Witness Name: Stuart Ayris

Statement No: 1

Exhibits: N/A

Dated: 21st February 2025

THE LAMPARD INQUIRY

Witness Statement of Stuart Ayris

I, Stuart Ayris, will say as follows.

PRELIMINARIES

1. My full name is Stuart Alan Ayris.

2. I retired from Essex Partnership University Trust ("EPUT") on Tuesday 13 August 2024 after almost 22 years working for the Trust.

BACKGROUND

3. I qualified in October 1997 as a Registered Mental Health Nurse.

4. By way of brief overview, my career progression was as follows:

    a. October 1997 to April 2002: I worked as a staff nurse at Warley Hospital in Brentwood (Adult psychiatric hospital, under the Barking, Havering and Brentwood Healthcare Trust).

b. April 2002 to October 2003: I worked as a Charge Nurse at The Christopher Unit in Essex (a newly built Adult Psychiatric Intensive Care Unit, attached to the Linden Centre).

c. October 2003 to March 2009: I worked as the Ward Manager of Finchingfield Ward at The Linden Centre in Essex (Adult acute admissions ward).

d. March 2009 to October 2009: I worked on the Trust Safeguarding Team with various responsibilities, including conducting Deprivation of Liberty Safeguards (DoLS) assessments within EPUT.

e. November 2009 to June 2014: I worked as the Team Manager at Maldon Community Mental Health Team in Essex.

f. June 2014 to July 2016: I worked as a Charge nurse at Ardleigh Ward, The Lakes (Adult Acute Admissions Ward).

g. August 2016 to May 2019, I worked as Bank Nurse on various teams, including Access and Assessment Team and the Mental Health Liaison Team conducting emergency psychiatric assessments at Colchester Hospital.

h. May 2019 to March 2021: I worked as a Community Psychiatric Nurse in the Psychosis Team in Holmer Court, Colchester.

i. March 2021 and March 2022: I took a year out from work to go on an extensive period of world travels.

j. April 2022 to January 2023: I worked Bank as a Community Psychiatric Nurse in the Specialist Mental Health team in the Gables (Braintree), before going on a short period of travelling.

k. July 2023 to August 2024: I worked as a Community Psychiatric Nurse for the Specialist Mental Health Team in the Gables (Braintree).

5. I worked solely within adult settings.

6. In addition to the work outlined above, throughout almost half my career I also provided training on average for approximately 20 days a year, including for Ethical Care, Control and Restraint, Care Programme Approach ("CPA") and Safeguarding.

7. The evidence I provide comes from having worked on the wards as a Registered Mental Health Nurse and, for several years, as part of the managerial staff.

8. My key concerns include:

    a. EPUT's focus on perception, and how the organisation will look if something tragic happened, as opposed to making every effort to ensure that nothing tragic happens in the first place. This takes place to the point where patient care is overlooked.

    b. Focus on statistics, and blaming individuals when something went wrong for systemic reasons.

    c. Lack of care, understanding and compassion.

LINDEN CENTRE

General Overview

9. I was Ward Manager of Finchingfield Ward at the Linden Centre. My line manager, for the majority of my time in this role, was Stuart McGough. His line manager was, for the majority of my time in this role, **[I/S]** who was responsible both for the Linden Centre and associated Community Mental Health Teams.

10. When I first started working at the Linden Centre, I noticed immediately that there was a set way things were done that was different to how I had been trained and how I had been accustomed to working at my previous employment in Warley Hospital, Brentwood. I felt like an outsider from the beginning, but I stuck to what I felt was right. This did not always go down very well. I did not go to as many managerial meetings as I perhaps should have.

11. Whilst a Charge Nurse at The Christopher Unit, I developed a nursing model that saw all staff directly involved in every patient's care, as opposed to having designated nurses. It had been identified that certain patients did not always connect with all staff members, and as such a system was developed whereby nurses were rotated so everyone was involved in different aspects of every patient's care, e.g. assessment, risk assessments and discharge planning. The nursing model was nominated for a Trust Award.

12. When I became manager of Finchingfield Ward, I adapted the nursing model for the larger ward environment. Some staff who had been on Finchingfield before I joined as Ward Manager were not happy with this. As a result, there was a large turnover of staff when I first joined and I interviewed and recruited people with a focus on personality more than experience. It was important to me that genuinely kind and open-minded people worked on the ward.

13. In my view this model worked because all the staff knew all the patients. I think its effect was evidenced by the fact that there were very few suicides (I believe there was one in the six years I was there). We had other incidents where people felt strong emotions such as anger and aggression but, because of the generally good relationship between patients and staff, these situations were fairly infrequent and generally well managed.

Admission, Care Plan & Observations

14. When a patient was admitted to Finchingfield Ward a care plan would be prepared to cover the first 72 hours of admission. It would be prepared by a qualified nurse (i.e. a registered nurse) in the Assessment Team and it would cover: observations, physical health, medications, legal status (i.e. whether a patient was voluntary or detained) and engagement with staff. The initial care plan also included a list of points to help patients throughout their admission. For instance, recommending that they engage with staff and take medication when it was offered. It was intended for people who had not been admitted before, so they understood what admission involved.

15. After the first 72 hours, a more personalised care plan would be prepared. Where possible, this would be done in collaboration with the patient. It would cover additional matters like what they wanted from their admission. It would also include a discharge plan. This care plan should then be reviewed on a weekly basis. There was an assessment diary that dictated when a care plan needed to be reviewed. In my experience, the extent to which care plans were consistently reviewed and updated had previously depended upon who the assigned nurse was. The use of the nursing model we used on Finchingfield Ward made it less likely that reviews would be missed or overlooked due to each sub team within the staff team (Assessment Team, Risk Assessment Team and Discharge Team) having their own diary system.

16. When a patient was admitted to The Linden Centre they would be on Level 2 observations, which means they should be engaged with a minimum of four times per hour. This could then be increased to Level 3, meaning they should always be in eyesight and Level 4, meaning they should always be in arms reach.

17. When I started on Finchingfield Ward, the nurse in charge of each shift was able to increase and decrease observation levels. That then changed, so that only doctors could decrease observation levels. I think that change occurred in around 2005-2006. I felt that was problematic because a nurse having consistent engagement with a patient was, in my view, in a better position to know what level of observation was required to keep a patient safe. Level 3 observations are very restrictive and can be detrimental to a patient's health. The priority was to try and reduce Level 3 observations as soon as it was safe to do so. I sometimes felt that increasing the observation level was done with the thought of protecting the Trust rather than thinking about what was best for the individual.

18. On Finchingfield Ward, if a patient was on Level 3 observation, the staff member responsible was not to sit down: they were encouraged to actively engage with the patient as a means of constantly assessing risk. The allocated staff would rotate with a different staff member every hour. I also

advocated matched patients with staff to ensure it was a good match: being under observation is unpleasant enough.

19. I think 'observation' is a misleading term. It was about engagement, rather than just observing someone.

Staffing

20. On Finchingfield Ward there would be four members of staff (two qualified and two unqualified) plus the manager on each day shift. If there was a patient on Level 3 observations, that would be covered by one of the four members of staff and there would be rotation within the team for this task every hour. At night there would be two qualified and one unqualified staff member on the ward.

21. Ideally, one of the two qualified nurses would be at charge nurse level. You needed two qualified staff to give medication. Qualified staff would handle any engagement with families and unqualified staff were more involved in patient engagement. I never felt that I had particular problems with staffing on Finchingfield Ward after the first year of my taking on the Ward Manager role. Although when I was a Charge Nurse at The Lakes we were understaffed and there was a lot of bank and agency staff usage.

Transfers

22. The need for a transfer would be determined by a doctor as part of their ward round if the necessity for a transfer was based on clinical need. It would generally happen where someone was deemed to need more secure care and, in those circumstances, we would refer to the Christopher Unit. The process involved two people from the Christopher Unit (including a Band 6 psychiatric nurse) coming to The Linden Centre and making a face-to-face assessment of the patient.

23. There was tension in that process because it was felt that the staff at the Linden Centre would know how much risk they could contain, but sometimes the people from the Christopher Unit would conclude that the risk could be contained on the referring ward and so would reject the

referral. The only option would then be to re-refer, but that usually meant re-referring after something bad had happened. I think this issue came about because the Christopher Unit became the only secure place to refer people to, so they had to prioritise the most high-risk referrals.

24. More routine transfers to other facilities were based on locality and where a patient's GP was located. Patients would be transferred to their local area when a bed became available there. Transfers could be very disruptive for the patient because they might have just settled into their environment and become comfortable with staff before being transferred. There were sometimes transfers to private facilities if there was no bed available, or to specialist units such as the Maudsley in London. Transfer decisions were doctor-led, with little patient or family involvement.

Relationship between staff, doctors and management

25. When I first started on Finchingfield Ward, it seemed largely medically-led: what the doctor said goes and the staff did not have much of a say. Over time the relationship became more collaborative. Medication is important of course but there is much more to it that staff can help with because they spend so much time with the patients during the week.

26. Our approach to self-harm is a good example. Our first question was "do you feel better" or "did it help" rather than to immediately medicate, increase the observation level or remove all items from their rooms. Our approach was more humane, and it was effective. I don't think, however, that senior management were fully in agreement and I don't believe our approach was replicated on other wards.

27. The fact that our general approach and the nursing model worked was evidenced by us frequently having empty beds which led to us providing care and treatment for patients from other wards within the Linden Centre and beyond.

Decision-making to avoid complaints:

28. As time went on, I started to feel decisions began to be made to appease patients and avoid complaints.

29. The use of medication is an example, in particular the use of night sedation. It was provided to almost everyone within a few days of arriving (largely at the request of the patient, because it is hard to sleep on the wards). In my view, the use of night sedation was excessive and led to patients becoming dependent on it.

30. Another example is the provision of coffee. The patients requested coffee throughout the day and night; this was provided. Given the excessive use of night sedation, I felt it wrong that we, as a hospital ward, were providing caffeinated drinks 24 hours a day and made a decision to switch to decaffeinated beverages in the evening. This was overturned by senior management on the grounds that it had led to patient complaints of being treated differently to patients on the adjoining ward (Galleywood Ward).

31. When I worked as a Charge Nurse on Ardleigh Ward at The Lakes, the Doctors would not necessarily overuse medication, but they would ask patients "what do you want to be on?" and then almost always grant the patient's wishes. I felt this to be, at times, an abdication of professional responsibility in order to avoid complaints under the guise of involving patients in their own care and treatment.

Restraints

32. When I became Ward Manager of Finchingfield Ward, I was given the opportunity to train as an Ethical Care, Control and Restraint Instructor. I accepted in order that I could be a role model for others on the ward should incidents occur and to ensure the procedures were followed as compassionately as possible. I was therefore part of the Ethical Care, Control and Restraint Training Team that worked across the Trust to train people on proper procedures.

33. When the alarm would go off in Galleywood Ward, the staff from Finchingfield were sometimes asked to assist. We would, for example, get a call asking for "two males". I would either always take three people with me

in order to have control over the whole incident, or I would ensure that the right people were sent, i.e. those who were kind and trained in the techniques, regardless of gender or size. Someone who is kind is more effective in seeking to de-escalate aggressive situations.

34. When physical restraint was required, we would continuously talk the patient through the process. If someone had dementia or a learning disability, you had to tailor your communication as much as you could.

35. Medical sedation could be used. However, there was a flowchart of things to try before it was, as part of the Trust's 'Rapid Tranquilisation Policy'. It was very important to explain to the patient why it was being used. It is obviously open to abuse and you are reliant on the person providing care acting ethically. There were not a lot of safeguards in place generally to ensure procedures were followed, but I believe that proper procedure was followed on Finchingfield Ward and we managed such situations productively.

Treatment of comorbid issues

36. The approach to physical and mental health needs was disjointed: people were given medication that had physical effects for years. I'm particularly thinking of those diagnosed with forms of Personality Disorder or ADHD who were prescribed anti-psychotic medication.

37. Despite the fact that a significant proportion of patients at the Linden Centre were admitted with pre-existing drug and alcohol issues, there were no permanent drug and alcohol workers attached to the wards or the Day Hospital. I thought the approach to treating those with drug and alcohol dependency was terrible.

38. The general knowledge of staff at The Linden Centre in relation to co-morbid issues was poor. There weren't any specialists in dementia or learning disabilities, for example. In respect of physical comorbidities, we often relied on the doctors who were training in psychiatry but might have already done three years training, for example, in general medicine. Or there might have been a staff member who was diabetic, for example, and so had some understanding of what was required for a diabetic inpatient. In that sense,

the treatment of comorbid issues was inconsistent. It might depend on who was working on the ward at any one time. We would take inpatients to Broomfield Hospital as and when required due to physical ill health as it was on the same grounds as The Linden Centre.

Staff attitudes

39. I heard about difficulties with staff attitudes in other areas of the Trust during the courses I taught. Due to the high turnover when I first began and the fact that I was largely able to recruit the staff I wanted, I did not have so many issues related to staff attitudes on my ward, although there were, inevitably, some.

40. When I first arrived, there was an issue about staff accessibility to patients. The office door was often closed and the majority of staff were behind that closed door. Only one person was in the actual corridor. This created a physical divide between patients and staff, and patients would have to really try hard to get the help they needed. I insisted the office door remain open, with one person in the office and all others on the ward. This did not sit well with the staff. Senior management introduced something called "Patient Engagement Time" ("PET time") where, for 1 hour during the day phones, would be off, the office door shut and staff were to dedicate their time to the patients. To me, this seemed the wrong way around, a dedicated "paperwork hour" being more appropriate, with the remaining time spent with patients.

41. I managed things on the ward the way I saw fit and it became apparent that there became a distinct divide between the way Finchingfield Ward and Galleywood Ward operated. These included the way we managed level 3 observations, our approach to issues around self-harm, insisting that the majority of staff at any one time were out with patients and not behind a closed office door, increased nursing input in ward reviews and trying to foster a general atmosphere of positivity. As the divergence between the approaches of the two wards became clearer, and particularly due to the fact Galleywood Ward's Ward Manager (Rahma Saibon) had been in post for many years, I began to feel increasingly isolated in my role.

Nursing model and risk assessments

42. On Finchingfield Ward we used the nursing model I'd adapted from the one previously used on The Christopher Unit. This broke down the staff group into three rotating teams: Risk Assessment, Assessment and Discharge Planning. Risk assessments were collaborative and we would sit with the patients and speak to them about their associated risks and the reasons for them being on certain levels of observation. This resulted in better understanding from the patients and therefore fewer incidents. That did not mean however that our documentation was always perfect or that we did not have our share of incidents from time to time.

43. The general attitude towards health and risk assessments from the Trust appeared to me to focus almost solely on the paperwork being up to date. There appeared to be very little attention on the fact that many of the patients were experiencing a crisis point in their life. Instead, the emphasis was on audits. Big yellow incident form books had to be filled out and then carbon copies placed in all the relevant folders. These seemed to me to be largely pointless as we never received feedback in relation to the incidents from Risk Management.

Ward Environment

44. The ward environment was very difficult for patients. They were initially in dormitories with six people in each room. The set-up was poor and it was a difficult physical environment to manage. However if you were walking around and actually speaking to people, then it was not impossible. In time, things changed so that we had more shared rooms and then single rooms. We tried to manage things by putting certain people together and keeping certain people apart, depending on their particular needs. I always advocated trying to see things from how it must feel from a patient's perspective.

45. I also witnessed the transition from mixed wards to single-sex wards. I'm not sure if that was a local or national decision. A lot of people admitted had had abusive partners or been abused by someone of the opposite sex, and on

mixed wards some male patients could be loud and aggressive, so some female patients would feel anxious and stay in their rooms. On single sex wards, female patients were often more comfortable to come out of their rooms. I think we were quite ignorant to these issues before the transition.

46. On the other hand, there could be difficulties with single sex wards. Some patients were less comfortable with them and it could be difficult being a male nurse on an all-female ward. I don't think it's a straightforward issue.

47. The Linden Centre became increasingly restrictive and evolved into something like a secure unit. Rather than Risk Management asking itself "why are people absconding", they just added more barriers to prevent people from leaving. My only real concern about the ward environment was that it just became more and more locked up.

48. I have only one experience of a ligature risk, which was the day after Benjamin Morris died. I went to Galleywood Ward and discovered the wardrobe door handle that had been used. I knew some of those handles were on the Finchingfield Ward. I went back to take them off and was informed by my Clinical Manager, Stuart McGough, to put them back on because I was damaging Trust property. This was apparently a job for "Estates". In my view it was better to act immediately to try and mitigate the risk, rather than have to write a report, wait for a response, etc. The handles were subsequently changed by Estates but I cannot recall how long after Mr Morris' tragic death.

49. The process for reacting to such environmental risks was in my view appalling and not conducive to helping anyone. Decisions regarding changes of such gravity should be as immediate as possible. In my view, we should be speaking to and engaging with the patients to see what the risks are. It seems strange to me that decisions about the safety of a ward are made by people who may have never worked on such a ward before.

Absconsion

50. Absconsion did happen when I was manager of Finchingfield Ward, but not too often. I felt we had relatively good relationships with the majority of

patients, so they were less likely to abscond. If someone did abscond, we would discuss with them why they didn't want to be there. After weekend leave, people often wouldn't want to come back, which I thought was understandable. As the ward environment became more and more restrictive I thought it made people more likely to want to leave when they had the chance.

Discharge

51. Decisions around discharge would be made at a CPA discharge meeting involving a Care Coordinator and the family.

52. Once someone had been discharged, the ward would have to speak to them within 24 hours of discharge and the Care Coordinator would need to meet with them within 7 days of discharge. That was based on national guidance because of the statistically high risk of suicide within 7 days of discharge. Having since worked as a Care Coordinator, the process can feel chaotic. Meetings are frequently cancelled or you can be sitting waiting for hours. Meetings are now conducted via MS Teams, but that hasn't made things any easier. The pressures on a Care Coordinator are significant. You might have around 40 patients within the community and be needing to see 4-5 patients per day in addition to various non-patient-facing commitments.

Patient involvement in care

53. Wards operated quite individually and were not micromanaged. My approach was to involve the patient as much as possible in their own treatment and care. This approach made sense to the staff that I worked with.

54. The dynamic between doctors and patients changed over time. It was initially the very traditional "what the doctor says goes". For example, in the Christopher Unit at one stage a doctor said to me "the ideal patient is one that is medicated to just above a coma". Over time, that attitude changed and doctors began advocating for their patients more. In my view the balance then swung too far in the other direction to one of, "whatever the patient wants", in order to reduce complaints.

Family involvement in care

55. When I went into the community, I realised the extent to which we did not involve families when on the ward. There was no real "process" for their involvement; it was not systematic.

56. Most often, family were invited to patient reviews, although not systematically. I learned over time though that not all families were supportive.

57. I did always try to involve them at the point of discharge, but really they should have been involved from the beginning. The care coordinator in the community teams would often know the families more, and would invite them to reviews, but that was the extent of family involvement.

58. Once I started working in the community, I began to appreciate how disjointed and poor our inclusion of family members was at The Linden Centre. It was less a priority to learn about a person's life than it was to treat the immediate episode that had led to admission. It would have made a massive difference to keeping individuals safe if we knew more about their life, their previous traumas, their likes, their dislikes, their fears etc.

SERIOUS INCIDENTS

59. Following a serious incident, there was support for staff and patients. In my ward, it was understood that an incident is not over until you have shaken hands with the patient, they have understood why the restraining had to take place, and were okay. My staff were all very receptive to this approach.

60. There was about half a day of "Root Cause Analysis" training. I cannot recall if this was online or in person. I cannot recall any other serious incident response training such as the use of ligature-cutters, other than being told where the instruments are. Given the heat-of-the-moment approach and the adrenaline, I find it very surprising that people were just expected to handle it.

61. There were two types of investigation – the "7 day report" (a more basic investigation based on the paper records) and an "SUI report" (a more

detailed investigation based on interviews that had a standard of 30 days for completion but that could be extended where there were mitigating circumstances). The Investigations Team was run by [I/S] and she was very efficient about reminding investigators about deadlines and following up.

62. I don't know how decisions were made about when something warranted investigation. I would just receive a request and it would be in relation to something that happened on another ward – you wouldn't be asked to investigate something that happened on your own ward. There was a specific report format to follow and I felt I could always contact [I/S] with any questions or concerns.

63. I do not remember there being any follow-up from the reports I was involved in writing. We received little update or learning from a higher level; I understand there were meetings above my level about strategy/policy but I don't recall much ever coming down to us. Nowadays, we receive emails with "learnings" from serious incidents on different wards. This did not happen back when I was a manager.

64. I wrote many SUI reports. For some reason however, despite being a manager for 13 years, I was never asked to undertake a staff investigation.

Serious incident: Diane Hammond

65. Diane Hammond was a patient on the Finchingfield Ward. She had Electroconvulsive Therapy ("ECT") on a Friday, then went on leave and over the weekend took her own life by jumping in front of a train.

66. As a result of that incident, the Trust policy changed so that anyone having ECT on a Friday would not be allowed to go on leave until the following Monday, following a review by the doctor.

Serious Incident: Benjamin Morris

67. My role was to write the 7-day report, following Ben's death in 2008. This task came either from senior management or from [I/S] I had no role in relation to the incident, which took place on a neighbouring ward

(Galleywood Ward). I had only met Ben once, a few days before the incident, in the canteen. I was not on duty on the day of the incident.

68. I had written many reports and felt confident in writing the report. I had the support I needed in order to do so, and had previously received good feedback from [I/S] although I had heard from her that some managers across the trust were unhappy at times with the length of my reports and my conclusions and observations.

69. On this occasion I received some pushback from my senior manager, Stuart McGough, stating that Rhama Saibon (Manager of Galleywood Ward) was unhappy with my report in that it did not paint the ward in a good light. I recall feeling some pressure to amend the report so that it was less damning but cannot recall specifically the source of this pressure. I did not change my report.

70. I remember feeling angry about what had happened with Ben: there was a general sense that he was a troublemaker, when in fact it was the environment that enabled the incident to take place because the ward, in my opinion, was poor at treating people with Mr Morris' complex array of needs, particularly in the management of challenging behaviours.

71. At the Inquest, which was my second ever Inquest, I felt quite isolated. I attended with Ben's mother who was an inpatient in a ward in Colchester at the time. Even just from that it looked like I was not on the Trust's "side", like I was a witness for the "other side". There were senior managers there and I remember wondering "why?". I remember sticking to what I had said, but thinking it was odd to have to go back and work with some of these people.

72. A director called Paul Keedwell (Director of Nursing, who had interviewed me) said to me in the corridor (I cannot remember whether this was before or after the Inquest) that they had had high hopes for me. The inference was that I had not "played the game". Another manager [I/S] had previously told me that I was "too kind to be a manager". The way this was said to me, I took it to be a slight as opposed to a compliment.

My move out of the Linden Centre

73. Following the Ben Morris report, I was subject to disciplinary action for failing to follow procedure in relation to the big yellow incident form books, which is said to have put the patients and staff at risk. It was said that I had not properly filed the forms, carbon copies of which have to be filed in various places including with Risk Management, in the patient's folder, and other places. I was given a final written warning. As a result, I was removed from my role as Ward Manager. I did not agree with this outcome. I felt I had been scapegoated due to the report I had written in relation to Ben's death.

74. I do not remember how long after writing the report I had my disciplinary hearing and was told I would be moved on. In my recollection, one was a consequence of the other.

75. I recall coming to the office and seeing the yellow books were missing. I do think I was made a scapegoat of a common issue in the Trust at the time, but ultimately the reporting system changed as a result to a much better system, called Datix – an electronic reporting system - so I am at least grateful that some good has come from it.

76. I was eventually moved to Maldon Community Mental Health Team to be their Team Manager. It would have been my preference to stay on the inpatient ward. I felt really sad to have to leave as I had worked really hard for a number of years to create the environment in Finchingfield Ward. It also made no sense for me to be told that I was a risk to patients and staff, and then be sent to manage a team in the community with, by default, far less supervision and oversight on my day-to-day work.

MALDON COMMUNITY MENTAL HEALTH TEAM

77. I was moved to be Team Manager in the Maldon Community. I did not apply for the job but was just moved there.

78. The structure of the team was as follows: Team Leader was a Band 7 Manager (that was me); the rest of the team were a combination of Social Care and Trust staff. I reported to **[I/S]** who was a clinical manager managing two teams in the community. She in turn reported to **[I/S]**

79. I understand that the structure has changed since I left. Now the Community Teams are made up of several Band 7 Managers, who report to a Band 8.

80. The teams operated individually. Each team managed a "caseload", which was divided between the staff. I took the more complex cases, to enable the others to do good work with their patients. During the 6 years I was there, I do not believe there were any suicides.

81. The working relationship between the Community Mental Health Teams and inpatient staff was difficult. The approach was not collaborative, there was quite a lot of animosity. I put the reason down to stress and individual personalities, and to a systemic lack of knowledge about the other person's position. When I worked at Warley Hospital, I would spend a day a week working in the Community Mental Health Team. This gave me a perspective that I otherwise would not have had. I think it would help if there was more rotation: community nurses working on the wards, and inpatient staff working in the community.

82. What did help is that during my time in the community, the consultant psychiatrist worked both in the community and as an in-patient consultant at the Linden Centre. This system changed to one where there are inpatient based consultant psychiatrists and community based psychiatrists.

83. The feeling in the wards when patients would come back in following some time in the community was often one of, "oh no, they are back again", or "they're just here for the accommodation". Patients were seen to be a nuisance. I do not think this was so much the case on Finchingfield Ward when I was Team Manager. In reality though nobody wants to be in hospital; it's an awful place to be.

NEPT/SEPT MERGER

84. I was not around as much at the time of the merger, as I was suffering from pneumonia and therefore reduced first to part-time and then became a bank staff member; I was therefore more distant.

85. The difficulties I did notice included:

a. There were issues in the IT system between North and South. If I had a patient in the South, I did not have access to discharge summaries, did not get invited to the reviews etc.

b. As a result of the merger, the organisation became huge which can make one feel tiny and insignificant in a massive machine; we used to know Human Resources' names, managers' names; that stopped being the case.

TRAINING

Managerial training

86. When I was moved to a managing role in the community, I immediately informed the existing team that this was my first managerial post in the community. I also told them the circumstances of my leaving The Linden Centre. I received no specific training for my role as Community Team Manager. I did not question it because having just received a final written warning, I just wanted to get on with the job. Our team had a very collaborative approach and functioned well.

87. As part of my final written warning, one of my conditions was to have regular supervision. I found this to be helpful as my supervisor was great. Her name was **[I/S]**

Staff training

88. When I was Ward Manager and Team Manager, there was good and regular training for staff which they could apply for in their areas of interest. Staff seemed to value it, and there was progression and a way to enhance knowledge. That has now changed and there is largely only mandatory training.

89. The main training I received was the "Control and Restraint" training, which encompassed risk assessments. The name changed to "Ethical Care, Control and Restraint", after a period of time. The nature of the training changed a

lot during my time as an instructor: it became less of a hands-on approach and more of a de-escalation approach; I believe this is how it should be.

90. I do recall CPA and Risk Management training for all staff at the Linden Centre and community staff. It was mandatory and all day, but it did focus more on how to fill out forms rather than practical training.

91. I do not generally have concerns about the training. My only observation is that more recently it is all online and of a tick-box variety. I believe this is because the Trust is short-staffed. When we were properly staffed, in-person training was possible and was in my view more effective.

SUPPORT

92. As a Ward Manager I had regular meetings with other team managers, and supervisions once a month separately with my line manager Stuart McGough, and with my clinical supervisor [I/S] I found the former to be approachable and we would speak about how things were on the ward; I was able to report any concerns and had no barriers. I did not receive any benefit from the latter; I believe this supervision was more about Trust/Job status and getting me to be the type of Manager that the Trust wanted me to be, and there was a clash of personalities. [I/S] told me once that I would get more respect from others if I wore a tie. One of the previous managers whilst I was a charge nurse on The Christopher Unit [I/S] advised that I should not socialise with unqualified staff as I would lose their respect.

93. As a Team Manager in the community, my line manager was [I/S] who was an occupational therapist; she was very supportive.

94. Generally speaking, I did not feel there was a lack of support; I was not out of my depth, had acquired the skills I needed in order to manage people, and I received enough support. I also think the support for staff was good: there was a formal debriefs after the suicide of Diana Hammond, there were posters around, and we were well-staffed.

95. I set out below specific circumstances in relation to support I did not receive:

a. When I was at Warley Hospital, I found someone hanging in the toilet. This was on 11 October 1998. This had a massive impact on me, and inspired me to make sure that would not happen to anyone else. I did not receive any support thereafter, other than going for drinks with colleagues and being asked whether I was "okay". I went to the Inquest with the support of one of the charge nurses on the ward. This was when I worked for Barking, Havering and Brentwood Trust.

b. At the Ben Morris inquest, I received no support and felt cast aside.

c. When I suffered from pneumonia, I also received very little to no support. After taking 3 months off work, my first shift back was a late shift in which I was rostered as the only qualified nurse. The Ward Manager, knowing this, still informed me he was leaving early that day. I ended up handing in my notice in May/June 2016, as I was simply unable to carry on working with this level of support.

STAFFING LEVELS

96. There were no specific issues with recruitment when I managed Finchingfield Ward and Maldon CMHT; I knew who the relevant Human Resources person was, and who I needed to contact in Payroll. We were almost always able to fill a role before someone left.

97. My understanding was that Galleywood Ward did use a lot more bank and agency staff than we did in Finchingfield Ward. I am not sure why that was the case.

CULTURE

98. In the Team Manager meetings I attended, there was a general culture of detachment and superiority both between senior managers and senior ward staff, and towards patients. The attitude from above could be condescending, and they were looking for managers who would "sort the staff out". I was at times ashamed to be a part of the management team. Once some people reach the management level, they seem to forget that

the actual job is to help people through a crisis point in their lives. It becomes about statistics and how things "looked".

99. When we had CQC visits, we would be told in advance. Suddenly the wards would be painted. It was farcical.

100. By contrast, few actual changes were made when we had serious incidents; in those situations, the culture was to blame individuals rather than consider internal structures. For example, I believe I was scapegoated at the Linden Centre when I was given a final warning and was lumped in with what was wrong there.

COMPLAINTS

101. I did not have that many experiences of patients or families raising complaints. There were day-to-day issues such as patients not liking how they were spoken to by staff, and those issues were resolved productively then and there. I would sit down with the relevant parties to talk about what happened, and the matter was not resolved until hands were shaken.

102. We did have one incident where it was alleged a Charge Nurse, [I/S] [I/S] wilfully damaged a patient's soft toy. I was informed by a member of staff and took the issue straight to my line manager Stuart McGough. There was a complaints process that I was not involved in. The Charge Nurse was moved to the Christopher Unit whilst the complaint was investigated. I understand several months later this person in fact became the manager of the Christopher Unit. I do not know the outcome of the investigation.

103. This was not unusual in that staff subject to disciplinary action would find themselves moved to other areas within the Trust (as indeed happened to me). For example, I regularly had Colchester staff sent to me to work whilst they were undergoing investigation in their own area.

REFLECTIONS

104. In my view the personality and structural issues go hand in hand. Ultimately responsibility lay with our Chief Executive, Andrew Geldard. He was known

to have a very domineering personality and those he employed reflected that attitude. I understand his role previously was financial and not clinical.

105. When you have people in management that are conflict-driven, arrogant and aggressive, then the question "how can we do things better?" is reduced, learnings are not implemented, and no improvements (structural or otherwise) are made. I think there is an attitude of "we know what we are doing, the problem is the people down there". With this attitude, management will never look at the systems in place and see how they can be improved.

I believe the facts stated in this witness statement are true.

Signed: [I/S]

Date: 21st February 2025