.	WITN0462005	RE_ EIP LMHT City North	Email correspondence from Eileen O'Regan re: Concerns on funding for EIP
3.	WITN0462007	FW_ Medical input into EIP	Email correspondence from Michelle Malone re: attaching current spread of EIP medical sessions
4.	WITN0462008	Copy of EIP Sessions V2.xlsx	Spreadsheet of EIP sessions

5.	WITN0163056	FW_ IST EIP review final version	Email correspondence from Tracey Taylor re: IST EIP review final report – dated 14.12.2018
6.	WITN0163057	RE_ NCAP EIP Audit 2019_20 - Outlier Investigation Report	Email correspondence from Tracey Taylor re: the completed NCAP EIP Audit 2019/20 Outlier Investigation Report dated 09.03.2020
7.	WITN0163058	FW Local analysis of most recent NCAP audit.msg	Email correspondence from Jo Horseley re: Local analysis of most recent NCAP audit dated 12.02.2020
8.	WITN0163059	FW_ AMH Programme Board Risk Register	Email correspondence from Charlotte Davidson re: attaching Risk Register dated 03.06.2020
9.	WITN0163060	FW_ EIP and Medical Time	Email correspondence from Michelle Malone re: EIP transformation work dated 17.07.2020
10.	WITN0163061	FW_ EIP and Medical Time (2)	Email correspondence from PA re: attached spreadsheet of EIP medical time
11.	WITN0163062	FW_ EIP and Medical Time (1)).	Email correspondence from Michelle Malone re: requesting further information on medical time dated 17.07.2020
12.	WITN0163063	EIP Workforce Configuration Options Paper	Email correspondence from Vidyah Adamson re: first draft of the EIP Workforce

			Configuration Options Paper dated 20.07.2020
13.	WITN0163064	RE_ SMT with Leads (1)	Email correspondence trail on 22.07.2020 between F Seedat and V Adamson re: workforce configuration models lacking medic time
14.	WITN0163065	EIP Model Options Paper V5_docx	Email correspondence from V Adamson re: attaching EIP Options Paper shared with Commissioners
15.	WITN0163066	FW_ transformation updates	Email correspondence from Michelle Malone re: transformation updates and attached update on activity in relation to EIP and services for those with a personality disorder dated 10/09/20