

Witness name: Sarah Hayler

Statement No: **WITN0496001**

Dated: 7 September 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF SARAH HAYLER

I, SARAH HAYLER will state as follows: -

Introduction

1. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 17 July 2026 (the "Request"). It was drafted on my behalf by Solicitors acting for Nottinghamshire Healthcare NHS Foundation Trust ("the Trust"), with my oversight and input, following discussions in writing by email and by video conference.
2. At the outset, I would like to offer my heartfelt thoughts and sympathy to all involved.
3. I had no involvement in the care of VC. I worked in a different City Team to that which VC was treated in. My evidence relates to my experience working in Nottingham, rather than to the care provided to VC.

Professional Background

4. I qualified as a Registered Nurse in 1990 and a Registered Mental Health Nurse in 1992. My employment history is as follows:
 - i. 1990-1991 – Staff Nurse on Ashwell Ward (Health Care of the Elderly)
 - ii. 1991-Training to become Registered Mental Health Nurse at Nottingham School of Nursing
 - iii. 1992/3 -1999 – Staff Nurse on Carlton Ward (Acute mental health)

- iv. 1999-2000 Medical Representative for Family Planning Sales
- v. 2000-2005 – Community Psychiatric Nurse at Mandala Centre (County Mental Health Team).
- vi. 2005-2024 - Community Psychiatric Nurse and Clinical Lead at Stonebridge Centre (City based Mental Health Team)
- vii. 2024-present - Clinical Care Practitioner on Mental Health Response Vehicle with East Midlands Ambulance Service and Nottinghamshire Healthcare NHS Foundation Trust

Clinical Lead Role

- 5. I initially worked as a Community Psychiatric Nurse within the City Recovery Service, which later became the City South Local Mental Health Team. During this time, I also held the role of Clinical Lead before reverting back to Community Psychiatric Nurse in 2023.
- 6. My responsibilities as Clinical Lead included but were not limited to, overseeing the day to day running of the multi-disciplinary team (MDT) to ensure the smooth coordination of care for patients. This included allocating referrals and managing the distribution of caseloads, supervising care coordinators (CCOs) who are predominately community psychiatric nurses (CPN) or on occasion occupational therapists or social workers. I would lead and chair the MDT meetings, and monitor risk and timely reviews of the patients. In addition I would escalate any clinical or operational issues to the service and operational managers. I would also carry out urgent initial assessments of patients to determine their needs and signpost as required. I also supported patients who had not been allocated a Care Coordinator, assess their risk and develop a support plan. As a Care Coordinator, I would also write care plans and risk plans, provide psycho-education and administer medication and be an advocate for patients.
- 7. My supervision responsibilities were a mixture of managerial and clinical supervision. Exhibited to this statement is a list of the staff members I was responsible for providing managerial and/or clinical supervision: **WITN0496002** The second tab ("supervisions given") records the name of the staff member, their team and directorate, the type of supervision, the date, whether any safeguarding issues were discussed and whether any issues were escalated.

8. Managerial supervision was usually undertaken by an individual's line manager. This involved a meeting that is a formal process where the manager reviews performance, discusses concerns with regards to the person's caseload and place within the team, adherence to policies and procedures, and any changes of these that may be taking place.
9. Clinical supervision can be provided by a line manager or someone that has a greater understanding of the person's workload and needs. It is the opportunity to receive professional support and guidance and a safe place to reflect. The aim is that this will hopefully improve the person's overall care, make them feel valued and provide an opportunity to discuss concerns about their practice, obstructions within the team and workload. It also includes psychological and emotional support.
10. As the records show, I provided some supervision to members of the EIP South team between 2018 and 2020. It was my practice to make handwritten notes of these supervision meetings and I have asked the Trust to try to locate these notes and provide any found to the Inquiry.

Concerns about caseloads and resourcing

11. On 7 December 2018, I received an email from Dr Danel Tsoi (Consultant Psychiatrist) forwarding on an email from Sarah Toone (Service Manager City Community Teams), which had been sent to all LMHT consultants regarding the transformation of services. This included a breakdown of the number of patients allocated to each consultant in the City LMHTs, which ultimately meant that the team were 4 Physician Associates short. As I did not provide supervision to medics I did not know how many patients were going to be on each Consultants caseload. I recall that there was concern that the expectation was that medics were going to have a substantial increase due to areas being covered by our team. Dr Tsoi also flagged that this capacity issue ought to be discussed with Dr Seedat (Clinical Director) or Dr Thangavelu (Lead Consultant), given that a member of staff was also due to go on maternity leave in February 2019. I responded to Dr Tsoi's email and advised that I was interested to know how this issue could be taken forward [WITN0496003] Unfortunately I have no further recollection about any steps taken following this email exchange.

12. I have no recollection of Dr Adamson, Dr Lloyd, Emma Robinson, Sharon Heath or any other member of the EIP team having concerns as to EIP resourcing and/or the ability of the EIP to deliver its services.

Dr Lloyd's email of 30 April 2019

13. I have read the extract from Dr Lloyd's email provided to me by the Inquiry [WITN0206043], stating as follows: *"We are currently under pressure from our team leaders to discharge high risk AO clients on the grounds that they are not engaging! There seems to be a lack of understanding about the nature and ethos of AO model."*
14. The Inquiry has asked me several questions about this email. I do not have any specific memory of this email but have attempted to answer the Inquiry's questions as best as I am able to do.
15. I can confirm that I was one of Dr Lloyd's Clinical Leads during this period of time in April 2019.
16. The Assertive Outreach Model was previously a separate, standalone service providing specialist skills and resources to manage patients who struggled to engage with services. The standalone service was disbanded in approximately 2015 and the function was undertaken by the Local Mental Health Team ("LMHT").
17. The model at the time included a larger amount of support workers who could attempt active engagement with patients within the community. The caseload was smaller with approximately 10-12 patients per Care Co-ordinator, which in turn allowed for more frequent contact. The whole team took responsibility for the patient rather than a single CCO which gave multiple chances to build a connection and meant that if the CCO was not available or on leave the patient was well known to other team members and trusted them. This structure also reduced the chance of disengagement if a trusted CCO left. The focus was not just on mental health and medication, but also on housing, benefits, education, and employment.
18. In the new model, there was no out of hours or weekend working, team-held caseloads, or daily meetings to discuss all the AO patients. To my understanding, post 2017, AO patients continued to be clustered (a national system that groups patients based on the

nature, severity and complexity of their presentation) so that they remained identifiable as group of AO patients, and specific Consultants were also identified to provide medical input to this specific patient group. Those on the AO pathway were all allocated care co-ordinators.

19. I did not work in the AO service prior to the transformation. However, I do recall that the staff who had been working in the AO service were concerned that the patients that were part of the AO service were likely to disengage or not receive the same care. A 9-5 service was not always the best way to provide care for people who are acutely unwell and live a chaotic lifestyle. They had previously worked in a way that there were a number of staff that knew their patients and would adapt their care to suit them. I have no recollection of flagging any concerns in a formal manner but know that staff were unhappy about the changes described above for these reasons.
20. My view is that every possible attempt should be made to engage with patients so that a therapeutic relationship is gradually built, not just calling at the home address or inviting to a medical environment. Attempting to see the person at different venues, different times and with regular staff is important. Discussing the concerns daily with the team and having this documented in patient's notes is also important.
21. Sadly, some people will not engage with any service and as long there is no risk to themselves or others, discharge might be appropriate. I would hope that every possible attempt was made to engage with a patient even if it is minimal at first, and that the patient is given the information about how to access support. I believe that there was always a multi-disciplinary team meeting where concerns and risks were discussed. I do not have any specific recollection of any members of my team discharging assertive outreach patients on the grounds of non-engagement.
22. When I was clinical lead I would ensure that the management and/or discharge of assertive outreach patients was discussed in a formal meeting with the multi-disciplinary team and a clear care plan was put in to place describing what attempts had been made. Clinical supervision was also a mechanism by which particular cases could be discussed.
23. I was not aware of any members of my team applying pressure or being pressured to discharge high risk assertive outreach patients.

24. I do not believe that Dr Lloyd ever raised with me any concerns about a lack of understanding by myself or the team as to the nature and ethos of the assertive outreach patients, nor (with the exception of the email described above) did Dr Lloyd ever mention any pressure being applied to clinicians to discharge these patients.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, 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: 7 September 2026

Index to the first witness statement of Sarah Hayler

Exhibit	Document
WITN0496002	Management spreadsheet
WITN0496003	Email exchange with Dr Tsoi
WITN0206043	Email from Dr Lloyd dated 30.04.19