Wednesday, 8 July 2026

(10.00 am)

(Proceedings delayed)

(10.06 am)

THE CHAIR: Ms Harris.

MS HARRIS: Good morning, Chair.

Chair, today we will hear evidence from those who work or who worked at EPUT or its predecessor Trusts. This morning the Inquiry will hear from Mr Stuart Ayris who has already joined us at the table, who worked at EPUT and its predecessor Trusts for over 22 years, including a significant period of time at the Linden Centre.

This afternoon, we will hear from Chloe Cawston, who is still employed by EPUT, and she is currently a service manager for the Linden Centre. And we will hear today about how care was provided in inpatient units.

As with previous days, Chair, there may be aspects of today's evidence that are difficult to listen to. For some people it may not be possible to sit through the two sessions, and as with the other days, anybody in the Inquiry room should feel free to leave at any time.

I take this opportunity to remind those engaging with the Inquiry that emotional support is available for

all who require it. Present here again today are emotional support staff from Hestia, an experienced provider of emotional support at these types of hearings. They are currently in the room and can be identified by orange-coloured scarves. There is a private room downstairs where anyone who needs emotional support can talk to Hestia support staff or if you prefer, you can speak to a member of the Inquiry Team and we will put you in touch with the support staff, and we are all wearing purple-coloured lanyards, as always.

For those following the hearing online, information about the emotional support that is available can be found on the Lampard Inquiry website at lampardinquiry.org.uk. The "support" tab is on the right top-hand corner. We want everybody engaging with this Inquiry in whatever way to feel safe and supported.

Chair, that introduction having been made, can I now introduce, please, Mr Stuart Ayris who I think now needs to be sworn.

STUART ALAN AYRIS (affirmed)

Questioned by MS HARRIS KC

MS HARRIS: I think you have said during the course of your affirmation but please can you state your full name for the record.

A. Yeah, Stuart Alan Ayris.
Q. Mr Ayris, you've provided two witness statements to the Inquiry.
A. Yeah.
Q. One some time ago dated 21 February 2025, and another more recent statement dated 4 June 2026?
A. Yeah.
Q. You have a copy, I hope, of both of those statements in front of you.
A. Yeah.
Q. You signed both of those statements?
A. Yeah.
Q. And each of them bears a statement of truth.
A. Yeah.
Q. Now, I'm going to pause you for a moment because you're nodding --
A. Oh, sorry.
Q. -- but it may be for transcript purposes we'll need you to say, "Yes," clearly.
A. Yes, sorry.
Q. No, no, it's my fault, I should have said. Thank you very much. If you just speak clearly and say, "Yes".
A. Yes.
Q. Have you had an opportunity to read both of your statements recently?

A. Yes.
Q. Is there anything you wish to correct in either of those statements?
A. No.
Q. Do you stand by those statements?
A. Yes, I do.
Q. I think, as you're aware, both of those statements in full will form your evidence to the Inquiry --
A. Yeah.
Q. -- along, of course, with the answers to the questions you give today.
I've got a message to ask you to speak up.
A. Oh okay, sorry.
Q. We've just begun and I know it can be a bit nerve-racking but if we just both remember to speak clearly.
A. Yeah, will do.
Q. Thank you, Mr Ayris.
You are now retired, but for around 27 years, I think, you were a Registered Mental Health Nurse.
A. That's right, yes.
Q. And from 2002 until you retired in 2024, you worked for, firstly, North Essex Partnership NHS Foundation Trust and then, when it merged, you worked for EPUT?
A. Yes, I did, yeah.

Q. Now, there is, it may seem an obvious thing to say, a distinction. Because until that merger, you were working for I think we should just use the shorthand NEPT?
A. Yes.
Q. And then after the merger you worked for EPUT?
A. That's right, yeah.
Q. During the course of your giving evidence -- this is for me as well -- can we try and make clear as best we can the periods of time that you're referring to so that we make sure that we draw the distinction between when you were employed by NEPT and when you were working for EPUT after the merger?
A. Yes, yeah.
Q. Thank you. In terms of your experience and where your different positions when you were working for EPUT, I think the easiest thing for us to do is have look at what you put in your statement and I'm going to ask if paragraph 4 of your witness statement could be put up on the screen, please. Hopefully you've got that as well.
A. Yeah.
Q. It's really so we can orientate ourselves with where you were during that 22-year period.
We start off pre the 22 years. October 1997 to April 2002 you worked as a staff nurse at Warley

Hospital in Brentwood, which was an adult psychiatric hospital under the Barking, Havering and Brentwood Healthcare Trust?

A. Yes, that's right.

Q. So that was before you joined NEPT?

A. Yes.

Q. But that was your first position?

A. It was. It's where I did my nurse training and then I carried on working there, yeah.

Q. That was going to be my next question. It's where you did your training?

A. It is, yes.

Q. If we look then back at the screen, from April 2002 to October 2003, you worked as a Charge Nurse at the Christopher Unit?

A. Yes, I did.

Q. Now, that was a brand new unit at the time, wasn't it?

A. It was, yes.

Q. An adult Psychiatric Intensive Care Unit?

A. Yes.

Q. There you were employed by NEPT --

A. Yes, I was.

Q. -- as it then was.

In October 2003 you moved to work as the Ward Manager at Finchingfield Ward at the Linden Centre?

A. That's right, yeah.
Q. And you were there for a period of six years?
A. Yes.
Q. Again, that was an Adult Acute Admissions Ward?
A. It was, yeah.
Q. And that was NEPT?
A. It was.
Q. From March 2009 to October 2009 -- and we'll hear about how you moved to this position a little bit later in your evidence -- you worked on the Trust Safeguarding Team and had various responsibilities.

Just in a sentence, what was your role on that team?
A. I was a best interest assessor which is basically assessing people who were placed in various units around the county who it was felt there was deprivation of liberty issues. So I would go and see the person, and do a report on their circumstances, and their capacity.
Q. So you were undertaking assessments but would it be right to say you had limited or less direct patient contact?
A. Yes, yes.
Q. You've written in your statement "within EPUT", but in fact that was NEPT as well, wasn't it?
A. Yes, I've never really took account of when the changes occurred to be honest.

Q. That's all right, that's why we will make it clear by doing this exercise.
A. Yes.
Q. From November 2009 to June 2014 you worked as a team manager at the Maldon Community Health Team in Essex?
A. That's right.
Q. That was community-based care there?
A. Yes, it was.
Q. And we'll come again in your evidence to how you interacted with inpatient units and some of the working between community teams and inpatient units, but that was your providing mental health care in the community?
A. Yes, it was, yes.
Q. From June 2013 to July 2016, you were back on the ward?
A. I was, yes.
Q. This time you were a Charge Nurse at the Ardleigh Ward at The Lakes?
A. Yes.
Q. From August 2016 to May 2019 you explain that you worked as a bank nurse on various teams including the Access and Assessment Team, the Mental Health Liaison Team conducting emergency psychiatric assessments at Colchester Hospital. Now, this period crosses with the merger.
A. Right, okay.

Q. So is it NEPT into EPUT then, at that stage?
A. I believe so, yeah.
Q. And is that largely community based again?
A. Yes, it is. The assessments weren't in people's homes but they were in a unit alongside The Lakes, and the A&E liaison team that was doing assessments in Colchester General Hospital, yeah, so it was assessing patients who were based in the community but not assessing them in their own homes.
Q. May 2019 to March 2021, you worked as a Community Psychiatric Nurse in the Psychosis Team in Holmer Court in Colchester?
A. Yes.
Q. So again, a community-based role?
A. Yes, yeah.
Q. From March 2021 to March 2022 you went travelling?
A. Yes, I did.
Q. April 2022, you were back again and from then until January 2023 you work as a bank nurse as a Community Psychiatric Nurse in the Specialist Mental Health Team in the Gables in Braintree. Again, Gables provides outpatient services and outreach; is that right?
A. Yeah, I was a Community Psychiatric Nurse with a caseload of patients I would see in the community.
Q. So again a community role?

A. Yes, yeah.
Q. Then the final period of time we have is July 2023 to August 2024 when in fact you were at the same job but in a permanent position?
A. Yeah, that's right.
Q. -- (overspeaking) -- all right.
So what I wanted to do by looking at your witness statement was identify, firstly, where it was NEPT and where it was EPUT and, secondly, that there are quite significant periods where you're working in the community rather than an inpatient setting.
A. Yeah.
Q. And again, whilst before we leave this page, if we look at number 5, your experience is solely with adults?
A. Yes, it is, yeah.
Q. Thank you. You can take that down now.
I don't ask you necessarily to look at your witness statement but I'm going to give the references as we go along in case you'd like to. You also explain, by way of your experience and background, that for about half of your career, half of your working time, you were a trainer for the Ethical Care, Control and Restraint on the Care Programme Approach and safeguarding. I'll come back to that in just a moment, and you provided that training for about 20 days a year; is that right?

A. Yeah, that's right.
Q. So that's paragraph 6 of your witness statement. As I say, we'll come back to that in a moment.
At paragraph 8 of your first statement you set out what you describe as your three key concerns in relation to EPUT.
A. Okay.
Q. So it's paragraph 8. We'll come back to the organisation in a moment but just let's look at your concerns. Your first concern, you say, is EPUT's focus on perception, how the organisation will look if something tragic happened as opposed to making sure that nothing tragic happened in the first place. And you say this takes place -- I'll come back to that in a moment -- at a point where patient care is overlooked?
A. Yeah.
Q. Your second concern is what you describe as a focus on statistics --
A. *(The witness nodded)*.
Q. -- and blaming individuals when something went wrong for systemic reasons?
A. Yes.
Q. And your third concern, you say, is a lack of care, understanding, and compassion?
A. Yes.

Q. Now, you make reference to EPUT?
A. Yeah.
Q. And we've just been through your career and we can see that a significant part of that was in fact when you were employed by the predecessor organisation, NEPT. So can I just ask you this: to what extent are those concerns drawn from your experience, early experience, say at the Linden Centre, and from the events following the death of Benjamin Morris as opposed to your experience overall?
A. I would say the majority is my concerns when I worked for NEPT, yes, when I was at the Linden Centre, and in the community at Maldon.
Q. And in the community, did you say, in Maldon?
A. Yeah, yes.
Q. Can I just ask you this, because you talk in the present tense because you say, when you are talking about focus on perception you say, "This takes place to the point where patient care is overlooked."
Was it still a feature, then, of EPUT's approach at the time you retired in 2024.
A. Yes, it was. In the team I was working in, yes, I believe it was.
Q. Do you have any specific examples, later examples, let's say, where EPUT focused on how something would look

rather than patient care?
A. Yeah, I mean, when I worked, for example, in the community in Braintree, they had a system of grading people's risks using red, amber or green as to regarding if someone was rated as red, they would be an urgent risk, and obviously down to green, maybe less of a risk. Meetings would go on for two or three hours discussing these ratings and to me they bore no reflection whatsoever in the way those risks were then managed in the community. So on paper it would seem that there was a lot of attention paid to looking at people's risks but in reality in terms of mitigating their risks, it just didn't match up.
Q. Can I go back, then, to the Care Programme Approach which was obviously in place for the majority of the time you worked for NEPT and then EPUT, and your role as a trainer. Now, this Inquiry has already heard evidence about the Care Programme Approach, and we understand that following a period of transition it was replaced by the Community Mental Health Framework?
A. Yeah.
Q. Do you recall roughly when that transition or when that was replaced?
A. No, I think it -- because there was a period of time when I had kind of a year off then I was working as

a bank nurse for a couple of years and I kind of didn't get involved or didn't involve myself in the wider issues around the Trust so I can't really remember when that happened, but I think it was in the last maybe six years, maybe. Certainly later on.

Q. With respect to your role as a trainer, with the Ethical Care, Control and Restraint, when mental health care was provided in accordance with the CPA, with the Care Programme Approach, when were you training? Which period of time were you providing that training?

A. It was while I was at the Linden Centre and then when I was in the Maldon Community and I think for a short period of time while I was on Ardleigh Ward as well.

Q. So that's around what, 2014, 2015?

A. Up until about then, yeah. Yeah. Yeah, the Ethical Care, Control and Restraint training changed quite extensively and you had to revalidate as a trainer and I chose not to revalidate.

Q. Was this all part of the same course or were these individual modules?

A. No, the Control and Restraint was a course where we taught staff how to ethically physically restrain patients, how to de-escalate situations and issues around how to deal with conflict whereas the CPA training was more about the paperwork involved in

assessing patients, risk assessments, and discharge planning. So they were two very separate courses.

Q. And you provided both, did you?

A. Yeah, I was assistant -- yeah, the Care, Control and Restraint was about 25 different trainers and two or three of us at a time would train a group of staff. And the CPA training, there'd be a main trainer and I'd assist the main trainer.

Q. Mr Ayris, I've just had another Post-it to ask us both to slow down.

A. Yeah, I knew I was going to do that, sorry.

Q. No, it's my fault, I'm asking questions quickly and you've got a lot to say so we have just got to remember that someone is transcribing so we'll pause from time to time.

A. Sorry.

Q. Sorry, we were just talking about your training. Can I just ask, who was it that you were delivering it to?

A. Staff.

Q. All staff, which levels of staff?

A. Yeah, all levels of staff.

Q. Given the period can I assume it was face-to-face?

A. Yes, it was, yeah.

Q. Was it assessed?

A. Was -- did we pass off our students?

Q. Yes.
A. Yes, certainly the Control and Restraint was. The CPA training was more about information giving.
Q. Were you assessed? Was it quality controlled?
A. Each year as a Control and Restraint trainer we have to be assessed, yes. Yes, that was an annual revalidation.
Q. You made reference to safeguarding; was that different or part of the same course?
A. Yeah, that was very much when there was still three of us that were best interest assessors. When we didn't have an assessment that day, we'd be asked to go along and just support the person who was doing the training.
Q. In terms of safeguarding, how would you describe, then, what safeguarding means in the context of inpatient mental health care?
A. I think it's ensuring that patients' rights are upheld within an organisational setting, making sure, in terms of their dignity, their respect, that the law is followed. Yeah, and that their voice is heard. And that anything that needs to be reported on or be acted upon, that process should take place.
Q. Can I just also ask you this, a slightly different question: in terms of the CPA approach, obviously there were policies and procedures in place and available. When you worked at NEPT, was there any guidance by way

of practitioner handbook or anything like that circulated to staff to help?

A. I'm not sure there was a handbook. There was certainly all the forms and I think there was printed guidance about how to fill in the forms. But I can't be sure if -- yeah, I think there was a manual of sorts that was on the ward.

Q. A manual of sorts?

A. I think so, yeah.

Q. Okay. And just on that, was there an appropriate risk profile tool which was used for those within enhanced CPA status?

A. I think the same risk tools were used across the board. From what I remember, anybody that's admitted to a ward is automatically put on enhanced CPA. So it would have been the same risk tools.

Q. Finally this: you've already made reference, although I take on board you couldn't be exact as to when the Community Mental Health Framework came in after the period of transition, did you yourself receive any training in relation to that --

A. No.

Q. Okay. Just in terms now, moving to the main part of your evidence, and so you know where we are going, I think the main part of your evidence that you give in

your statement is around the Linden Centre, isn't it? And that's six years between 2003 and 2009?

A. Yes.

Q. But we will then go on to look at some of the observations you can make through your community work.

A. Okay.

Q. And I think there's a short period of time on The Lakes, but the majority of your evidence as I understand it -- you'll correct me when we go through -- is to do with Finchingfield Ward?

A. Yes, it is, yes.

Q. Before we start on Finchingfield Ward, though, can we begin with your first role for NEPT, which is at the Christopher Unit.

A. Yeah, yeah.

Q. Now, you've already told us that you did your training at the Barking and Havering Brentwood Trust.

A. *(The witness nodded)*.

Q. What other training, if any, had you received before starting at NEPT?

A. It would have been whatever mandatory training was available at the time. I remember at Warley Hospital we did control and restraint training. I did a 998 course which is about teaching and assessing and mentoring students. And I can't remember what specific training

other than that because I went there as soon as I qualified, so -- and the last six months of my nursing training placement was at the ward that I ended up working on, so it was a crossover between learning from ward-based stuff and learning at college.

Q. I should have said really at the outset, we take on board that a lot of what you're giving evidence about is over 20 years ago.

A. Yeah.

Q. So if there are areas where you can't remember specifics, please do say.

A. Yes, will do.

Q. You do explain, however, at paragraph 11 of your witness statement how that when you were at the Christopher Unit you developed a nursing model, and that nursing model saw all staff directly involved in patients' care as opposed to there being a system of designated nurses?

A. That's right, yes.

Q. Have I described it accurately?

A. Yeah.

Q. And you explain that, and this is in your statement:

"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, for example, assessment, risk assessment, and discharge planning."

A. That's right, yes.

Q. And you also explain that that nursing model was nominated for a Trust award?

A. It was, yes.

Q. By that, do you mean a NEPT award?

A. Yes.

Q. When you say you develop the model, can I ask what you mean about that. Was that something you brought in from your previous employment or was it something that you yourself designed, or with others? How did it come about?

A. Yeah, when I was at the Christopher Unit, at the time I think it was only about a six- or seven-bedded unit and there would have been maybe eight or nine qualified members of staff and often we only had three or four patients, so you might have three or four members of staff fully responsible for a patient's -- all the paperwork, engaging with other agencies, while the other members of staff basically were just coming to work, do the medication. So there's a big disparity between the responsibilities.

So yeah, basically I designed this system whereby the named nurse system -- so each patient still had an

allocated nurse but the allocated nurse would only be responsible for getting to know the patient and for -- basically spending time with the patient and learning as much as they could about them. Whereas the other members of staff, say there was six others, there would be two in -- sorry, I'll start again.

Say there were ten members -- nine members of staff, there would be three in the Assessment Team, three in the Risk Assessment Team and three in the Discharge Team. So they -- each of those would be responsible for every patient's risk assessment, whereas the named nurse would only be responsible for getting to know the patient and building up trust with that patient.

So what would happen then is every member of staff would know something about every patient and would have to engage with them on a positive therapeutic level, as opposed to being just a stranger.

THE CHAIR: But that was on a ward with quite a small number of patients?

A. It was, yes, yeah. Because there would always be a situation -- well, there were situations where if a member of staff -- the named nurse was on holiday or off sick, that patient was then kind of left with no real contact point amongst the Staff Team, and the nursing model just kind of overcame that whereby every

member of staff did have contact with everyone.
MS HARRIS: So your nursing model, sorry, meant that when somebody was away, they were just as familiar with another member of staff.
A. Yeah, that's right, yeah. And also because each -- there were three diaries that we brought in, an assessment diary, a risk assessment diary and a discharge diary. So the -- say you're in the Assessment Team, you would come into work, look at the assessment diary and see this needed to be done or you look in the risk assessment diary. So that way nothing was missed. It wasn't all down to one member of staff to kind of do everything.
Q. We'll come back to that in a moment because that's something you then tried to put in place in Finchingfield --
A. Yeah.
Q. -- on a larger scale and, as I said, you will explain it in a moment, but just back to this model for a moment. You talk about developing it. Was it a practice you'd seen elsewhere? Was it a standard practice elsewhere? Did you base it on something you'd seen or heard?
A. No, it was just something I'd kind of thought about over a period of time, and wrote it up, and then presented it to the manager of the unit, who said, "We'll give it

a go", and we did do and then there was an innovations award thing, there was lots of different kind of stuff like that, and the manager submitted it to that.

Q. This probably answers my next question, you describe in your statement how care was very doctor-led at that --

A. Yeah.

Q. -- clinician-led at that period of time. Did you have to consult with others, other healthcare professionals, clinicians, doctors, before introducing that model, or --

A. No. No.

Q. You've already explained how, because there were three diaries, nothing was missed or you felt there was less --

A. Yeah.

Q. -- possibility of things being missed. Are there any other ways in which you consider your model assisted with risk assessment and risk management?

A. I think it helps newly qualified staff in terms of during the -- because people would rotate within the teams every four months, and during the course of a year a newly qualified member of staff would be kind of very up to speed on all areas. But yeah, in terms of risk management, it was just highlighted that -- because we had an actual team responsible for it, it was always at

the height -- at the top of what people would think about each day when they went into work, particularly because it was an intensive care unit, people were there because of the level of risk they posed, so on that unit it was kind of very much the biggest thing.

Q. And do you consider that the model supported patients then in achieving psychological safety?

A. Yeah, I do. As much as you can achieve that on these kind of places.

Q. In terms of this model, was it monitored at all? Did -- we -- we know you took it to senior managers, they said "Give it a go", it was nominated for a Trust award for innovation --

A. Yeah.

Q. -- or something of that nature. Was it monitored? Did anybody review it or look at the metrics or assess it?

A. I can't remember, I'm afraid.

Q. There was no audit of outcomes or any particular metric?

A. I think we just kind of were left to get on with it and we felt it worked, and that was it. I don't think -- there was certainly no outside kind of audit of it.

Q. Under this model, did patients who self-harm have access to psychotherapy treatment or specific psychological interventions that were tailored to their need if -- within this arrangement?

A. Not under the model. The model was mainly directed in terms of what staff would do.
Q. So that was a separate consideration?
A. Yeah, yeah.
Q. Were there any other particular changes that you introduced in relation to the provision of nursing care?
A. Nothing specific, I don't think.
Q. Moving on, then, to the Linden Centre to Finchingfield Ward. You were the Ward Manager. Your line manager was a gentleman called Stuart McGough?
A. Yes.
Q. And he, in turn, had another line manager who we won't name today.
A. Yeah.
Q. When you started in Finchingfield in October 2003, what type of ward, was it?
A. It was an acute admissions ward.
Q. Mixed?
A. Yes.
Q. How many beds when you started?
A. When we started --think maybe 20 and I think in time that was reduced to 18 because there was a short corridor of single rooms that were then turned into meeting rooms, I think.
Q. And it was next door to Galleywood Ward?

A. Yes.
Q. And what type of ward was Galleywood Ward?
A. That was acute admissions mixed ward. We just covered different areas of -- geographical areas.
Q. So they were the same type of ward?
A. Yes.
Q. Same size?
A. I think so.
Q. Roughly?
A. Yeah, I think so.
Q. In your witness statement, in your first witness statement at paragraph 10, you say that once you started working there, you noticed that things were done differently to how you had been trained or how you were accustomed to doing things. You compare to Warley Hospital. Are you also comparing to the Christopher Unit?
A. The Christopher Unit and the acute admissions ward are two very different approaches, so yeah, that would be like comparing oranges and apples to a degree, but there's certainly a comparison with the acute mixed ward that I worked on at Warley Hospital to Finchingfield Ward.
Q. So the most meaningful comparison --
A. Yeah.

Q. -- is the one with Warley?
A. Yes.
Q. What were the main differences then, between Finchingfield and Warley?
A. Warley Hospital was -- it was much higher level of intensity. I'd never -- to this day, I'd never met more people -- people who were more in distress or higher levels of aggression than I saw when I was at Warley Hospital. We took patients from Barking and Dagenham so it was a different socioeconomic area, and although it was a very large hospital it felt like you were on a standalone unit even though you were a big hospital and I couldn't even tell you who the clinical manager was when I worked there.
Q. At Warley?
A. Yeah, you just worked on the ward. Because of the intensity there you only had four staff to, say, 24 patients. The real emphasis was you have to get to know the patients; you have to get on with them, because you are kind of quite vulnerable as a member of staff, and you have to really be positive in trying to make a difference each day. It was very much about engaging with people.
Q. So how was Finchingfield different, then?
A. Going back to the Christopher Unit, when I was on the

Christopher Unit, I couldn't understand how those patients weren't on an acute ward because they were the kind of level of risk patients I was used to dealing with on an acute ward at Warley and when I came on to Finchingfield Ward my immediate impression was: I can't understand how most of these patients can't be managed in the community. So it was a very different kind of level.

THE CHAIR: Did you find them less challenging than you had experienced elsewhere?

A. Yes, yeah, overall there was certainly patients that were very distressed, and were challenging, but certainly not the majority, and certainly not to the extent that I'd seen at Warley Hospital.

MS HARRIS: You say that you felt like an outsider --

A. Yeah.

Q. -- but that you stuck to what you felt was right?

A. Yeah.

Q. What was it that you felt was right that you stuck to?

A. When I came into Finchingfield, one of the main things I learned at Warley Hospital was how detrimental it is to people to stay on an acute admission ward for any length of time. If I can give an example, where was a young man who was very, very unwell, and he'd been very heavily medicated and he was gradually getting

better to the extent he could get some ground leave, and he'd been on the ward for about six or seven months, so I took him on the ground leave, and we went to the main road and he started crying and he said to me he'd forgotten how fast cars could go and it really affected me at the time. And I always remembered that.

So when I went into Finchingfield Ward it seemed that people were just left day after day to kind of wait for the doctor to decide what to do with them and no real impetus.

Q. You, at paragraph 12, you talk about how you tried to introduce your nursing model --

A. Yeah.

Q. -- although, as the Chair has already pointed out, you'd introduced it on a much smaller unit --

A. Yeah.

Q. -- and this was a ward with potentially 20 beds. But was it still that three team approach?

A. Yeah, it was, yeah.

Q. And you say that some of the staff weren't happy with that?

A. That's right.

Q. Were they resistant to it?

A. Yeah, they were.

Q. To what extent?

A. They were resistant to the way I was -- the way I kind of wanted them to work. It felt to me, when I was first there, that there was a lot of apathy. Patients were a nuisance. The staff would be in the office. There'd be a knock on the door and people would roll their eyes and -- I just couldn't believe it, to be honest. Because where I'd been, I was always -- at Warley, I remember I was told once that the more you learn about the life the patient has led, and their experience of life, the less likely you will be in the future to be talking about their death. And again, that was a Charge Nurse that said that to me and again, that really stuck with me.

So when I went to Finchingfield Ward, it just felt -- the level of apathy, I was astonished at, to be honest.

Q. And you say that in fact it let to a high turnover --

A. It did.

Q. -- which allowed you then to interview people and get staff you wanted on the ward?

A. Yeah.

Q. Sorry, I'm paraphrasing.

A. Yeah.

Q. And you said you were looking for genuinely kind and open-minded people?

A. That's right.
Q. Is that because those that were there when you arrived were not, you thought, genuinely kind and open-minded people?
A. I couldn't say in terms of whether they were kind and open-minded people but certainly on the ward in the roles they were in, I didn't feel they had the necessary kind of positivity to do the job I wanted them to do. I think you need to -- I need to differentiate between what they were like as people and what they were like on the ward.
Q. Understood, understood. It was how you wanted them to be on the ward that was important?
A. Yeah, I mean, to be honest, almost everyone I've met throughout my career were nice people. It didn't mean they were always effective.
Q. It was my clumsy way of asking it, Mr Ayris, it's my fault, but I think you've made it clear.

In terms of the model which you introduced, the Three Teams Model, with the diary to make sure things weren't missed, and we'll come on to, for example, weekly reviews in a minute, you say that in your view, the model worked and you base the fact on the -- you base that on the fact that in the time you were there, 2003 to 2006, you say there was just one instance of

somebody taking their own life.
A. Yes.
Q. When you make that comparison, were you making that comparison to other wards you worked on or other wards you knew about or?
A. Yes, there were certainly more incidents on Galleywood Ward who obviously didn't use the nursing model. But I wouldn't put it entirely down to the nursing model, it was the approach of the staff, the personalities of the staff that did make a big difference as well.
Q. That's on your ward, you say?
A. Yeah.
Q. What about incidents of self-harm, were they reduced in that period, do you think?
A. Again, not to do with the model, I don't think, necessarily, more the approach we took if somebody did self-harm, it was always about trying to learn and understand why they did, but to see it as an act -- behavioural act, which was the case before, where people would almost be punished for self-harming, where if they'd been self-harming to regulate their emotions for 20 years and suddenly they do that on the ward to try to kind of cope and they get everything taken out of their room and put on observations, it's -- I didn't agree with that.

Q. I'm going to ask you about your approach to that in just a moment --
A. Okay, sure.
Q. -- because you're very specific about that in your statement and about what you would describe, I think, as a more positive approach to dealing with incidents of self-harm.
A. Yeah, sorry.
Q. I promise I'll come back -- no, I promise I'll come back to that in a moment.

Can I then ask you about admission to Finchingfield --
A. Yeah.
Q. -- just picking up on one or two things you say in your statement. When the patient was first admitted, a 72-hour care plan was put into place.
A. Yeah.
Q. It would cover observations, physical health, medications, legal status and so on.
A. *(The witness nodded)*.
Q. Was there -- how were they put together? Was there a form to fill in with set criteria?
A. It was just a standard care plan that you would print out and then you would add in the different personal details.

Q. Were families and patients involved at that time? Sorry, family or patients involved at that time in the 72 --

A. In the compiling of the --

Q. Yeah.

A. No, they were just literally printed out from the computer. They were just standard forms.

Q. But you didn't involve the --

A. No.

Q. Would you call it a tick-box exercise?

A. Yeah, absolutely. Yeah.

Q. And then a more personalised care plan would be developed after --

A. Within the 72 hours period.

Q. Within the 72 hours.

You've talked about, in paragraph 15, how those more personalised care plans should have been reviewed weekly.

A. *(The witness nodded)*.

Q. I think that's where you say your nursing model meant it was less likely that they would be missed?

A. Yes, because the named nurse would be responsible for compiling the care plan with the patient and reviewing it but not having to do the risk assessment for that patient and the discharge plan, so they could focus very

much on that patient's care. It did mean that they would be doing risk assessments for other patients if they were in the Risk Assessment Team but that would be separate.

Q. Because I think you say that they were -- the review -- weekly reviews would be missed depending on who the designated nurse was?

A. Yeah.

Q. Can you give us a sense of how often weekly reviews were missed?

A. No, sorry, I can't. Just if somebody was on holiday or if they were off sick they wouldn't necessarily be picked up because there was no diary system for them to kind of use.

Q. And in terms of the weekly reviews, when they were completed, did they involve patients and their families?

A. They certainly involved patients. I can't say to what extent they involved families. All I can say was if it did involve families it wasn't sufficient.

Q. I think you -- that's something that you -- a reflection that you've developed since your community work, as well --

A. Yeah.

Q. -- in terms of --

A. Yeah.

Q. -- and I'll come back to that in a moment.

In terms of observations, at paragraph 16 of your witness statement, you confirm that when a patient was admitted to the Linden Centre, observation levels would automatically be set at level 2, which is four times an hour; is that right?

A. Yeah.

Q. Was that the Linden Centre overall or just Finchingfield Ward?

A. It was certainly the Linden Centre overall. I think it may have been a Trust-wide thing. It did cause difficulties, because patients, certainly people who were newly admitted for the first time, wouldn't always have been told that when they agreed to come in to be admitted. So they would come in to be admitted and then we'd have to say to them "You can't leave for 72 hours because you're on level 2 observations". So that would always cause some conflict.

Q. So it was the fact they were being --

A. Monitored.

Q. -- observed --

A. Yeah.

Q. -- four times an hour?

A. Yeah.

Q. What if their presentation called for a higher level?

A. Then it would be discussed during the shift and then during the course of their shift it would be elevated to a higher level of observation and then discussed with the doctor.
Q. So how long after their arrival on the ward could that happen if need be?
A. It could be immediate, if necessary, yeah.
Q. And how quickly could it be decreased?
A. I'm pretty sure that at the time when I first went to Finchingfield Ward, the nurse in charge and the staff could reduce the levels of observations, but over time, that became the task that only the doctor could perform. But yeah, to answer your question it could be just a discussion at then decreased even just for a certain period of time to see how things went, etc.
Q. You deal in your statement with how when you first started in fact it was the nurse in charge of each shift that was able to decrease and increase?
A. Yeah.
Q. But it later changed to being led by doctors in about 2005, 2006?
A. Yeah, roughly, yeah, I can't --
Q. Do you know what prompted that change?
A. I can only imagine -- I don't know specifically but I can only imagine the levels of observations were

reduced somewhere and then something bad happened and it was felt that it had to be a doctor's decision.

Q. So you assume it was reactive to something that had taken place?

A. Yeah, yeah.

Q. You describe it as problematic.

A. Mm-hm.

Q. Because you considered that the nursing staff were in a better position?

A. Yeah.

Q. Was that your preference, then: for nurses to take responsibility to changes of observations?

A. It was, yes.

Q. Why was that?

A. Because I felt certainly -- I could only speak for the ward I was on -- I think we developed a very good relationship with the patients -- most of the patients most of the time, I would say. So there was a degree of honesty back and forth so if a patient felt at risk they could -- so you know, say, "I want my observations increased". Equally, if we felt the patient didn't need to have that level of observations on them we could confidently decrease it knowing what the risks were.

THE CHAIR: Did you feel, though, that -- comfortable? Did all nurses feel comfortable with that?

A. No, they didn't, no.
THE CHAIR: No.
A. I think over time they did but you feel more comfortable with those decisions if you know the patient better and the more you know the patient, the more honest they will be with you, generally.
THE CHAIR: What part do you think, then, that the doctor should be playing in those decisions?
A. The doctor would generally see the patients once a week maybe for 10 or 15 minutes. If a doctor was around, we may have consulted the doctor, but I very much felt it was the staff that were more aware of what the risks were.
MS HARRIS: Did you raise your concerns or share this point of view with anybody?
A. I don't recall.
Q. You also say in your witness statement that sometimes you felt increasing observation levels was done with the idea of protecting the Trust --
A. Yeah.
Q. -- rather than thinking about what was best for the patient?
A. Yeah.
Q. What do you mean by that?
A. That -- I didn't see what good it did to have somebody

on level 3 observations for an extended period of time. Level 3 observations basically means somebody is within eyesight. So were basically being followed around the ward by a different member of staff every hour. To my mind, if someone needs that level of observation, the engagement needs to be intensified with the person, as opposed to just being watched. And if somebody is on level 3 observations, that member of staff then becomes fully accountable for if something goes wrong, which I didn't think was right.

Q. In fact you say in your statement, we'll come on to it in a moment, that when you're dealing with something like level 3 observations, to use the word "observations" is misleading and it should be "engaging" that should be described?

A. Yeah, it should be, absolutely, yes.

Q. Because of the one-to-one nature of it?

A. Yeah.

Q. And that it's important that the member of staff engages --

A. Yeah.

Q. -- rather than just studies, if you like, the patient?

A. Yeah.

Q. In terms of -- I'm just -- terms timeframe, are we still talking about Finchingfield Ward here?

A. Yes.
Q. And if, as you say, higher observation levels were put in place when they weren't really indicated, did you find this affected the ability of staff or staffing numbers to provide supervision for other patients for other things?
A. Yeah, I think at the time the thing was where if you had one person on a level 3 observation that was to be subsumed in -- managed by the current staff numbers. So if you had five on a shift, you could have one person on level 3 observations. If you had more than one person on level 3 observations, that would necessitate an extra member of staff. And if you couldn't get that extra member of staff it would take away from --
Q. From other activities --
A. Yeah.
Q. -- other therapeutic engagement for the other patients on the ward?
A. Yeah, absolutely. The same as if you that lots of patients on level 2 observations. If you had, say, 10 people on level 2 observations then that's two members of staff that are tasked during that hour with doing observations. So yeah, it would.
Q. Why do you think the Trust or NEPT, as it was then, thought it needed the protection? You said you thought

it was being done for the protection of the Trust?
A. I can't speak for the Trust, I'm afraid.
Q. Fair enough. Okay, maybe I could ask it this way: why, in your view, do you think it was being done for protecting the Trust?
A. I think it was a way of having individuals accountable for something that went wrong. So if somebody was on level 2 observations that member of staff conducting those observations would be accountable for what went wrong if something did.
Q. Can I just ask you the flipside.
A. Yeah.
Q. Do you have any experience or did you ever perceive any pressure to reduce observation levels because of staffing numbers or staff workload?
A. No, no, on Finchingfield we had very few patients on level 3 observations while I was there. If somebody's risks increased we just tried to engage with them more because I was always of the view that level 3 observations would -- could only be of detriment to the patient. If you're paranoid or if you're depressed or if you have got an urge to self-harm and the response to that is to have some stranger following you around or just looking at you, that's never going to help.
Q. My next question was going to be, do you consider this

policy change, this -- the doctor-led observations and this often increase in observation levels, had an impact on patient care and safety?

A. Yeah. Yeah, I do. If somebody was on level 3 observations, you would, in my experience, you'd see an increase in risk because of the -- how the person would feel being so restricted.

Q. Was there a collaborative approach at least between the doctors and the nursing staff in terms of observations?

A. Over time, yes. I think when I first came to Finchingfield I think the doctors -- the consultants on the ward were maybe as -- I don't know what the right word is -- sceptical or aghast at the way I felt things needed to be, because I wasn't shy in kind of saying to doctors.

Q. You weren't shy, did you say?

A. No, in saying to doctors how I thought things should be. It didn't make me popular but I was just advocating for the patients, I was always taught where I worked before that you do whatever you can for the patients, and that's what I did.

Q. You've already explained how you think that it's not really about observations; it's about engagement. In your view, then, was the impact of the observations -- I'll probably ask this in another way: if staff engaged

well with the patients when they were observing them on level 3, did you notice any positive impact?

A. Yeah, absolutely, yeah. If someone was ever put on level 3, our absolute priority was to get that level reduced by reducing the risks that led to that person being put on level 3 in the first place and you only reduce the risk by engaging.

Q. In your second witness statement, you say a little bit more about this. This is paragraph 52, for those who may be following the witness statement. You say that sometimes -- you reference many times when a patient was informed of a decision to increase observation levels after the fact, which was not appropriate, and you say "not at all conducive to the strength of the therapeutic relationship."

A. Yeah.

Q. What do you mean by that?

A. The patient we'd be seeing in the ward review maybe wanted to get some leave or go out, you know, get off the ward or something like that. They would then leave the room and then the doctor would say, "No, that person needs to be put on level 2 observations" or "No, tell that person they're not going to go on leave." So the nursing staff would then be left to give the bad news to the patient who in the moment wouldn't necessarily

understand that we were just passing on a message, even if it was one we didn't agree with.

Q. So this is your experience of observations being reduced -- or sorry, being changed, increased or reduced, against patients' wishes?

A. Yeah, I've got to say it didn't happen often on Finchingfield Ward. Over time my working relationship with the consultants did improve markedly, I would say. Hopefully they would say the same, but who knows.

Q. Sorry, in terms of observations being reduced, sorry, against patients' wishes, was that a common occurrence as well?

A. No, no. I don't think so. No, because most patients didn't want to be on the ward.

THE CHAIR: Didn't want to be on the ward --

A. Yeah.

THE CHAIR: -- and didn't want to be observed.

A. Yeah, if there was a certain level of observations, their chances of them being discharged in the next few days would be less.

MS HARRIS: So a reduction in observation was generally popular.

A. Yeah.

Q. Or well received?

A. Yeah, because it would be part of the discharge pathway.

Q. In terms of clinical assessments on the ward, you give information about this in paragraph 1 of your second witness statement and I won't take you to that, but you talk about informal assessments.
A. Mm-hm.
Q. You talk about there being a type of informal assessment.
A. Yeah.
Q. Is that really reflecting the kind of daily interaction between staff and patients?
A. Yeah, I've probably poorly phrased that. It was nothing as grand as an assessment. It was just getting to know the person.
Q. Were they documented at all?
A. Yeah, each shift the member of staff who was allocated to that person on the shift would document the engagement they had with that patient. Yeah.
Q. And if it was considered necessary, was it possible for nursing staff to request a medical if they considered a more formal assessment --
A. Yeah.
Q. -- they could request a more formal review?
A. Yeah, there would always be a doctor around that you could call, call in, yeah.
Q. And what kind of things would trigger escalation to

a formal review?
A. It would general be maybe a deterioration in someone's physical health or side effects from a medication, for example, or if a patient wanted to go on leave, we would call the doctor and the doctor would come and decide on that.
Q. Would suicidal ideation or expressing a wish to die or self-harm trigger such an escalation?
A. Not necessarily. It would depend, if -- because we could raise the observations if we needed to. If it was felt that some extra medication was needed then we would call the doctor but we would manage a high level of risk on the ward amongst the nursing staff.
Q. In terms of managing risk and assessing the risk, what risk stratification system did you use on the ward in Finchingfield Wald.
A. I can't remember the names, to be honest.
Q. Was it the Mobius?
A. No, it was something called HoNOS, I think, it may have been. Again, it is an acronym, I couldn't tell you what it meant but it was part of the CPA package.
Q. You deal in your first witness statement -- sorry, I'm jumping about but I'm trying to draw them together --
A. That's okay.
Q. -- with physical health assessments which you have just

referred to. And in terms of physical health assessment you describe the approach to physical and mental health needs being disjointed?

A. Yeah.

Q. And can I just confirm that when you make that observation are you talking again about Finchingfield Ward at the Linden Centre?

A. Yeah, I am, yeah. I think again that goes back to when I worked at Warley Hospital. It was miles away from any A&E department. So we had suction machines, we did stitches, we had drips. Lots of physical stuff that we would do as staff, whereas at the Linden Centre, because it was next door to Broomfield Hospital, I felt there was really no kind of skills amongst the staff in terms of basic physical things.

Q. You say no kind of skills to deal with basic physical things?

A. No, I don't think so, no.

Q. You say also that you were particularly thinking of those diagnosed with forms of personality disorder or ADHD who were prescribed antipsychotic medication.

A. Yeah.

Q. I'll come back to that in a moment.

A. Yeah.

Q. At your paragraph 38 you say:

"The general knowledge of staff at the Linden Centre in relation to comorbid issues was poor."

A. Yeah.

Q. There weren't any specialists in dementia or learning disabilities, for example, and we often required on doctors who were training in psychiatry but might already have done their three years of general training --

A. Yeah.

Q. -- or in general medicine. Or, in fact, you go on to say for diabetes you might rely on a staff member who was themselves diabetic?

A. Sure, and I have to include myself in that. My knowledge was no better than anybody else's, to be honest.

Q. Do you remember if there were ever any occasions when you required, for example, specialist information in relation to diabetes or learning disabilities and you couldn't access it?

A. No, I don't recall that, no. And again, I think that goes back to our failings with dealings with families and involving families because families would have known how to manage somebody's diabetes or -- and stuff like that. That was certainly a failing of ours.

Q. So you think if you'd got more family engagement --

A. Yeah.
Q. -- and information you'd be in a better position to care for those other issues as well as mental health?
A. Yeah, and certainly with autism as well, because the general knowledge there was just so poor. And again, I include myself in that.
Q. You've compared it already to Warley Hospital where you said there was good facilities and good knowledge?
A. Mm, yeah.
Q. Other than Warley, have you seen differences in other wards in which you've worked?
A. No.
Q. Or is that the prevailing issue?
A. Yeah. Prevailing issue, I believe, yeah.
Q. In relation to those with issues around drugs and alcohol you say at your paragraph 37 that:

"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 [and I'm using your word here] terrible".

A. Yeah.
Q. What was so terrible about that?

A. People were just referred to as "an alcoholic" or "a druggie" or whatever. No thought was put into how that person came -- why that person takes that amount of alcohol, why that person takes that amount of drugs and the trauma that may have led to that. And the same with people with personality disorder, I felt they were just maligned, spoken of in a very bad way.

Q. Did you say maligned?

A. Yeah, yeah.

Q. Just going back to the drug and alcohol for a moment, I'll come back to the other disorders.

A. Sure.

Q. What provision was available for patients with drug and alcohol dependency issues?

A. I believe there was like a -- nothing within the Trust, as far as I'm aware, at the time. There was an organisation, I think, called Changes or Open Road at the time, where patients could access outside of hospital but not while they were on the ward.

Q. And what about therapeutic options on the ward?

A. There was none.

Q. And what steps, then, do you consider should have been taken?

A. I felt there should have been certainly more training for people in terms of dual diagnosis, in terms of the

effect of alcohol and drugs on people's mental health. Again, going back to why do people want to blot everything out? What else is going on? It was just seen, right, they've had a drink, they need to be discharged or, you know, they just take drugs. Yeah, it was terrible, yeah.

Q. In fact, and we may as well reference it now, you conclude your second witness statement in terms of recommendations that you consider there should be a dual diagnosis team in all areas --

A. Absolutely, yeah.

Q. -- of EPUT?

A. Yeah.

Q. So that the priority is given --

A. Yeah.

Q. -- to the prevalence of poor -- well, poor outcomes with those involving alcohol and illicit substances?

A. Yeah.

Q. Just moving on to neurodivergent patients which we've already touched upon. Again, there's reference to the care being disjointed. What training -- we're talking about Finchingfield here still, aren't we?

A. Yeah.

Q. What training, did you have in the care of neurodivergent patients at that time?

A. None at all.
Q. None at all?
A. No.
Q. And to what extent, in your experience, were Galleywood and Finchingfield suitable for neurodivergent patients at that time?
A. I don't think they were. Like I say, I include myself in this. I had no real knowledge at all. I think, in time, where was an online training module in terms of autism but that was much further down the line.
Q. The Inquiry has heard evidence, I think, about training that was introduced by the Trust, and when you say online, are we talking about the Oliver McGowan training?
A. Yeah.
Q. Was there a system in place for considering the appropriateness of the ward environment for neurodivergent patients at all?
A. No, not at all, as far as I was aware.
Q. In your experience, then, was neurodivergence ever miscategorised as personality disorder or even just troublesome or challenging behaviour, do you think?
A. It must have been, yeah. But like I say, my knowledge was as poor as everybody else's in that it was only through the Ben Morris kind of case that I became kind

of aware of it, to be honest.
Q. You have already expressed your concern about those with autism or ADHD or some forms of personality disorder being prescribed antipsychotic medication. Do you consider that there was an overreliance on pharmacological approaches to those types of patients?
A. Yes, yes.
Q. Do you think that the lack of specialism and knowledge that you've described led to those patients being put on the wrong care and treatment pathways?
A. Yes.
Q. Do you think it led to them potentially receiving substandard or inadequate care?
A. Yes.
Q. Can you think of any specific examples where patients were failed because of the lack of specialism?
A. The main example would be Ben Morris.
Q. It would be Ben. It may be that there weren't any particular approaches but were some of the approaches used possibly counterproductive, then?
A. I should imagine if someone is prescribed medication that's unnecessary -- all medication carries with it side effects, et cetera, and so yeah, if someone is prescribed the wrong medication, it would have a detrimental effect.

Q. Was the lack of specialism in comorbidities including learning disabilities or neurodivergence something that you ever raised with managers at that time?
A. No, I don't think I did. Certainly towards the end of my time on Finchingfield we had three people admitted in a short period of time who were suffering with early onset dementia. We had absolutely no skills in managing that, and for all sorts of reasons, that was the wrong decision to place those people there. Incredibly distressing for them, for the other patients, and for the families and for the staff. And I raised that continuously in my last few months at the Linden Centre.
Q. We didn't refer specifically to dementia in your evidence but in your statement you -- I think you say the same about lack of access to specialism?
A. Yeah.
Q. So specialist services for dementia, as well?
A. Yeah.
Q. Can I ask you a little bit about, then, the ward environment, which also touches upon, I think, your approach to self-harm. You say at paragraph 25 of your witness statement that when you:

"... first started on Finchingfield Ward it seemed largely medically led ... Over the time the relationship became more collaborative. Medication is important but

there is much more to it than staff can help with because they spend so much time with the patients during the week."

A. Mm-hm.

Q. You also reference that your general approach, which we'll come on to, and that your nursing model worked because you frequently had empty beds?

A. Yeah, we did. Yeah, I think -- because on the care-based system you could look at the average length of stay in the different wards, the readmission rates, et cetera, and Finchingfield was regularly -- we had the shortest length of stay, the fewest readmission rates, which would indicate to me that the discharges had been appropriate and yeah, we regularly had empty beds so we had patients from various other areas of the Trust come in to --

Q. I was going to ask you about that, that you ended up caring for others because you had the space?

A. Yeah.

Q. Can I ask you, then, about your general approach as you describe it on Finchingfield Ward and particularly your approach to self-harm which you've already touched on. You describe your approach to self-harm as what you would call more humane --

A. Mm-hm.

Q. -- effective, that's the words you used.
A. Yeah.
Q. And you say that -- and this is your paragraph 26:
"Our first question was 'Do you feel better?' or 'Did it help?' rather than immediately to medicate or increase observation level or remove all items from their room."
A. That's right.
Q. And you say:
"I don't think, however, that senior management were fully in agreement and I don't believe our approach was replicated on other wards."
A. Yeah, that's right yes.
Q. And again, you've already touched on this but do we take from that that the preference of what was then NEPT senior management was to increase observation levels or to remove items?
A. Yes.
Q. And you disagreed with that approach?
A. Yes, I did, yes.
Q. Why did you disagree with that approach?
A. My views of self-harm are very much that it's an expression of emotion, it's not a behaviour, it's not a suicide attempt; it's the way someone has expressed themselves. And there would -- often the person would

say they would feel better as a result. Obviously, you, you know, there's danger involved in there if someone is cutting themselves, et cetera. But to punish someone who is expressing their emotions in the only way they've learned how, or could think of in the moment, I didn't agree with, because people's rooms in these sort of places, it's their haven of where they can actually feel like a human being and not a patient for a while. If you then strip all that out, then that can only be bad for that person's mental health.

Q. So you considered that to be a punitive reaction, did you?

A. Yeah, absolutely. Because the time should be spent speaking with that person about how they could maybe manage their -- that differently next time, or look at what's happening in the moment for them to have felt they needed to be expressing their emotions like that.

Q. So again, I don't want to put words in your mouth but you would advocate therapeutic engagement --

A. Yeah.

Q. -- rather than reaction of --

A. Absolutely.

Q. -- (overspeaking) -- punitive or reducing risk by removing items?

A. Absolutely. Because I think it was similar to people

I've met over the years who have alcohol problems by keeping a bottle of wine in the house, for example, they can then resist that. Whereas if you take everything out of somebody's room they will find a way of harming themselves one way or the other if they need to.

So I felt yeah, the benefits of actually engaging with the person and keeping their immediate environment as they would want it was always best. Obviously, if somebody had a razor on them or something sharp or something they could evidently harm themselves with, then we would remove that.

Q. Let me just pause. You'd take away the razor --

A. Yeah.

Q. -- or something that would give rise to a risk?

A. Yeah.

Q. But are you talking about personal possessions being taken away as a punishment?

A. Yeah, I know it certainly happened on Galleywood Ward and I don't know where else. And when I went to Ardleigh Ward that was the process then: that basically everything was taken out of the room, the person was just literally left with their bed and their bedding.

THE CHAIR: Do you think that was being done out of an abundance of caution, or as a punishment? I mean, as an indicator that if you do this, you know, this is the

consequence?
A. Yeah, I think it was certainly an abundance of caution. But I think the patient would -- often felt they were being punished because of it.
THE CHAIR: Then just to test your approach, do you think there were occasions on which a patient continued to self-harm because you had not taken away
-- (overspeaking) --
A. No, I don't remember any. I think the approach we took was very refreshing for the patient, as well. They would be relieved of the fact that we were saying "It's not a bad thing you've done, this is how you've expressed yourself, what's happening", you know, rather than just a blanket approach of this is -- because that's what they were used to.
MS HARRIS: Can I just pick up on the Chair's question there?
A. Yes, of course.
Q. Which is -- you've talked about removal of razors but can I just be clear, does that mean with your approach there would have been occasions or there may have been occasions where you would have left someone who self-harmed with access to an item with which they'd self-harmed or something else they could self-harm with?
A. No, absolutely.

Q. You'd remove the risk item?
A. Yeah, absolutely.
Q. In that sense, in the sense of the approaches described, would you agree that you personally took something of a permissive approach to self-harm?
A. No.
Q. Would you describe it as more of a positive approach, rather than a permissive approach?
A. I don't agree, I would -- again, going back to being a humane approach, I think it's an understanding of what the person's going through and a collaborative approach is how we can manage these instances if you feel like that in the future.
Q. Was that collaborative, positive approach, however you want to describe it, was that supported by NEPT's policies or procedures or was this --
A. I don't recall --
Q. Were you out there, so to speak, with this approach?
A. I don't --
Q. An outlier?
A. No, I don't think so because the approach was about kindness and compassion and engaging with the patient. And if there was ever a policy against that, I haven't seen it.
Q. Just in terms of practical steps, would giving a razor

to an individual expressing a desire to self-harm have been in line with that positive approach?

A. No, if people had razors and things like that, they would have been brought in from leave and the person not searched properly, et cetera. No, we didn't give out people razors.

Q. Do you recall any incidents whereby you or any other member of staff on Finchingfield Ward permitted a patient to have access to a razor when they wanted to self-harm?

A. I don't recall. I mean, what I -- I suppose what I don't want to give the impression of is that it was a fantastic place. We tried to do things in a certain way but there was still things that went wrong, still patients harmed themselves, and there were still incidents. We certainly didn't get it right all the time but I think most of us tried to.

Q. Taking on board that yes, you say you didn't get it right all the time and in your statement I think you make quite clear that there were lots of times when things weren't right, but do I understand your answer to have been that you don't recall any incidents by where, during which a patient was allowed access to a razor --

A. Yeah.

Q. -- when they felt like --

A. Yeah, but that certainly doesn't mean it didn't happen.
Q. You say it didn't mean it didn't happen?
A. No.
Q. Okay. In terms of the environment more generally, and I'll keep an eye on the time, if we maybe move a little bit and then I know we have to break at a certain time, I think for the transcriber but we have got a few more moments.
A. Sure.
Q. In relation to the ward environment of Finchingfield more generally you explain how it was initially quite difficult to manage, there were dormitories sometimes with six people in.
A. Yeah.
Q. It was difficult as a physical environment to manage, I think you say.
A. Yeah.
Q. But ultimately you moved to shared rooms and then single rooms?
A. Yeah.
Q. But that thought was given as to who to put together in that shared room?
A. Yeah.
Q. You have already said in your evidence, and it's in your witness statement at paragraph 44, that you always

advocated trying to see things from the patient's perspective?

A. Yeah.

Q. Do you feel you were alone in that approach or --

A. No, no, certainly there was a core team of staff that we'd developed over time that were excellent with that approach. I would say the majority of them were support workers. We had some fantastic support workers. I always made sure I didn't differentiate between the different grades because it's just people trying to help people, at the end of the day.

Q. You also reference the transition from mixed wards to the single-sex wards that you've described.

A. Yeah, I'm not sure when that happened because I know when I went to Ardleigh Ward it was certainly single-sex wards I can't -- I'm not sure about the Linden Centre --

Q. Did it happen while you for there, do you --

A. I can't remember, to be honest.

Q. All right.

A. I don't think it did but I'm not sure.

Q. But what you do say is that you recognise the issues with mixed wards, particularly on women.

A. Yeah.

Q. Particularly on women who may have been abused?

A. Yeah.

Q. And when men may be intimidating --
A. Yeah.
Q. -- and you deal with that at paragraph 45.
You also say that while you were there the Linden Centre became what you describe as increasingly restrictive and evolved into something more like a secure unit --
A. Yeah.
Q. -- you felt?
A. Yeah.
Q. In what way do you feel it became more locked up?
A. It was physically extra doors put in place. It used to be just the door to Finchingfield and then you had the reception and then out, and then there became a door in between Finchingfield and reception and then another entrance after reception. So yeah.
Q. Do you remember when those changes took place?
A. I think it was towards the end of my time there.
Q. But while you were there?
A. Yeah, certainly one of them did, but then I think when I visited Linden Centre as -- from the community it seems there was extra, yeah.
Q. So when you went back?
A. Yeah.
Q. And what were staff told about those changes and why

they were happening?
A. They just happened.
Q. Did they have an impact on inpatients that you saw, it becoming more locked up?
A. I couldn't say, because people were locked up anyway. Even though it's an acute admission ward, there was still -- you still had to ask permission for a staff member to let you through a door and then through another door. So I think maybe the extra two doors wouldn't have made much difference, really. It just felt, as a member of staff, that you were walking into a more secure --
Q. I understand. Did there remain a practical distinction between the voluntary and involuntary patients on the ward?
A. Not in terms of security.
Q. Did you raise concerns about the increased restrictions and the fact that the unit felt more locked up?
A. Only amongst ourselves. I don't believe I raised them, because the work was just done and then that was it. We weren't consulted at all about anything like that.
Q. You also say in your statement, this is at your paragraph 50, that:
"As the ward environment became more restrictive it made people more likely to want to leave when they had

the chance."

A. Yeah, yeah.

Q. Did you notice a change in the number of absconsions when the ward became more restrictive?

A. I couldn't say from memory, I'm afraid.

Q. When a patient absconded, what was the process after you made contact with them? So if someone absconded and then once you had got hold of them, what was the process?

A. Yeah, it would depend a lot on if they were -- because some people would have leave for an hour, for example, and then after two hours they weren't back and then we'd make contact with them, we would generally just ask them what was happening and could they come back to the ward and if they wanted to have formal leave, overnight leave, they'd need to discuss it with the doctor.

Q. Did you ever authorise absconsion as leave retrospectively?

A. No.

Q. I'm just going to ask you about one more separate topic and then I think that will bring us to about an hour-and-a-half, which is when we have a break. I was just assessing the questions.

A. Okay.

Q. When you made your statement you were asked about

ligature risks on the ward --
A. Yeah.
Q. -- just dealing with ward environment. And you say that the day after Benjamin Morris died, to which you've already referred, which was Christmastime 2008 --
A. Yeah.
Q. -- you went to Galleywood Ward which is where he had died?
A. Yeah.
Q. And you discovered the type of wardrobe door handle that had been used?
A. Yeah.
Q. And you went back to Finchingfield Ward --
A. Yeah.
Q. -- in order to take them off in Finchingfield Ward?
A. Yeah.
Q. And you were told by your clinical manager, then your line manager, which was Stuart McGough --
A. Yeah.
Q. -- that you were damaging -- or you would be damaging Trust property --
A. Yeah.
Q. -- and it was a job for Estates?
A. Yeah.
Q. Did you in fact physically -- did you get to physically

take any of those handles off in Finchingfield?
A. Yeah, I had an electric screwdriver in the car and I physically took them off.
Q. You had an electric screwdriver and you took them off?
A. Yeah, I took them off.
Q. And were you made to put them back on again?
A. Yeah, I refused to put them back on again.
Q. You refused to put them back on?
Did somebody else as far as you are aware?
A. Yeah, Estates put them on.
Q. Were they eventually removed?
A. I believe so, yeah, I can't remember, to be honest. Because it wasn't long after that that I left the Linden Centre.
Q. And to the best of your recollection, it was Stuart McGough that --
A. I think so, yeah. I can't be for sure. It was someone of a higher level.
Q. So it might not have been Stuart McGough --
A. Yeah.
Q. -- but another manager?
A. Yeah, yeah.
Q. Someone at a higher level to you?
A. Yeah.
Q. Is that the only time when you were on Finchingfield

Ward that a ligature risk was identified?
A. I don't know, there would be sort of regular I think yearly inspections when -- (overspeaking) --
Q. I was about to ask you about those. Did those yearly inspections take place as far as you remember?
A. Yeah, I think so, yeah. I mean, I was always aware of again, when I found somebody hanging at Warley Hospital after I'd been qualified a year, there was always -- that whole situation stayed with me and still does so I was all always intent on -- I would always be wandering around the ward just kind of making sure things were okay and one of the things that I was regularly doing was, if we had a toilet that was out of order, which wasn't an infrequent thing, because it had lots of people using it, the process was always -- the sign would be put on it and the door would be locked and I was always insistent that that door remain open because if somebody wanted to harm themselves, nobody would look inside a toilet that was out of order. So it's --
Q. Did you consider, then, that your -- you've already described how you wandered around the wards?
A. Mm.
Q. So we had the yearly inspections that you say you think were taking place?

A. Yeah.
Q. But you considered that in addition to those inspections you needed to be hypervigilant?
A. Yeah, absolutely.
Q. Were you that vigilant when you worked on other wards or was it just Finchingfield you felt you needed to be particularly vigilant about?
A. Certainly Ardleigh Ward, as well. Like I said, a situation when I first -- sort of a year after being qualified and that stayed it me, and like I say, still does, so that vigilance never changed, wherever I worked.
Q. More generally, whose responsibility was it, then, to assess the environmental risks on the ward?
A. As a Ward Manager I would say it's my responsibility to make sure the ward was safe.
Q. The time you were told, which you refused, you made clear, to put the handles back on --
A. Yeah.
Q. -- did you escalate your concerns about that to anybody?
A. Yeah, certainly to Stuart McGough, yeah.
Q. Did you say to Stuart McGough?
A. Yeah.
Q. Or whoever the manager was --
A. No, I certainly spoke to Stuart McGough about -- about

the situation with the door handles. He was well aware of it, yeah.

Q. Okay. So was there a procedure beyond Stuart McGough that you could escalate to?

A. I don't know. Yeah, no.

Q. At paragraph 49 of your statement you say that the process for reacting to environmental risks was appalling --

A. Yeah.

Q. -- and not conducive to helping anyone. How do you think things should have been done differently, then?

A. It seemed that any changes was as a result of a tragedy as opposed to looking at proactively how things could be different. And there was a massive, I felt there was a massive disconnect between what we did on the ward and what was discussed, and the experience of patients and staff on the ward compared to what was discussed at the team manager meetings or the area meetings that I went to. It felt like they were two different kind of establishments.

Q. Do we take from that that you would say that no one had a sense of what was happening then on the ground?

A. Yeah, absolutely.

MS HARRIS: Chair, we've been going for, I think, about an hour and 25 minutes. Would that be a convenient moment

for a short break?

THE CHAIR: Yes.

MS HARRIS: I think ten minutes or -- sorry, could we return at 11.40, please, Chair.

THE CHAIR: 11.40, thank you.

(11.27 am)

(A short break)

(11.46 am)

THE CHAIR: Ms Harris.

MS HARRIS: Thank you, Chair.

Chair, before we continue, I think you would like me to remind those in the room not to speak while the witness is giving their answers, so that the witness can be heard clearly in particular.

And also, Mr Ayris, you and I, I think -- I'm sure it's my fault -- have been talking over each other so --

A. Sorry.

Q. That's a request from the transcriber that we don't, so I'll be careful not to do that in addition.

A. I think it was me, as well, to be fair.

Q. I'm sure it was me.

Before I move on to ask about medication which is our next topic, can I just go back to ask you a couple of more questions about what you've described as your positive approach to self-harm on Finchingfield Ward.

A. Sure.
Q. And it's around the question of razorblades.
A. Yeah.
Q. Firstly this: we talked about access to razors, sometimes when razors were taken away.
A. Mm.
Q. Would there have been times when a request may have been made by a patient for a razor and they would have been allowed that razor unsupervised?
A. I'm sure it would have happened. It shouldn't have happened but that doesn't mean it didn't happen --
Q. I mean perhaps for washing or -- for bathroom reasons or things like that?
A. I don't specifically -- I don't recall, to be honest. I mean, if there was somebody who was absolutely no risk of self-harm and it wasn't in their make-up at all and there was no risk there, it may have happened, yeah. I can't recall specifically.
Q. So you can't recall but it may have happened?
A. Yeah.
Q. So maybe you won't be able to answer this question, which is that if there were concerns around self-harm, in respect of that patient --
A. Yeah, yeah.
Q. -- would that patient have allowed -- (overspeaking) --

A. They certainly should not have been, no.
Q. You say they should not have been?
A. No, no, definitely not.
Q. You also talked about taking razors away.
A. Mm-hm.
Q. But it's -- this is my fault, I didn't ask you specifically about other potential items of risk --
A. Yeah, yeah, other items, yeah --
Q. -- in a room. So you've already told us on Galleywood they took everything out --
A. Yeah.
Q. -- and you felt that was quite punitive?
A. Yes.
Q. On Finchingfield Ward would you take out other items, for example, potential items that could be a potential ligature or something of that nature?
A. Yes, absolutely, yeah.
And if there's a family photograph in a picture frame, and it had a glass frame, we'd take the photograph out, leave the photograph, and take the frame and stuff like that.
Q. So you'd remove other items of risk?
A. Yeah.
Q. But what about items you can't remove, for example headbanging is a particular form of self-harm?

A. Yeah, it is, yeah.
Q. How would you manage that in those circumstances?
A. That may have been one of those occasions where people were put on level 3 observations for a period of time to manage that level of distress and again to talk to the person to bring down that level of distress and engage with them. And medication, as well, maybe, on those occasions.
Q. All right, thank you very much.
A. Okay.
Q. Let's pick up, then, with medication.
A. Sure.
Q. Because that was what I was going to ask you next anyway. You've already alluded to it and at paragraph 29 of your first witness statement you say that -- you describe a culture of overly medicating patients, in your view?
A. Yeah.
Q. And you say at paragraph 30 in your view the use of night sedation was excessive and led to patients becoming dependent on it?
A. Yes.
Q. And again, let's just be clear, we're talking about your time on Finchingfield here --
A. Yes.

Q. -- it would appear from your statement.
Did you yourself witness patients being over-sedated?
A. Yes.
Q. Did this include elderly patients?
A. In terms of the older adult -- in terms of the older adults that were on the ward, yes, yeah.
Q. Sorry, maybe the word "elderly" was -- older adults.
A. Yeah, sorry.
Q. Would it have included patients that had other medical conditions, renally impaired patients, for example?
A. I would assume that the doctors would have taken that into account when they were prescribed but I can't be sure.
Q. Are you aware of any instances where this over-medication or this culture of over-medication led to patients being harmed?
A. I think anyone is harmed if they take medication they don't need to the levels that they need it (sic). My big issue was that behaviours were medicated as opposed to looking at why somebody behaved in a certain way. I've always believed that if -- that people are allowed to be angry, it's part of the human condition. And certainly on the an acute admission ward, if you don't want to be there, you're going to be angry. That

doesn't mean you should be medicated. The same with people who are very distressed and tearful, that doesn't mean they need to be medicated.

Q. Before I ask you a bit about that, just back to the night sedation?

A. Yeah.

Q. You also refer to the irony -- that's my word -- of the caffeinated drinks being given?

A. Yeah.

Q. And how you sought a move to decaffeinated drinks?

A. Yeah.

Q. Who did you approach or who did you take that up with, you know, because you were overruled I think on that, weren't you?

A. Yeah.

Q. Who overruled you? What level of trust management structure was that decision made at?

A. I think initially the complaints came from Galleywood Ward because patients were going on to Galleywood Ward to get coffee because I'd brought in -- and I'd explained it to all the patients at a meeting that we're going to be having decaffeinated drinks and the patients weren't happy but my view was that why are we allowing people free access to caffeine and then giving them increasing amounts of night sedation because they can't

sleep?
Q. You also say at paragraph 31 of your witness statement that you considered where would come a part when doctors would ask patients -- these are your words -- what they want to be on?
A. Yeah.
Q. And you considered that this abdicated professional responsibility --
A. Yeah.
Q. -- and you think it was to avoid complaints. Can I just ask you a couple of questions about that. Firstly, did you raise that concern with anybody?
A. Yes, I did this was on Ardleigh Ward.
Q. Right, so this is The Lakes, is it?
A. Yes, The Lakes, yes.
Q. I'll continue asking you about it, though, even though it's in the middle of our Finchingfield evidence.
Who did you raise it with?
A. The manager. The Ward Manager. And with the doctors.
Q. Why do you think -- you say you thought it was to avoid complaints?
A. Yeah.
Q. What -- why do you think they were doing it or what was your view?
A. When I went to Ardleigh Ward the overriding thing seemed

to be: don't upset the patients. So you'd have patients on lots of diazepam, lots of -- I think I need to explain that sometimes, when -- if somebody is on an acute admission ward, a lot of people want medication, they want to be out of -- not feel what's going on because it's such a terrible place to be, so quite often patients would ask for extra medication and the doctors would just give it, which I didn't agree with.

THE CHAIR: But some patients also know themselves quite well.

A. Yes, absolutely.

THE CHAIR: They know what they respond to --

A. Yeah.

THE CHAIR: -- how they feel better, as a result of things.

A. Yeah, absolutely.

THE CHAIR: What part does that part of -- what part does the patient's own insight play in all of this?

A. Kind of two parts. If someone is on something like diazepam, it's very addictive and it would lead to the patient just being asleep most of the day. So you can't engage with that person in terms of trying to find out what needs to happen for them to be discharged, what's the core of the problem.

Equally, someone would be described an anti-depressant and after a week would say to the doctor

"It's not working, can I have another one?" So the doctor would change it, and these medications take six to eight weeks to begin to be effective so that's kind of what I meant by that.

THE CHAIR: No, I don't think I quite understand that. Have another go at explaining that to me.

A. -- (overspeaking) --

THE CHAIR: What I'm getting at is the patient voice is something that --

A. -- (overspeaking) --yeah, yeah, absolutely.

THE CHAIR: -- (overspeaking) -- consider -- (overspeaking) -- isn't it?

A. Yes, it is absolutely.

THE CHAIR: And medication.

A. Yeah.

THE CHAIR: You're not suggesting that they shouldn't have input -- (overspeaking) --

A. No, absolutely not, no.

THE CHAIR: But you think sometimes the -- I don't want to put words into your mouth -- sometimes doctors were too compliant --

A. Yes.

THE CHAIR: -- with the wishes of the patient.

A. Yeah, my feelings were that the doctor is the expert and they would have more knowledge about what works with

certain kinds of conditions and symptoms and something like an antidepressant does take six to eight weeks to start working, so change it every week because a patient is saying "It's not working, can I have another one", that's an abdication of responsibility of the consultant, I feel.

THE CHAIR: Thank you.

MS HARRIS: Thank you.

In terms of overuse of medication, you give an -- or describe an event in your statement, first statement at paragraph 54, where you describe one doctor at the Christopher Unit, so this is in the very early days --

A. Yeah.

Q. -- telling you the ideal patient is one medicated to just above a coma.

A. That's right.

Q. Did you ever escalate that --

A. Yeah, absolutely.

Q. Who to?

A. The Ward Manager.

Q. What was the outcome?

A. That particular consultant was -- would often say things that were appalling. He would say he didn't mean it, it was just something he did, it was just the way he was, which I didn't accept. It was just a terrible -- I used

to think if they're the things he's saying, what else is he actually thinking that he doesn't think he can say.

Q. Did you ever have concerns about particular members of staff using sedation as a means of reducing workload, particularly overnight?

A. No.

Q. The concept of, which you've already explained, was one that concerned you, and you escalated it, but the concept of medicating to just above a coma, was that something you saw in practice on other wards?

A. It certainly happened at Warley Hospital when I was doing my nurse training. There was one of the wards where people had been at Broadmoor Hospital and had been stepped down to one of the wards there and each morning there was just a big tumbler and a concoction of different liquids poured in and, yeah, so certainly there, but not at EPUT or NEPT.

Q. Not at NEPT or EPUT?

A. No.

Q. Do you ever receive -- ever recall receiving a complaint from a patient on Finchingfield about excessive sedation?

A. I don't recall. But again, that's not to say that it certainly didn't happen and that patients did feel excessively sedated.

THE CHAIR: The patients did feel?
A. Yeah.
MS HARRIS: So you're aware that patients felt that?
A. Yes, yeah.
Q. Do you agree -- do you consider, sorry, not agree, do you consider over-sedation to be an abuse of position?
A. Yes.
Q. And degrading to patients?
A. Yeah, yeah, absolutely.
Q. You describe safeguards I think in place in relation to rapid tranquilisation which is something different.
A. Yeah.
Q. Do you consider that there were insufficient safeguards in place around sedation and over-sedating patients?
A. It's difficult to answer, I'm afraid. Yeah, I don't know.
Q. What about systems in place to monitor whether staff were over-sedating? Was that being monitored? Were there systems in place?
A. Not specific staff. At each ward review they would look at the medication card and see how many times -- it's called PRN medication was given. There'd be a combination of it being given by staff or asked for by a patient. Sometimes patients wanted extra medication if they were in distress.

Q. You say you recall that patients felt over-sedated?
A. Yeah.
Q. Would a record have been kept of those patients making those complaints?
A. Yeah, any conversations that we had with patients would be written up by that particular nurse in the nursing notes.
Q. Would they be kept under review --
A. Yeah.
Q. -- if you'd certainly got a number of patients?
A. Yeah.
Q. And then what would happen?
A. You'd speak to the doctor in the ward reviews. And I'd say the doctors on Finchingfield were good at listening to the patient's view on that type of thing.
Q. Just moving on, if I may, to staffing. Again, Finchingfield Ward, you talk about four members of staff, I think two qualified and two unqualified you say. This is paragraph 20 of your witness statement.
A. Yeah.
Q. What do you mean by "unqualified"? What do you mean by unqualified?
A. Support workers, yeah.
Q. Because I think you said you didn't really distinguish between the different grades --

A. No.
Q. -- because I think you said people were there to help people.
A. Yeah, the qualified were qualified nurses and the support workers were -- had no specific qualifications for the role.
Q. What kind of responsibilities did the support workers have?
A. General, to be around helping patients in terms of how the ward worked, menial tasks like helping with making beds if the patients weren't able to do that, keeping the areas clean. That was kind of the basic task but the personality of the person would make a massive difference to the patients, as well. They'd always spend time with the patients. They would generally be the ones that would be in the day area and be visible for the patients. And I don't think the patients often knew the difference between -- because we didn't wear uniforms back then.
Q. What training did the support workers have?
A. I think some of them did NVQ courses, you certainly didn't need a qualification to get the job on the ward but they did all the mandatory training that was required of them and NVQ courses in care.
Q. And who was responsible for supervising them?

A. The qualified staff. Sorry, the nursing staff, yeah.
Q. You mention having no particular problems with staffing on Finchingfield Ward?
A. Yeah.
Q. But you talk about understaffing at The Lakes, I think --
A. Yeah, and on Galleywood Ward, yeah.
Q. And on Galleywood Ward?
A. Yeah.
Q. And you would describe bank and agency staff?
A. Yeah.
Q. What's the practical difference between bank and agency staff?
A. Bank staff were generally -- a regular member of staff can do extra hours on the nurse bank, and that's generally what we would use, and also bank staff would have to be interviewed by the Trust to be employed as a bank member of staff, whereas an agency staff would come from outside of the Trust.
Q. So bank were employed by the Trust?
A. Yeah.
Q. Agency weren't?
A. Yeah.
Q. Was there a particular process which the Trust used, as far as you were concerned, to fill gaps with bank staff

before going to agency staff?
A. Yeah, I think -- I can only speak for Finchingfield Ward --
Q. Of course.
A. -- is most of our shifts were filled up with staff that wanted to do extra hours and on the occasion we couldn't fill that, we had the numbers of different bank staff that we'd phone up and say, "Can you do this shift" and then where was a bank kind of administrative place where we would phone up and say "We've covered this shift". If we couldn't cover a shift, they would then try and phone around to get the shift covered for us.
Q. So it would be overtime followed by bank, followed by agency --
A. Yeah, there was no overtime it was still bank --
Q. No, you said extra hours, people doing extra hours?
A. Yeah, on bank.
Q. On bank?
A. Yeah.
Q. Okay.
A. Then if they couldn't be filled, then you'd have to ask the clinical manager for admission to go to an agency to get staff in.
Q. Can I ask about the impact of bank and agency staff.
A. Mm-hm.

Q. It may be the answer is different for the two of them from what you're describing.
A. Yeah.
Q. So what impact does filling gaps with bank staff or agency staff have on the quality and frequency of observations or the engagement that you've already described to us, or empathetic connection between staff and patients? How does that play out on the ward?
A. On Finchingfield, like I said, the majority of the staff member would do bank as well. So in essence it kind of wasn't much difference to the patients. They didn't know that person was doing an extra shift or whatever. And if we had a bank member of staff that was really good we would keep asking them to come back so then they would get to know the patients on the ward.

In terms of agency staff, we didn't have much use for them on Finchingfield, but my impression that when they came was that they were there to do the hours and they had no real interest in anything other than finishing the shift.
Q. And I think you referred to understaffing at The Lakes --
A. Yeah.
Q. -- which I know is later on?
A. Yeah.

Q. Did you have more agency staff at The Lakes then?
A. Yeah.
Q. And you say there was -- I don't want to put words in your mouth -- a significant difference then --
A. -- yeah.
Q. -- in the care provided by agency staff to bank staff?
A. Yeah.
Q. Is that what I'm taking from this?
A. Yeah, both in terms of ability and interest, to be honest.
Q. Can I ask you about transfers?
A. Yeah.
Q. Something else you refer to in your statement.

You refer to transfers and I think again we're dealing with Finchingfield --
A. Yeah.
Q. -- mostly. You say the need would be determined by a doctor.
A. Yeah.
Q. And it would be based on clinical need?
A. Yeah.
Q. And in your experience you say -- this is your paragraph 23:

"It was usually when someone needed to move to a more secure unit."

A. Yeah.
Q. And it was the Christopher Unit, I think, for the most part?
A. Yeah.
Q. And you describe the process where two people would come from the Christopher Unit?
A. Yeah.
Q. There would be a face-to-face assessment?
A. Yeah.
Q. You're -- you're -- I'm summarising but tell me if I've got this wrong. Then you describe a tension because sometimes the staff from the Christopher Unit would determine that your ward was fine with the risk?
A. Yeah.
Q. You could contain the risk?
A. That's right.
Q. And you consider that that came about because of, really, for a resource issue because there came a time when the Christopher Unit was really the only secure unit to refer to?
A. That's right, yes.
Q. And I think you've already told us it was small, would you say six -- (overspeaking) --
A. At the time it was six or seven beds but I understand that over the years it's grown, it's got an extra wing

to it, so there may be 12 or 13 beds now, I think, I couldn't be sure.

Q. But at that time it was smaller?

A. Yeah, it was.

Q. And you say the only option would be to re-refer in due course?

A. Yeah.

Q. But that, unfortunately, would be when something had happened?

A. Yeah.

Q. To use your words, when something bad had happened?

A. Yeah.

Q. To what extent, as far as you're aware, was this tension known to the senior management at the Trust?

A. Yes, it was known.

Q. How do you know it was known? Can you tell us how you know it was known?

A. Because both myself and the manager on the other ward would feed back to Stuart McGough, the clinical manager, and say "This is the situation, we've got a patient here we feel needs to be in the Christopher Unit, they feel they don't need to be in the Christopher Unit. Can you speak to the equivalent manager?"

Q. So that was a case-by-case basis?

A. Yes, it was, yeah.

Q. Did you ever escalate it as an overall and ongoing concern?
A. I don't think so because it wasn't that frequent that we had to refer someone to the Christopher Unit.
Q. Right. Did it persist, though? Did that problem, that persist throughout your time there?
A. It did very much depend on the member of staff from the Christopher Unit that did the assessment. It felt like, different people had different thresholds for what they felt was appropriate.
Q. Were you aware then, having escalated, of any attempt to address the problem to bring the consistency in?
A. No, no, I don't remember anything being fed back.
Q. In terms of the Christopher Unit being the only secure place to refer people, when -- was that -- did there come a time when -- when did that become the position?
A. At a time when I was on Finchingfield, I'm quite sure there was two other secure units, one in Harlow called Shannon House and I think Maple or Cedar Ward in Colchester. And they did both close down, one and then the other, but I don't know what period of time that was over. And there was a new secure unit built at the back of Finchingfield called Edward House. Again, I'm not sure when that was.
Q. And in terms of, then, of the -- you being limited to

the Christopher Unit, was that suited to all high-risk referrals or were there many people for whom it wasn't suited to?

A. Like I say, there weren't many people that we would refer. We did try to manage things on Finchingfield. It was generally, yeah, if someone was a high risk, certainly of aggression, that would be the main kind of reason that we'd refer to the Christopher Unit. Because they had links to the forensic services, as well.

Q. Picking up on your early answers, for example, about neurodivergent patients?

A. Yeah.

Q. And looking back now and you've already given your answers about lack of specialist knowledge --

A. Yeah.

Q. -- and you candidly included yourself in that.

A. Yeah.

Q. Looking back now, was the Christopher Unit perhaps sub-optimal for certain types of patients?

A. Yeah, absolutely.

Q. But you were unaware of that?

A. Yeah, absolutely.

Q. Did this tension between transfers apply to other admissions or wards? You know, then patients were moved elsewhere?

A. No, because the patients that were moved elsewhere would be say to the -- if we had patients from other areas on Finchingfield, which was quite frequent, when a bed came up on, say, Ardleigh Ward or the person's local area we'd get a call to say, "We've got a bed for the person now. Can you transfer them?"

Q. So they were going closer to home or something of that nature?

A. Yeah.

Q. Were those transfers ever delayed then by the lack of beds and resources available?

A. Yeah, sometimes we'd have someone on Finchingfield for two, three weeks at a time, and then they'd go back to their local area, different consultant, different approach, different staff. So it was very destabilising.

Q. And did you ever raise concerns about that?

A. Yeah, we did. We did often ask if we could keep the patient on the ward to finish their care and treatment.

Q. You refer, I think, in your statement to those types of transfers being disruptive?

A. Yeah, absolutely, yeah.

Q. So you weren't raising concerns so much about the delay but about the fact that where was this disruption in the patient's care?

A. Yeah.
Q. All right. You refer to transfer decisions being doctor led with little patient or family involvement?
A. Yeah.
Q. Why was that the case?
A. I think I'm referring there to the specific incident from where I worked in the community and I had a patient on a secure ward in Colchester.
Q. We'll come back to that in a moment in fact and everybody found out about it after the event?
A. Yeah.
Q. Is that the incident you're referring to?
A. Yes.
Q. All right. But in terms of, then, patients and their families to out-of-area transfers, were they informed about those? Were patients and families involved in that?
A. Yeah, they were, I don't remember there being many -- do you mean by out of area by out of the Trust?
Q. Yes.
A. I don't remember there being many of them to be honest, or any examples. Certainly, if they were, the families should have been informed beforehand.
Q. Perhaps you would want to answer this question more generally, but it may be that you can link it to

transfers. What was the impact that you saw of lack of family engagement in transfer decisions, for example on the patient or on the family, if the family weren't involved in the transfer positions -- sorry, decisions, what was the fallout? What was the impact that you saw?

A. The decision was always made regardless of what the family or the patient felt. If there was a bed in the local area, then that was it. The patient was going there regardless. And of course they should have been informed every time and to my -- to my knowledge.

Q. What -- and it may be you can't answer this in relation to this passage of evidence, but in your experience, what was the primary reason for out-of-area placements? Was it bed availability?

A. Bed availability, yeah.

Q. You explain at paragraph 14 of your second witness statement that when a patient was transferred, the care coordinator would be expected to be invited to the reviews on the receiving unit.

A. Yes.

Q. And to be kept up-to-date on incidents, or granting of leave, discharge planning, so on and so forth.

A. Yeah.

Q. But in your experience that didn't always happen.

A. That's right, yeah.

Q. Did that apply to out-of-area placements, as well?
A. Yes.
Q. So the care coordinator should have been invited to those --
A. Yeah.
Q. -- reviews as well?
And what was your understanding of the role and oversight of a transferring Trust for the ongoing care of patients in a receiving Trust?
A. I don't know, to be honest.
Q. Can you help us with any reasons, to the best of your knowledge why care coordinators didn't attend the ward reviews on the receiving units?
A. Not at the time. It may have been if they were told at the last minute because a care coordinator will have five or six appointments in their diary booked from the week before. So often it would be difficult for them to get to something if they've only got an hour's or a day's notice, even.
Q. And this is where I think in your statement you do refer to your experience from when you were a care coordinator later on --
A. Yeah.
Q. -- and you talked about the patient that was moved to a secure unit without your knowledge?

A. Yeah.
Q. Without the next of kin being informed?
A. Yeah.
Q. And you found out after the event?
A. Yeah.
Q. Did you complain about that?
A. Yes, I did, yeah.
Q. Can you just give us a time period for that?
A. That would have been probably within the first two years that I was at Maldon Community Mental Health Team, so that was 2009 maybe, 2010. Something like that.
Q. Did you receive any feedback from that complaint?
A. No, no.
Q. You also explain in your second witness statement that there are different processes in place for communication with a care coordinator after a transfer of a patient. And it depends on, or it's determined by, whether they went to North Essex-based facilities?
A. Yeah.
Q. Or South Essex-based facilities?
A. Yeah.
Q. And if it was a previous North Essex facility then you could follow progress better because the records would be on the Carebase or Paris system?
A. Yes.

Q. Have I understood this correctly?
A. Yes.
Q. But if a patient is transferred to a South Essex, what was previously a SEPT facility --
A. Yeah.
Q. -- it was still the use of SystemOne --
A. Yes.
Q. -- which was a different system?
A. Yes.
Q. So you couldn't get information?
A. No.
Q. How -- until how recently did that persist?
A. I'm pretty sure it persisted until I retired.
Q. So when you retired in 2024 --
A. Yeah.
Q. -- there was still this anomaly between the two systems --
A. I think so --
Q. And it depended literally on where you were sent.
A. Yes.
Q. So if you were in a North Essex facility everybody could get better information about what was happening?
A. Yeah.
Q. All right. Can I ask you about staff attitudes. You explain in your witness statement, first witness

statement at paragraph 39, that you'd heard a bit about -- you'd heard something about difficulties with staff attitudes during the courses that you -- (overspeaking) --

A. Yeah.

Q. Is that the training you've already talked to us about?

A. Yeah.

Q. So what period of time are we talking about that you'd heard about difficulties --

A. Kind of throughout the time I was the control and restraining instructor. There was lots of space within those four days of training or two days refresher training where staff would sit down and just talk about their own areas. Sometimes we would encourage that as part of the course, but sometimes it would be during breaks and stuff like that.

Q. So is it a kind of keeping one's ear to the ground?

A. Yeah.

Q. And you said you did training, I think you said, until about 2015?

A. Yeah.

Q. And what kind of things were you hearing, then, about staff attitude?

A. Basically it was more to do with the attitudes of their managers. Predominantly people felt overwhelmed, they

felt bullied, they felt that their voices weren't heard. And it was difficult, because in those kind of scenarios, those people tend to be the ones that speak up. So the ones that kind of were okay, you probably didn't hear from. So it could have been -- it's a difficult thing to assess because if someone is not happy at work and they've got a forum where they can talk about it, it doesn't mean that -- there's no corroborating evidence so to speak.

Q. So you were --

A. It was a place where people could let off steam.

Q. So you were hearing about the bad rather than the good, you'd say?

A. Yeah.

Q. All right. You say you didn't have so many staff issues on Finchingfield --

A. Mm-hm.

Q. -- because after the high turnover you recruited people that, you know, that you thought worked well in that environment?

A. Yeah.

Q. But you've already explained, and I said I'd come back to it, that when you first arrived there was an issue because staff would often be in the office with the door closed?

A. Yeah, absolutely, yeah.
Q. And you insisted that the door remain open?
A. Yeah.
Q. That one person would stay in the office but all of the others should be out on the ward?
A. Yes.
Q. But it didn't sit well with the staff?
A. No.
Q. What was their issue with it?
A. I think the issue was that they were having to engage with the patients. I don't think it was something that a lot of them wanted to do. They weren't happy at work.
THE CHAIR: Can I ask you about this, because this also arises in relation to your nursing model --
A. Yeah.
THE CHAIR: -- which you described as existing staff being resistant to --
A. Yes.
THE CHAIR: -- and not enjoying. Is that a case of learnt behaviour? Is it a case of or was it a case of actively not wanting to do the things you're suggesting? Or was it just because they had been led to expect a different thing of how they should work? What do you attribute that resistance to these changes?
A. I think there's -- I think there's some learned

behaviour, that's the way it always was, is part of it.

THE CHAIR: Yes.

A. And also, the hardest part of working on a ward is engaging with the patients. It's very emotional, it's very draining and it's very difficult and some people either didn't want to do that or they had had enough of doing that and they kind of just become enclosed. And by shutting themselves in the office with their colleagues it felt safer for them, and I was asking them to break out of that, which was resisted.

THE CHAIR: So it was more, really, to do with their willingness or their personality themselves.

A. Yeah. It was the individuals, yeah.

THE CHAIR: The individuals. Thank you.

MS HARRIS: Thank you, Chair.

Because you then go on to explain that senior management introduced this concept of the PET time, the Patient Engagement Time.

A. Yes.

Q. Where for one hour a day staff phones would be off, the office door would be shut in the right way, with the staff on the patient side, and staff were to dedicate their time to patients.

A. Mm-hm.

Q. And you say, quite clearly, you think that was the wrong

way round?
A. Yes.
Q. They should have had a dedicated paperwork hour --
A. Yeah.
Q. -- and the rest of the time staff the staff should be out. Does that mean, then, that for this PET time, with this hour of PET time, that for the rest of the working day, staff were able to use their personal mobile phones?
A. Sorry, it wasn't their own phones, it was the office phone.
Q. The office --
A. The office phone, yeah. Yeah, my argument was if you're not engaging with the patients what are you doing with your time? You know. So I told my staff to ignore that completely and carry on doing what we were doing.
Q. When was it introduced? Do you remember?
A. It would have been towards the end of my time on Finchingfield, I think.
Q. And who was responsible for determining that one hour patient engagement time was enough?
A. That was just something that came down to us.
Q. Did you yourself, particularly in the beginning, observe staff failing to engage, then, with patients?
A. Yeah, yeah.

Q. Did you observe instances of staff sleeping on observations?
A. No, no.
Q. You may have just answered this, but so I'm clear, did staff carry and use personal mobile phones during a shift?
A. They weren't stopped from carrying them. I honestly don't think -- I don't think I even had one at that time, I was a bit late to the party with that. So I don't see it was a big issue at the time. I remember one time someone had put something on Facebook to say, "Handover is boring", or something like that, so they were obviously using their phone and they got in trouble over it. I don't remember it being -- having to tell people "Get off your phone, get off your phone." Certainly on Ardleigh Ward it was an issue.
Q. On Ardleigh Ward?
A. Yeah.
Q. The Lakes?
A. Yeah.
Q. So 2014 to 2016?
A. Yeah.
Q. At times when you witnessed this lack of staff engagement, did you ever observe patients looking after each other?

A. Yeah. Patients -- there was always a big affinity on the ward. I think because it was generally a reasonably good atmosphere, if you can have one in those types of places, and there was a lot of time that patients spent with each other, yeah definitely.
Q. Sorry, just to make a distinction, so patients looking after patients, anyway because of the atmosphere, but did you ever observe patients looking after patients because there was no one --
A. No.
Q. -- no staff to do it?
A. No, I don't recall an incident there. You would get patients come to you and say, "So and so is upset" and things like that, and then -- that kind of thing.
Q. We have touched on some of the differences between Finchingfield and Galleywood. And in your statement at paragraph 41, you use the phrase "a distinct divide"?
A. Yeah.
Q. Galleywood was managed by your colleague Rahma Saibon?
A. Yeah.
Q. And you said you tried to foster a general atmosphere of positivity but you felt isolated --
A. Yeah.
Q. -- because she had been in post for years.
A. Yeah.

Q. Put shortly, what were the difference, then, in yours and her management styles and approach?
A. In terms of -- obviously I've not worked for Rahma so it's difficult to say how it felt to work there but having gone on the ward and it was quite a dreary place. There was -- almost every time one of us went to Galleywood Ward, the office door was shut and a lot of the staff were in the office. There'd be times where we'd phone from Galleywood Ward for something, get no answer and go over there and find staff in the office.

There was a general -- and you'd see queues of patients queueing up at the office door. It just felt so wrong, to me, to be honest. It didn't feel like -- feel like a place that people could be cared for in. And again, that's not to say they weren't nice people. It's just the way the job was done there was very different to the way I believed it should be done and the way it was done on Finchingfield.

Q. Can I ask you about some of the specific differences, if there were any.
A. Yeah.
Q. How did their approach to self-harm differ? Do you know?
A. Yeah, it was very much a case of increasing observations, then removing items -- stripping people's

rooms, yeah.
Q. So that's what you described as you thought the punitive approach?
A. Yeah, yeah.
Q. What about their approach to level 3 observations?
A. They would almost always have somebody on level 3 observations, sometimes two people, sometimes three people.
Q. How were the fact that there were differences overseen and managed?
A. I think more or less every morning myself and Rahma and the manager of the day hospital would have a meeting with Stuart McGough in the mornings, and any issues that we had to bring to him, we would. How issues on Galleywood were managed, I wouldn't have been privy to.
Q. Sorry, it may be my fault in the way I asked the question, but were there any concerns about the fact that the two wards were doing things very differently?
A. I don't know. I don't know. We just carried on doing the way I thought it should be done.
Q. And given that there were different approaches, it would appear, from the two wards, were you ever given clinical input for the correct approach for individual patients?
A. No, no.
Q. Were you ever concerned, on Finchingfield, that your

approach might not work for a particular patient's risk profile?

A. No, no.

THE CHAIR: You have had talked a lot about the engagement, the need to --

A. Mm --

THE CHAIR: -- understand the patient's motives, and doing things --

A. Yeah, yeah.

THE CHAIR: -- and to consider behaviours, the cause of behaviours.

A. Yeah.

THE CHAIR: There must, however, still have been occasion when behaviours were very challenging.

A. Absolutely, yeah.

THE CHAIR: There must, were there not, occasions when you had to use physical restraint --

A. Yes.

THE CHAIR: -- where discussion and conversation was --

A. Yeah.

THE CHAIR: -- not the answer?

A. Absolutely, yeah and that was one of my reasons to become a control and restraint instructor because I wanted to make sure the way I worked, we did it the way it should be done. And so therefore -- and then the

staff can be confident in me, because I was always trying to be the -- if the alarms went off, I always tried to be the first one there to make sure I kind of led how it went and our approach was very much if you had to restrain a patient, the whole incident wasn't finished until you could sit down with that patient. Back in the day you'd have a cigarette with them, or whatever, and explain why you had to do what you had to do, and making sure they were okay, and there were no hard feelings and they could carry on trusting us because I think if you just -- to be physically restrained by somebody is awful. Certainly if you're distressed or if you're a female being restrained by a group of men, and for then just to be left is just the most abhorrent thing. So we were very, very big on making sure that the person felt okay afterwards.

THE CHAIR: Thank you.

MS HARRIS: If there were differences in the way you were doing things on Finchingfield as opposed to Galleywood, are you aware of this having any impact on patients as to whether, in terms of consistency, whether they were concerned that there was a lack of consistency about how they were being treated on Finchingfield as opposed to others on Galleywood?

A. I know there were occasions where, due to the amount of

observations on Galleywood, and we had a bed we would take somebody who was on level 3 maybe, and they would be very clear about how it felt different, and we would often get those levels of observations reduced before they were transferred back to Galleywood. So it would be anecdotal from patients about how it felt.

Q. I'm going to -- sorry -- move on quite quickly because I'm conscious of the time.

A. Sure.

Q. Can I just ask you about risk assessments.

A. Yeah.

Q. Which you deal with at paragraphs 42 and 43 of your first witness statement, and you deal with the model there and you talk about the risk assessments being collaborative and you talk about the -- you say there's a general attitude from the Trust towards health and risk assessment was focused on paperwork being up-to-date, with the emphasis being on audits?

A. Yeah.

Q. You described the big yellow incident form books --

A. Yeah.

Q. -- having to be filled out. And you say the forms seemed pointless because you never received any feedback in relation to the incidents?

A. Yeah.

Q. You referred to no one from risk management coming back to you about them, I'm summarising, and can I ask you this: how were incidents then reviewed or escalated, do you know?

A. Yeah, so -- yeah, there were big -- this size -- sort of books, sort of triple copy, carbon paper, whatever. So if there was an incident on the ward, say if somebody had self-harmed or if there had been an altercation between patients or a member of staff had been verbally abusive or even if a table had broken or something, a form would be filled in. So I would come in in the morning and I would review those forms, deal with whatever needed to be dealt with. So, speak to the patient, make sure the patient was okay. If something needed to be ordered to be replaced, I would do that.

And then what was supposed to have happened is I would send the top copy to Risk Management, to my mind it was a filing exercise. They got that to file away. One copy went in the patient notes. And then that was it. Yeah.

Q. So no learning disseminated from any of this?

A. No, it was just a case of -- to my mind, it was about alerting me that something had happened as the manager and then dealing with that. And if there was ever an incident with a patient, that would always be in the

nursing notes anyway so it felt having -- you know, so the extra bit in the back of the notes of carbon paper was kind of replicated in the nursing notes.

Q. Did you ever raise concerns about the fact you thought the forms were pointless?

A. No, no, I just -- no. I certainly didn't give them the gravitas that clearly the Trust did, as I found out.

Q. Yes. As you --

A. Yeah.

Q. -- we'll come on to that in just a moment.

Where were the books kept?

A. Just in my office on the ward.

Q. Did you ever chase for any feedback?

A. No, because I didn't feel that feedback was necessary -- it was very much informing them of what had happened because on the form you'd put, you know, what had -- the incident and then how it was dealt with. So it wasn't necessarily expecting feedback.

Q. And --

A. Which is why I kind of thought it was just a filing exercise.

Q. I understand. And did this focus, then, on paperwork rather than care that you've described elsewhere in your statement, this presumably being an example of it, did it manifest itself in any other ways?

A. I don't know, certainly, my priorities when I was on the ward was making sure people were safe and okay and that the incident book wasn't on a high list of my daily priorities.
Q. Discharge planning, sorry, I'm moving --
A. Yeah, it's okay.
Q. -- through quite quickly. You describe discharge planning at the point of admission, which is at paragraph 15 of your first witness statement.
A. Yeah.
Q. What are your views as to whether discharge planning at the point of admission is effective and appropriate?
A. It is to a degree if you're looking at the situation the person was in before they got admitted, but during admission, other issues could come to light. And just being on an acute admission ward, as you can imagine, is a trauma in itself. So people can develop anxiety and become distressed. So it is helpful to know from the beginning what needs to happen for somebody to be discharged but other issues can come into play during the course of the admission.
Q. What's your view as to the impact that early discharge planning has on patients?
A. It is difficult because some patients actually wanted to be in hospital and asked to be there voluntarily and

sometimes found it safer and a better place to be than outside. So the thought of discharge then was quite frightening to them. Whereas other people who -- because a lot of people change their minds when they confirm in, because they come in voluntarily and suddenly to be told they can't leave for 72 hours and there'd be these locked doors and you have to see a doctor for this is, and then they say, "Oh, I didn't know it was going to be like this, I want to go".

So it was -- early discharge is important but you can't set dates in stone for people.

Q. Are you aware of any patients being discharged against their wishes?

A. Not specifically, I don't think. Certainly more on Ardleigh Ward. When I was on Ardleigh Ward it was very much there were some patients that had been there for a long time, they had developed very strong friendships. And they didn't want to be discharged.

Q. Let me ask you this: was there a particular type of patient then or demographic of patient that would be discharged or would be upset to be discharged against their wishes?

A. Generally younger people who had difficult childhoods, who had difficult lives outside. Often people who had been diagnosed with emotional unstable personality

disorder, for which -- so life is very difficult and chaotic, and on the ward there is structure and people that ask. And there's other people that feel the same, whereas I think before they come on to the ward they feel very isolated in the community. So then the thought of being taken away from that support group is very difficult for them.

Q. Did you ever feel pressure to discharge as quickly as possible due to lack of beds?

A. I personally not, no.

Q. Can I ask you briefly about allegations or incidents of sexual safety.

A. Yeah.

Q. You have already talked about some of the pressures around a mixed ward.

A. Yeah.

Q. At paragraph 67 of your second statement you say that you don't recollect reports being made to you of sexually abusive behaviour while you were the Ward Manager of Finchingfield?

A. Yeah.

Q. Would a report have come to your attention as Ward Manager?

A. Yes, yeah. The fact that I can't remember doesn't mean it didn't happen.

Q. So there may have been one --
A. Yeah.
Q. -- but you just don't remember --
A. Yeah, I can't say that things like that didn't happen, no.
Q. Okay. And we know that certainly when you started it was a ward with -- a mixed-sex ward with a range of ages.
A. Yeah.
Q. Are there any cohorts of individuals that you consider to be most vulnerable or at risk of sexual exploitation and abuse?
A. Yeah --
Q. -- (overspeaking) --
A. Usually young females. Yeah, the young females on the ward, yeah.
Q. Were you ever made aware specifically of anyone being particularly vulnerable to sexual exploitation or abuse?
A. I can't remember, sorry.
Q. Is that something that may have happened --
A. Yeah, yeah.
Q. -- but 20 years have passed?
A. Yeah, yeah.
Q. If someone had -- if you had been made aware of that, would additional measures have been put in place to

monitor them?
A. Yeah, yeah, absolutely.
Q. And if someone had disclosed to a member of staff that they'd been sexually assaulted on the ward, should that have been brought to your attention as well?
A. Oh absolutely, yeah, yeah.
Q. And what steps would have been taken to address that?
A. I would speak with the patient, get the family involved, the police if necessary, and obviously my Clinical Manager, yeah, that shouldn't happen.
Q. Do you ever recall that happening?
A. I don't, I'm afraid.
Q. Might it have happened?
A. Yeah, yeah, absolutely.
Q. In terms of additional measures to monitor them more closely, what would they have been?
A. They would make sure that when the nursing staff were allocated at the start of the shift that it would be a female member of staff that they were allocated, making sure there was sufficient females on the ward, and making sure everybody was aware of the sensitivity of it.
Q. You also say you don't recall any specific risk assessment with regard to sexual safety, but you say it would have formed part of the vulnerability part of the

risk assessment?
A. Yeah, I think so, yeah.
Q. You say that you are convinced more could have been done?
A. Yeah.
Q. What --
A. In all areas of the management of the ward and the way the ward ran, absolutely. In terms of the level of understanding, level of knowledge --
Q. Does that include in relation to sexual safety and wellbeing?
A. Yeah, absolutely.
Q. What steps do you think should have been taken?
A. I think there should have been training for staff as to how to -- in those situations. Yeah. I don't believe there was any.
Q. Moving on, again quickly, to the question of leave and absconsions. In your second witness statement you provide detail at paragraph 18 about arrangements for leave, which you say would be discussed in a multi-disciplinary ward review.
A. Yeah.
Q. And that family members would be spoken to before the patient. You state that:
"During leave reviews, care coordinator or

representative from the Community Mental Health Team would be present but unfortunately that would not always happen".

A. Mm.

Q. Were leave decisions taken frequently, then, without patient or family involvement?

A. There would always have patient involvement. But yeah, yeah, I'd like to think that most of the time the family were involved but I can't say for sure that was always the case.

Q. What factors were considered during leave reviews?

A. The risk to the person, and the support that they would be getting in their home environment, whether family would be present, or if the care coordinator was able to visit. I tried as much as possible to have leave during the week as opposed to weekends. When I first went to Finchingfield it seemed to be accepted practice that people would go on leave at weekends but to my mind that was the wrong way round because there's no community support at that time at weekends so we tried to change it to during the week.

Q. I was going to ask you about that. Would you then consider that unescorted leave on a Friday is a high-risk decision?

A. Yeah, absolutely.

Q. What about factors such as recent self-harm attempts? Would they be part of the discussion?
A. Yeah, that would all be part of the risk. Some people would be more at risk, I felt, being on the ward, it was the fact that they were on the ward that sometimes the risk was heightened and it was the distress that may lead someone to self-harm, but it was all discussed because -- sorry, being a patient on a ward with another 19 people that were very distressed can cause kind of anxieties that you wouldn't get at home.
Q. What was your view, then, of the continuity of care available during periods of leave? And this might have changed, of course, throughout your time working.
A. Yeah, it would depend if the care coordinator was available to visit. Because what we tried to do was have leave as part of the discharge process, not somebody wants to go on leave for a couple of days and then come back on the ward for a week. There needed to be a purpose for leave and it needs to be towards discharge. So you would involve the care coordinator with that to visit while they were on leave to then report back, speak to the family to see how it was going.
Q. And you would get feedback, I think you say?
A. Yeah.

Q. Did you ask the patients if you could get feedback from the family?
A. Um --
Q. Did you get their consent for that?
A. I think we would generally, yeah, yeah, yeah. That would definitely be the process. And I think they would understand, because we would try and explain as much as we could to the patients what the processes were. And that would have been part of it.
Q. You also refer to the importance of communication between, as you say, the community and inpatient teams.
A. Mm-hm.
Q. With out-of-area patients, is -- how was that communication expected to operate between the home Trust's community team, if you like, and the inpatient out-of-area Trust?
A. Yeah, it was really difficult. It was basically by phone call, really, or email sometimes. You'd try and find out what ward the person was on and you'd try and find out when the ward reviews were, hopefully get given a time for it and then you'd drive down to Basildon and frequently I went down there and the review had either finished or it had been postponed. Yeah, it was really poor in terms of the patient's continuity.
Q. Did you observe out-of-area patients slipping through

the gaps?
A. Yeah, absolutely, yeah.
Q. And who would maintain overall responsibility, then, during periods of leave?
A. In terms of ...?
Q. For the patient's care?
A. The ward.
Q. The ward?
A. Yeah, still the ward, yeah.
Q. Again, I'm going to move on quickly. Can I ask you a little bit about clinical records. I think you explain that when a patient was admitted to an inpatient unit, the paper records would be created?
A. Yeah.
Q. We're going back now some time, aren't we, with your evidence?
A. Yeah.
Q. But any existing file would have to be requested from the records department which could sometimes take a couple of days?
A. Yeah.
Q. Because this is the beginning, this is when you're Christopher Unit in Finchingfield?
A. Yes, yeah.
Q. Does that mean that sometimes people were being assessed

on admission but without full access to records?
A. Yes.
Q. How often would that occur?
A. Certainly if people came in during the night or weekends, yeah.
Q. I think you also explain, and we've picked up on it with some of the transfers, that if a patient was coming in from a SEPT service --
A. Yeah.
Q. -- there'd be no access to notes because they were using SystemOne?
A. Yes, that's right.
Q. You also explain that paper nursing notes were filed separately to medical notes?
A. Yes.
Q. And you don't recall a doctor ever requesting to see nursing notes?
A. No. Maybe sometimes if they had a report to do but certainly not as general -- because it was expected that the nurses would feed back to the doctors what had happened.
Q. So they would be reliant on others to provide them --
A. Yes.
Q. -- the information rather than seek it out for themselves?

A. Yes, yeah.
Q. What impact do you think that had?
A. I think in a way it was not a particularly negative because as a nurse you were able to tell the doctor everything you felt you needed to tell them whereas I think if they just looked in the notes you wouldn't be convinced that they would maybe understand everything or they might pick and choose certain things.
Q. So you weren't concerned that doctors were making decisions without the relevant information?
A. No, I think it was more comprehensive because before each ward review the nurse would give a rundown of how the patient had been since the doctor had last seen them.
Q. A slightly separate question. Did agency staff have access to clinical records?
A. Yeah, because they would have to do -- write nursing notes the same as anybody else.
Q. And what about records, again for out-of-area placements, where systems may have been different? How -- what was your experience of the access --
A. The most you could ever hope for was a Discharge Summary, to be honest. You wouldn't get any up-to-date stuff in between.
Q. You've given evidence and I won't ask you any questions

about it, given the time, about Carebase and Paris, and the instability of both of those systems.

A. Yeah.

Q. Can I just ask you more generally about records. Are you aware of any incidents where records were allegedly fabricated by staff?

A. I don't know about that but I'm certainly aware that records were copy and pasted from day-to-day, because that was very clear from when you're in the community, you're looking at how the person is getting on, on the ward and then where would be cases where somebody's records were copied and pasted on to a different patient's records as well. That wasn't -- it was unusual but it certainly happened.

Q. I was going to ask what impact that had on the quality of the records but you perhaps answered that --

A. Mm.

Q. -- because if you've got the wrong person's information --

A. Yeah, it's appalling, yeah.

Q. -- it's just ... appalling.

Were there any barriers to staff speaking out? So when you discovered the cut and pasting, for example --

A. Yeah.

Q. -- or when you discovered someone had the wrong

information --

A. Yeah.

Q. -- in their records, were there barriers to staff speaking out about that?

A. I was always very vocal so as far as I was concerned there wasn't, no.

Q. To what extent were staff, certainly on the ward, able to complete records contemporaneously?

A. Yeah, it was certainly possible, yeah.

Q. Again moving on, I want to ask about patient and family involvement in care.

A. Okay.

Q. You describe a balance -- within your statement you describe a balance shifting from what the doctor says goes to doctors advocating for their patients and then to a latter stage, which the Chair has already asked you about, about whatever the patient wants, in order to reduce --

A. Mm-hm.

Q. -- complaints.

A. Yeah.

Q. You've given examples of where you think, for example, medication was changed too quickly without time for it to --

A. Mm-hm.

Q. -- to settle in. What prompted the shift, do you think?
A. I don't know, because it -- because I'd never worked in that part of the Trust before, I don't know how long that had been a prevailing factor or whether it was because of a certain incident. I didn't know. I just very much noticed the difference.
Q. When was it, then, that the shift took place, do you think?
A. I don't know. I was working in the community in Maldon which was kind of the different end of the Trust, so --
Q. So it was when you were in the community?
A. Yeah.
Q. What was in place at a systemic level, do you think, to ensure that patients' wishes were properly taken into account into decisions that they disagreed with, if that makes sense?
A. There was an advocacy -- had access to advocacy and I'd like to think staff would have advocated for them, as well. Certainly on Finchingfield that was the case. I think less so on Ardleigh Ward.
Q. So on Finchingfield you'd have advocated for patients --
A. Yeah, and I often would say to patients, you know, you know, encourage them to complain because often the things they were complaining about, they would be things I wasn't happy with either. And so I was often

directing patients to PALS to complain or to write to the Chief Executive and stuff like that.

Q. Would you routinely refer them to the advocacy services?

A. Yeah, yeah.

Q. And were they able to obtain support --

A. Yeah.

Q. -- for example, from the independent mental health advocates?

A. Yes, yeah.

Q. And were decisions escalated to Ward Manager level routinely?

A. Yeah, yeah.

Q. And as you say, they were told of their right to complain?

A. Yeah, absolutely. I'd make sure of that.

Q. Encouraged, you --

A. Yeah, absolutely. Yeah.

Q. In terms of family involvement in care, you describe it at paragraph 55 as "disjointed and poor"?

A. Yeah.

Q. What time are we talking about?

A. Um, certainly on Finchingfield but I don't think it was any better on Ardleigh Ward.

Q. So it was Linden Centre and The Lakes?

A. Yeah.

Q. To what extent do you consider care and family involvement was encouraged and taken seriously, then?
A. On the ward, I don't think it was a priority. I think it was a case of families were there to be informed of events, meetings, et cetera, not to be learned from and not to get information from. It was very much a one-way kind of street. It was only when I started working in the community, I just felt so ashamed in terms of the fact of how it had been, because there was a patient on the ward that I'd known very well on and off for a number of years, they'd had extensive admissions. And then when I became a care coordinator, I went to her house and saw her wedding picture on the wall and it suddenly struck me how much, you know, this person has lived a life before they became a patient, and yeah, from then it just -- it was a lightbulb moment for me and yeah, I felt very ashamed of the way we'd not engaged with people more.
Q. Obviously, there was policy and legislation in place where care and family involvement was encouraged.
A. Mm-hm, yeah.
Q. What effort, do you recall, and you may have just answered this question, did senior manager -- what effort was made by senior management to assess whether or not on the wards staff were complying with the

requirement to involve families?
A. I don't know. There was certainly no occasion where I was told "This isn't good enough" or "You're not engaging with the families enough." I don't believe it was monitored.
Q. Can you recall any particular incidents -- as I say, you've now worked in the community and realised --
A. Mm-hm.
Q. I think the words you use in your statement is it would have made a massive difference if you'd known a lot more about your patients?
A. Yeah.
Q. Can you recall any particular incidents where information from family would have materially affected a patient's wellbeing, or informed --
A. I can't think of specifics, no.
Q. And presumably this need to involve --
A. Mm-hm.
Q. -- families and obtain information from families applies equally to decisions about safety on the ward?
A. Yeah.
Q. Leave?
A. Yeah.
Q. Discharge?
A. Absolutely.

Q. As it does in the community?
A. Yeah. I think we were so intent on getting to know the patient that we didn't realise we were only getting half the picture or two-thirds of the picture.
Q. Well, I was going to ask you that. Why were families, carers and friends not systemically involved?
A. I don't know. It was -- when they came to visit, certainly we would sit down, if they've got any issues or anything, but there was no outreach to them. I think the community, the care coordinator would have had much more involvement with the families over time, so we would get information from them to inform us. And again, it was only -- because I didn't really know the area. I'd come from East London way to work in Chelmsford and I'd heard of these places that patients lived and it's only when I worked in the Maldon community I realised that some relatives were having to travel 15 miles on public transport to get to see their relative at the Linden Centre, and the fact that we didn't welcome them or "Did you have a nice journey" or "Do you want a coffee", looking back, that's all things we should have done. Yeah.
Q. What specific changes did you effect yourself or observe being affected to family inclusion as a result of your experience in the community?

A. Me personally, where I had a caseload of patients, I would spend as much time with the family as I can. Sometimes more time with the family than the person. Because these people are living lives, they're not numbers or they're not a section-number, they're not a room number. It was only when I was in the community that that whole thing came clear to me. So, yeah.
Q. What do you then consider the main systemic issues or structural barriers are that make effective family involvement in inpatient care difficult to achieve?
A. I think they're very, very busy places. That's not an excuse. That's kind of an explanation. They're inherently chaotic. Things are changing all the time. I don't know, sitting here, what can be done differently. I couldn't honestly say.
Q. I will just ask you about serious incidents, please, which is a slightly different topic.
A. Yeah.
Q. You say at paragraph 59 that following a serious incident there was support for staff and patients. I think there you're talking about restraint.
A. Yeah.
Q. Because you talk about the evidence you've already given to the Chair, that it's not over. You've said, I think today, that you'd have a cigarette, but you've said in

your statement until you've shaken hands with the patient?

A. Yeah.

Q. In relation to restraint, then, was there a formal procedure in place that explained how staff from different wards were to be deployed during incidents of restraint? Because I think you sometimes called on other wards, didn't you?

A. Yeah, no, you'd put -- sometimes you'd hear an alarm go off and then you'd go to the panel and then you'd go -- two or three people -- I never sent one person from Finchingfield, I'd always say it's got to be a minimum of two, because you need three or four people to restrain somebody. So I always wanted a couple of people from Finchingfield to be involved because I think we did it well.

Q. So you were -- there was a procedure.

A. Yeah.

Q. Did it increase the pressure on the wards from where the staff --

A. Yeah --

Q. -- come?

A. Yeah, it did, yeah. Quite often during the course of the day we'd be attending alarms on the other ward, yeah.

Q. At paragraph 59 onwards in your first witness statement you describe your experience of the serious incident investigation process?
A. Mm-hm.
Q. Can I ask you this: does that account primarily reflect your experience at the Linden Centre?
A. Yes, yeah.
Q. You say there was half day of root cause analysis training?
A. Yes.
Q. Who was that delivered to?
A. I think it was to managers.
Q. And was that one-off training?
A. Yes.
Q. Do you consider that was sufficient?
A. I think it's sufficient for me in terms of -- I was quite confident in the reports that I was able to make, to compile.
Q. You say that you were surprised there was no serious incident response training such as the use of ligature cutters and people were expected just, to use your words, to "handle it"?
A. Yes.
Q. Did you ever raise that as a concern?
A. Yes, I did, and in time that became part of the control

and restraint training. Because as part of that resuscitation and the thing called the green bag, like an emergency bag with all the different equipment in it, became part of that training.

Q. It may be an unfair question but can you remember when that became part of the training?

A. It certainly wasn't at the beginning of when I used to start doing control and restraint. So I'd say maybe halfway through.

Q. Halfway through you being the trainer?

A. Yeah, yeah.

Q. In relation to serious incidents response training then, were all staff required to carry ligature cutters?

A. No.

Q. You make reference I think in your statement just to being told where they were?

A. Yeah. They were in the office yeah. Sorry, not in the office, the clinic room.

Q. And was training provided to all staff? By that I mean qualified and unqualified?

A. Yeah, because all staff were required to go on the control and restraint courses.

Q. And basic life support?

A. Yeah.

Q. What about intermediate live support?

A. No, as trainers we were trained in that.
Q. So the trainers were trained in intermediate -- (overspeaking) --
A. Yeah. I think it may have been something the staff could request to be trained in. I'm not sure.
Q. What about training provided to bank and agency staff?
A. I think bank staff had to do mandatory training before their payroll number was triggered before they could sort of come on to the ward. I don't know about agency staff. The bank staff would attend the control and restraint training as well.
Q. Any other training you think staff should have been given in relation to responding to serious incidents?
A. I think there should have been much more about de-escalation about what should happen after the incident. The control and restraint course was very much a physical hands-on "This is how you do it" and there wasn't enough emphasis as to how the patient feels or what should happen afterwards.
Q. So that's restraint. What other serious incidents? Any other training that you feel should have been provided?
A. I can't think of any.
Q. Okay. Were you ever involved in having to deliver bad news to families?

A. Yes.
Q. Do you have any training about that?
A. No.
Q. In terms of incident reports, again, because of the time, I shan't go into detail, but in your witness statement, second witness statement at paragraph 74, you say you received very little update or learning from a higher level from some of the -- from any of the reports that you wrote?
A. Yeah, yeah.
Q. And you don't recall getting any feedback as to whether your recommendations were acted on?
A. That's right, yeah.
Q. And in fact you did, I think, a report -- or did you review of the case of Glenn Holmes?
A. Yeah.
Q. In 2012?
A. Yeah.
Q. But have only recently discovered that some of the recommendations were in fact implemented over --
A. Yeah, that's right, yeah.
Q. Did you ever raise concerns about not getting any response to your reports?
A. No, no.
Q. Were you provided with any training on how to engage

with families, friends and carers during the writing of those reports --

A. No.

Q. -- or the review?

Were there updates or learning disseminated to staff from other incident reports or root cause analysis reports?

A. I think over time as part of a Trust newsletter there would be a section of learning from seriously untoward incident reports but I don't know when that came in but it certainly came in at --

Q. That came in later on?

A. Oh, definitely, yeah.

Q. How do you consider, then, that learning was embedded or put into practice?

A. I don't think it was.

Q. In terms of writing the reports, do you consider you had sufficient time to write the ones you were asked to do alongside your clinical duties?

A. Yeah, I would always do them at home.

Q. You'd do them at home?

A. Yeah, yeah.

Q. Were you given the time to do them at home?

A. I just did them at home. Yeah, it wasn't something you were paid for, it was just something --

Q. You just did them.
THE CHAIR: So you did them at home in your own time?
A. Yeah.
MS HARRIS: Can I ask you very briefly, then, about the Serious Incident Report that you wrote in relation to the case of Benjamin Morris, Ben Morris.
A. Yeah.
Q. We've already touched on the fact that you wrote that report following his death just after Christmas in 2008. You know that his mother is a Core Participant in this Inquiry --
A. Yeah.
Q. -- and she has given evidence to the Inquiry already.
A. Yeah.
Q. And your evidence at paragraph 69 of your first witness statement, to use your own words, is that you received some pushback --
A. Yeah.
Q. -- from your manager, Stuart McGough, who told you Rahma Saibon who you've already referred to, was unhappy because it didn't paint Galleywood Ward in a good light?
A. Yeah.
Q. When were you told that?
A. It would have been after I'd written it. I can't say when, specifically. I'd had feedback from a previous

report that I'd done as well, from a service manager, to say I'd been very harsh on his team.

Q. Sorry, a --

A. Sorry, I'd had a previous report that I'd written, a case in Harlow where a service manager had seen it at a meeting and said to me at a meeting that he was unhappy because he felt I'd been very harsh in the report.

Q. Now, I won't go into detail because it's in your witness statement at paragraph 70, but you were very angry about what had happened to Ben Morris, weren't you?

A. Yeah, the issues that I'd -- that were in the report, I'd been raising for months, to be honest. There were quite a few incidents that happened on that ward over the period of time that I was on Finchingfield Ward, yeah, and the issues hadn't changed.

Q. Are you aware of anyone else who wrote reports feeling similar pressure?

A. No, I didn't have any contact with anyone else that wrote reports.

Q. And do you consider that the pressure was linked to this culture that you've described of prioritising the image of --

A. Yeah.

Q. -- the Trust?

A. I do, yeah.
Q. Did you raise any concerns with senior management following the death of Benjamin Morris?
A. There was a lot of staff on Finchingfield that were very unhappy. Two of them had been involved, I think, with Ben before. So yeah, I did raise it with Stuart McGough, yeah.
Q. You attended the inquest with Ben's mother?
A. Yes.
Q. You also explain in your second witness statement that you were then replaced on Finchingfield Ward?
A. Yes, that's right.
Q. You were moved to do administrative work and audit work, in effect?
A. Mm-hm.
Q. And you talk about the comment from the Director of Nursing who said that you -- they'd had high hopes for you --
A. Yeah.
Q. -- and you took it to mean that your career was over?
A. Yeah.
Q. You consider that following this report -- and I'm moving quite fast because I'm mindful of the time -- that there was a serious of events that leave you feeling punished for writing what you think was deemed

too negative a report?
A. Yeah, and generally I think at the period of time we had -- I think I said before -- three patients on the ward with early onset dementia and I was very vocal about how I felt that was wrong and something -- these people needed a better standard of care in a more appropriate place. So I think in general I was a thorn in the side, I guess, and I guess difficult to manage, I would say, and not afraid to say what I thought to people at various levels.
Q. You were subject to disciplinary action --
A. Mm.
Q. -- in relation to the yellow incident form books you've told us about?
A. Yeah.
Q. Can you help us, what time period did the conduct that was the part of the disciplinary action, when did that relate to?
A. I --
Q. When was it said that you didn't -- you hadn't been dealing with the yellow incident forms properly?
A. I thought it was somewhere sort of between January and March.
Q. 2009?
A. Yes, yeah.

Q. Sorry, which year?
A. It was -- the time period when I wrote the report for Ben Morris.
Q. So you wrote the report at the beginning of 2009?
A. Yeah, so I think it was some time after that.
Q. When did the conduct -- do you know when the conduct for which you were disciplined first came to the attention of the management?
A. No. No, I just remember coming in to work one day and someone said, "Oh, Risk Management have taken all your yellow books", and I actually thought, "Great, you know, that's where they needed to go anyway for filing." Yeah, and it was quickly after that I was told I was going to be disciplined.
Q. What was the final outcome of your disciplinary -- (overspeaking) --
A. Final written warning for three years. Yeah, and then I was moved from Finchingfield Ward. I think the phrasing, it was "putting staff and patients at risk" which obviously was devastating to me because I had spent my whole time making sure that didn't happen.
THE CHAIR: Was the move from Finchingfield Ward expressly stated to be as part of the disciplinary --
A. No, I was told I needed a break from the ward, and that I was going to be doing --

THE CHAIR: Who told you that?
A. It was the area director.
Then, yeah, I was replaced on Finchingfield Ward by one of the Charge Nurses from Galleywood Ward which, again, I found difficult.
MS HARRIS: You were then moved to work in the community.
A. Yeah.
Q. Can I just ask you a couple of questions, please, about assessments in the community. You -- at paragraph 5 of your witness statement, you say that assessments could be classed as routine or urgent.
A. Mm-hm.
Q. Was there a protocol as to when that -- they would be assessed as urgent?
A. Urgent would be assessment within 48 hours.
Q. Were there any circumstances in which immediate assessment was mandated?
A. Yeah, we'd sometimes go and see people the same day, yeah. We'd have meetings every morning with the team where we'd look at all the new referrals that have come in and look at what everyone's day looked like, yeah.
Q. Were there any measures that could be put in place pending an urgent assessment?
A. Sorry, I don't understand.
Q. If you considered that somebody needed to be assessed

urgently, but you couldn't get there, would any measures be put place?

A. No, we would always get there.

Q. Are you aware of any patients that came to harm as a result of late assessments?

A. I'm not aware of any specifics.

Q. In terms of having worked as a Ward Manager, I just want to ask you quickly about how inpatient wards and community teams such as the Crisis Resolution Home Treatment Team and the Community Mental Health Team worked together. In your experience, having worked as a Ward Manager, do you consider you received sufficient information from the Crisis Resolution Home Treatment Team, for example, about patients recommended for admission?

A. Yeah, because they would always come in person. They were based at the Linden Centre so they would come in person to the ward and there'd be a face-to-face handover, yeah.

Q. Would teams and wards contact each other, then, when -- for input when carrying out assessments?

A. Yeah.

Q. You do refer, however, later on in your evidence, to a tension between -- or you say the communication between inpatient units and community teams was never

without its issues?
A. Yeah.
Q. And you provide an example I think from 2023 when a colleague left a discharge planning meeting in tears and the meeting continued in her absence.
A. Yeah.
Q. Did you ever report or escalate that incident?
A. Well, the manager of the team I worked in was part of that meeting.
Q. What was the nature of the tension, then, between inpatient and community teams?
A. It would generally be a disagreement about discharge, because the inpatient wards certainly when I last worked, were very few beds available. I had somebody who was on a Community Treatment Order waiting six weeks for a bed, and they should have gone in straight away. So the inpatient wards very much wanted to discharge people. But from the community side, it had to be a safe discharge, and I think because of the community -- the care coordinator would have a better idea about what the person's requirements for safety were in the community, whereas somebody might not pose such a risk to stay on the ward but they would still pose too big a risk to be in the community and it was very much -- and certainly the one that you referred to,

that whole meeting, it was -- the way people were talking to each other, it was just terrible. It was -- yeah, no collaboration whatsoever.

Q. I think you describe the approach as disjointed.

A. Yeah, at the very least. It's -- a lot of it is where people who work on the wards that have never worked in the community and vice versa and I don't think that helps. And I think where I'd done both for quite a significant period of time, I felt I had a good idea in that area. But there was no -- one thing I used to bring up frequently was could there be rotation amongst teams from the ward and into the community so everyone had an idea of what everyone else was going through.

Q. I just want to -- before -- we've only got a couple of minutes left, I think, I'd just like to ask you a little bit about complaints and more to the point, culture --

A. Yeah.

Q. -- while you were working. You've already given evidence that as time went on, you started to feel decisions were being made to appease patients and avoid complaints?

A. Yeah.

Q. And you've explained, I think, that -- that what you were referring to at the Linden Centre or later on in the Linden Centre --

A. At Ardleigh Ward.
Q. And at Ardleigh Ward?
A. Yeah, it was mainly Ardleigh Ward, yeah.
Q. At paragraph 32 of your second statement you say that staff could raise concerns about a patient's care and treatment to their Ward Manager --
A. Yeah.
Q. -- using a whistleblower policy. Did that ever happen to you when you were Ward Manager? Did you ever receive those complaints?
A. No, no.
Q. In terms of culture you describe a general culture of detachment and superiority between senior managers and senior ward staff towards patients. Did that extend to dealings with the family as well, as far as you could see?
A. I'm talking about meetings that I attended, like staff meetings, and -- yeah, so.
Q. Do you think that the -- there was an impact of that culture on patient care?
A. The meetings I went to and I have to say, I went to them as infrequently as I could in the end because I felt it was a waste of my time, I'd rather be with the patients and the staff. And people would -- the senior managers would talk about staff in a very derogatory way, and it

just -- yeah, it just didn't sit well with me at all. It was a very superior -- you wouldn't think they were in a healthcare setting or worked in a healthcare setting, particularly mental health.

Q. Was your impression, then, that the culture of the Trust made it difficult for individuals like yourself and other staff to effect change?

A. Yeah, I mean because I would -- I was thinking about it recently is that a lot of the staff that kind of spoke up like myself didn't really have great careers. I would say I think those sort of people weren't the type of -- certainly not the sort of managers that were wanted. It was very --

Q. You said that people that spoke up like yourself didn't have great?

A. Careers. No, they kind of didn't progress at all.

Q. Sorry, do you feel that speaking up hindered your career?

A. Yeah. And to be honest, I think it was good. I don't think I would have been any good above dealing with patients on a daily basis because that's what I wanted to do and that's what I was good at, so it kind of did me a favour in a way but I do think that was the reason, yeah.

Q. You talk about, again, just you've given examples of

perception, you think, being important to the Trust.
A. Mm-hm.
Q. And you talk, for example, about when a CQC inspection would be announced that in fact work would be done to paint the walls?
A. Yeah.
Q. And I think you describe it as farcical.
A. Yeah.
Q. How widespread were your concerns about the culture and the superiority, the farcical response to CQC and the very few lessons being learned after serious incidents?
A. I mean my experience could only be from what I'd experienced on Finchingfield Ward and in the community and I ended up coming to the conclusion that I just need to do the best that I can for patients. The Trust just seemed to get bigger and bigger and bigger and I was less aware of who was who. So I just concentrated on doing what I could do on a daily basis to help people. And the teams I worked in were the same.
Q. And that Trust getting bigger and bigger, do you attribute that in particular to the merger?
A. Yes.
Q. You talk about the CEO of NEPT when you were working for NEPT, having a domineering personality, and those he employed reflected that attitude?

A. Yeah.
Q. Was that something that was felt, as far as you were concerned, throughout the Trust?
A. Yeah, yes.
Q. And the culture you describe of "We know what we're doing; the problem is down there"?
A. Yes.
Q. "Down there", do you mean the staff on the ground?
A. Yeah, absolutely.
Q. In your view, did this culture that you're describing result in the -- a defensive approach to patient safety incidents?
A. Yeah.
Q. And to the internal and external investigations --
A. Yes.
Q. -- as you've described?
A. Yeah.
Q. Are you able to give any examples of the culture of blaming staff for systemic issues?
A. I can't think of any specific examples right now.
Q. Do you think the culture had an impact on staff retention?
A. Yeah, I think people were coming to work afraid of being -- of getting in trouble, and I think they've began to feel that the less they engage with patients

the less likely they are to be accused of doing something wrong. So yeah, it had a definite effect.

Q. Do you think it meant that it had an impact on patient safety insofar as it meant remedial action wasn't always taken in relation to systemic issues?

A. Yeah.

Q. Did you raise concerns about the culture?

A. I did when I was a manager. When I stopped being a manager, like I said, my focus was just trying to help people on a daily basis.

Q. Why do you use the words "conflict-driven", "arrogant" and "aggressive" when you describe the management?

A. That was my experience of it. There was just no compassion at all, from my experience.

THE CHAIR: Those comments about Senior Management, did they apply specifically to NEPT Senior Management?

A. Yes, yes, because I didn't really have anything to do with Senior Management when I stopped being a Ward Manager.

MS HARRIS: Can I just ask, before I finish, a question I should have asked about The Lakes about Ardleigh Ward, which is this: during your time at The Lakes, what activities were available to patients there; do you remember?

A. Yeah, there was like a team separate to the wards that

would come and do activities on the ward. I think they would do like a newspaper group where people would sit around and talk about current affairs. And I think there was a day hospital. There were things that people could do off of the ward, but I can't remember any specifics, really.

Q. Are you aware of any illicit drugs being smuggled on to the ward?

A. Yeah. It did happen, yeah.

Q. What about bullying by patients?

A. I don't know. I can't think of any specifics. There was certainly a time where there was like a core group of patients that were very kind of comfortable on the ward, I think. But I wouldn't say bullying, as such. Not that I remember well.

Q. Did you consider that the environment at The Lakes, at Ardleigh Ward, was therapeutic?

A. No.

Q. And I should perhaps have asked you this: at paragraph 103 of your first witness statement, where you talked about how you felt you'd been moved on --

A. Mm-hm.

Q. -- after writing the report, the seven-day report, for Ben Morris, you say:

"It was not unusual for staff, subject to

disciplinary action, to find themselves moved to other areas within the Trust"?

A. That's right.

Q. What was your impression of why that happened?

A. I don't know. Certainly two of the staff that came to Finchingfield Ward came from the Colchester area following disciplinary. So I don't know why that happened, yeah.

Q. Do you know the kind of things they were being investigated for --

A. No.

Q. -- when they were being moved around?

A. No, no. I mean, what I would say is that they were very good members of staff on the ward, and I would say they were similar to myself in terms of not sitting back if we thought things needed to change.

Q. So they'd also -- you have described yourself as vocal --

A. Yeah.

Q. -- would you describe them?

A. Yeah.

MS HARRIS: That's all I'm going to ask for now.

Chair, do you have any further questions for Mr Ayris?

THE CHAIR: No.

MS HARRIS: Mr Ayris, what will happen now is we will have a short break --

A. Okay.

MS HARRIS: -- to see if there are any other questions, I think for ten minutes. If you wouldn't mind staying within the vicinity, we'll come back about 1.25.

A. Okay.

(1.15 pm)

(A short break)

(1.25 pm)

THE CHAIR: Ms Harris.

MS HARRIS: Thank you, Chair.

Mr Ayris, there's just a few more questions for you. We won't be very much longer. The first is this: you have already given evidence about the seven-day report you wrote following Ben Morris's death at the end of 2008. You've already given evidence of how you went to look at the handles in Galleywood Ward.

A. Yeah.

Q. You went back to start trying to remove them with your electric screwdriver on Finchingfield Ward?

A. Yeah.

Q. And you said that you were told you mustn't do that, it was damaging Trust property and it was a job for Estates?

A. Yeah.
Q. And you said initially you thought it was a conversation you'd had with Stuart McGough?
A. Yeah, I can't be --
Q. But then you said it might have been somebody else?
A. Yeah.
Q. You have also given evidence that after you wrote the seven-day report you felt that you'd had, to use your words, some pushback from Stuart McGough?
A. Yeah.
Q. Now, might that have been somebody else that gave you the pushback?
A. Yeah, it could be, yeah.
Q. So it may not have been Stuart McGough?
A. No, I can't be specific.
Q. So can I just break it up?
A. Yes, of course.
Q. Are you -- what is your evidence about the pushback? Do you recall getting pushback?
A. Yeah, I may have heard it from the person that commissions the reports. I certainly heard it from Rahma, as well.
Q. So you heard it from Rahma, you think?
A. Yeah.
Q. Possibly the person that commissioned the report?

A. Yeah.
Q. But it might not have been from Stuart?
A. No, I have to say Stuart McGough was always very kind and very supportive to me.
Q. Okay, so he was always kind and supportive to you?
A. Yeah.
Q. All right, thank you. That was that one.
I asked you some questions around sexual safety. Do you remember?
A. Yeah.
Q. Did you have any training on how to deal with, first of all, any aspect of how to either monitor those who were vulnerable or deal with complaints made when you were on Ardleigh Ward?
A. No.
Q. I asked you some questions around the completion of clinical records and whether or not staff were able to complete them contemporaneously --
A. Yes.
Q. -- and I think you said they had the opportunity to?
A. Yes, yeah.
Q. Can I ask you one question further.
A. Mm-hm.
Q. To your knowledge, as far as you were aware, did nursing staff or support workers usually complete their records

contemporaneously?
A. When I was on the Finchingfield, certainly, yeah.
Q. Were there times when you worked elsewhere where that wasn't the case?
A. Yes.
Q. So where would that be?
A. That would have been on Ardleigh Ward.
Q. So they weren't -- they weren't contemporaneous on Ardleigh Ward.
A. No.
Q. What was the situation?
A. It was where you'd come in and there'd be no report from the previous afternoon or something like that.
Q. And what would you have to do in those circumstances? Would it be your responsibility to chase that up, or how was that dealt with?
A. As a Charge Nurse, I would, yes. And there were times when I worked in the community where there was no entry from the previous day on the ward, if I had a patient on the ward.
Q. So if we understand your evidence correctly, Finchingfield Ward, the records were contemporaneous --
A. Yes.
Q. -- and you say better kept?
A. Yeah.

Q. I know those weren't your exact words.
A. Yeah.
Q. Ardleigh, not so much?
A. No, I think the Carebase system was a lot easier in keeping paper records, people were more likely to do it. I think people did struggle with the Paris system initially when it came in.
Q. So that was part of the Paris system -- (overspeaking) --
A. Yeah, I think so.
Q. And the community, again you say there were gaps in the records?
A. Yeah.
Q. Okay. You very candidly -- different subject -- you very candidly included yourself when we -- when you gave evidence about the lack of specialist knowledge --
A. Mm.
Q. -- particularly in relation to neurodivergent patients back in 2006 or 2007 --
A. Yes.
Q. -- or around that time, certainly when you were at Finchingfield?
A. Yeah.
Q. And then you mentioned later down the line, the online training --

A. Yeah.
Q. -- the Oliver McGowan training?
A. Yeah, I did.
Q. Did you undertake that training?
A. Yes, I did. It was mandatory for everybody.
Q. Yes, but it was in terms of your departure --
A. Yes, I did.
Q. Once you'd received that, did you feel that you were able better to address the issues that arose --
A. Certainly, yeah.
Q. -- in relation to neurodivergent patients?
A. Yeah, I mean, it was the tip of the iceberg, it was a whole new thing for me, really, because there's loads more to learn, but it did open my eyes to it, yes.
Q. Did you consider it useful?
A. Yeah.
Q. But you say there was a lot more you could learn about it?
A. Yeah.
Q. All right. Can I take you back, sorry, again, to ... to the removal of items from rooms following self-harm.
A. Mm-hm.
Q. Now, you described the approach about taking the item, items of risk, I think?
A. Yeah.

Q. Can I just ask you one question beyond that which is if someone had self-harmed by ligaturing?
A. Yeah.
Q. What would your approach be or what would the correct approach be, as far as you were concerned? Would you remove any potential ligature items in those circumstances?
A. Yes, definitely.
Q. So I'm thinking hoodies?
A. Yeah.
Q. Bedding?
A. Yeah -- (overspeaking) --
Q. Curtains?
A. Yeah.
Q. Tights.
A. Yeah.
Q. All those types of --
A. Yeah.
Q. All right. You have already given evidence that in your view those wards were not suitable for people with dementia.
A. Yeah.
Q. You already talked about how traumatic that was both for them and for others on the wards?
A. Yeah.

Q. What alternatives were there, then, for treating patients with dementia when in a crisis?
A. There was the Crystal Centre which is next door to the Linden Centre which was a ward for people suffering from dementia on that ward but because of the age of these people that were suffering with dementia they were put on an adult ward as opposed to the -- so it was due to their age as opposed to the appropriate care that they could receive.
Q. So they were on your ward which you considered was entirely inappropriate --
A. Yeah.
Q. -- given --
A. Because they were under 65.
Q. And finally this: you -- we talked a little bit about over-sedation and the culture of over-sedation?
A. Mm-hm.
Q. And you dealt particularly with the question of over-sedation on Ardleigh Ward.
A. Yeah.
Q. Did you raise that with management?
A. Yes.
Q. Who did you raise it with?
A. The Ward Manager.
Q. And what response did you receiver?

A. He would speak to the doctor. That was --
Q. And did you get any feedback from that?
A. No, none at all.
Q. That was the last you heard of it?
A. Yeah.
Q. All right. On the question, then, of raising matters, you said at the very end of your evidence, when I asked you, had you raised concerns regarding the culture of the senior management and senior staff at NEPT and/or EPUT, who did you raise that with?
A. Just Stuart McGough. I talked to him a lot about how I felt about how things were.
Q. So this was back at Finchingfield?
A. Yeah.
Q. So that's two thousand and --
A. Yeah.
Q. Between 2003 and 2009?
A. Yeah.
Q. Have you raised concerns about the culture of senior management since, in your more recent employment?
A. No. My most recent employment, all my focus was just on the people that I was looking after. I tried to keep myself away from almost the other stuff, to be honest.
Q. And did you get any response from raising that concern --

A. No.
Q. -- with Stuart McGough?
A. No, I think he was very good, very good listener. I think a lot of it was, kind of, this is how I feel about things but I wasn't necessarily expecting him to do anything about it.
MS HARRIS: Thank you, Mr Ayris. That's all the questions I have now. Just checking.
Chair, do you have any further questions?
THE CHAIR: I don't. Thank you very much indeed.
Can I thank you very much for your evidence. It has been very helpful indeed. Thank you.
THE WITNESS: Thank you.
MS HARRIS: I think -- could we come back again at 2.15? Thank you very much.
THE CHAIR: 2.15.
(1.34 pm)
(The Short Adjournment)
(2.15 pm)
(Proceedings delayed).
(2.21 pm)
MR COKE-SMYTH: Good afternoon, Chair.
We have this afternoon Ms Chloe Cawston. Can I ask that you please start by telling the Inquiry your full name.

THE WITNESS: It's Chloe Ann Cawston.
MR COKE-SMYTH: And I'm going to ask that you are now sworn so that we can hear your evidence.

CHLOE ANN CAWSTON (sworn)

Questioned by MR COKE-SMYTH

MR COKE-SMYTH: Thank you.

You should have in front of you a witness statement which was prepared in response to a Rule 9 Request from the Inquiry; do you have that?

A. Yes.

Q. It runs to a total of 40 pages and 218 paragraphs. Can I just ask you to turn to the last page, please.

A. Yes.

Q. Is it dated 8 June 2026?

A. Yes.

Q. And is it signed by you?

A. Yes.

Q. And it also contains a declaration that the facts contained in it are true. And have you had the opportunity to read through that statement recently?

A. Yes.

Q. Is there anything, before we start, that you want to correct from within it?

A. No.

Q. So does it remain true to the best of your knowledge and

belief?
A. Yes.
Q. Now, that statement is going to stand as your evidence, but I'm going to ask you some further questions arising from it but please rest assured, if you don't mention something or if I don't cover it, everything in that statement will form part of your evidence.
A. *(The witness nodded)*.
Q. I want to start, please, just by dealing with your background and your experience. And it may help if you just have in front of you the paragraphs of your statement that deal with that, so from paragraph 3 on page 1, and it may help just to start to have that up on screen, please.
So it's right that you began working in mental health in 2008 for the North Essex Partnership University NHS Foundation Trust or NEPT.
A. Yes.
Q. And that was as a bank staff member in 2008?
A. Yes, that's correct.
Q. That was at the Linden Centre; is that right?
A. Yes.
Q. Can I just ask this: was that as a healthcare assistant or were you a nurse at that point? What was your actual role?

A. That was as a bank support worker while I was doing my training.
Q. And so you do your training and complete that in 2011?
A. Yes.
Q. So you're then qualified as a mental health nurse?
A. *(The witness nodded)*.
Q. And you then take up a role as a staff nurse on the Christopher Unit, and that's still NEPT?
A. Yes.
Q. And then, 2016, you change Trusts and you move to the South Essex University NHS Foundation Trust or SEPT, and you then take on a community health team role; is that right?
A. So in 2016 I worked in North Essex. That was part of the community health team and then it was 2018 that I moved to SEPT. Sorry, 2016 when I moved to SEPT on Grangewaters Ward.
Q. Then also at SEPT and slightly later in 2016, you take on your first management role as a Ward Manager on Grangewaters Ward at Basildon Mental Health Unit; is that right?
A. Yes.
Q. Then in terms of the timeline, it's right that the merger between SEPT and EPUT happened in 2022?
A. Yes.

THE CHAIR: Sorry, SEPT and NEPT.
MR COKE-SMYTH: Sorry, SEPT and NEPT, forgive me, thank you, Chair, SEPT and NEPT, 2017, and so you continue in that role but you're now working for EPUT.
A. Yes.
Q. So any work after 2017 you're working for EPUT. And in 2018 you became a Matron at the Basildon Mental Health Unit; is that right?
A. Yes.
Q. 2020, you then became a Service Manager covering Basildon Mental Health Unit and the Linden Centre?
A. Yes.
Q. 2021, a period of maternity leave?
A. *(The witness nodded)*.
Q. Then back in 2022, still as a Service Manager at EPUT --
A. *(The witness nodded)*.
Q. -- now covering the Linden Centre --
A. *(The witness nodded)*.
Q. -- and the Crystal Centre?
A. *(The witness nodded)*.
Q. And what about the Basildon Mental Health Unit?
A. No, I'm only solely based in Mid Essex.
Q. Now, when I come on to ask about the various different topics which you cover in your witness statement, can I ask that you make it clear if you're referring to the

period before 2017?
A. *(The witness nodded)*.
Q. And if you are, if you identify which Trust you're referring to because you obviously worked for both SEPT and NEPT?
A. Yes, of course.
Q. I suspect most of your answers will relate to after 2017.
A. *(The witness nodded)*.
Q. If that's the case, we'll work on that basis, but if you're talking about earlier, please make that clear.
A. Yes.
Q. It's also right that when we talk about your role as a Service Manager you've only ever been a Service Manager at EPUT; is that right?
A. That's correct.
Q. Can I just ask a few more questions about the role of the Service Manager, please. Firstly, the locations where you've been a Service Manager, so I think in 2020 you were a Service Manager at both Basildon Mental Health Unit and the Linden Centre.
A. *(The witness nodded)*.
Q. And then later on, the Linden Centre and the Crystal Centre. What type of unit is the Basildon Mental Health Unit?

A. So that has a number of wards. So it has the Assessment Unit, it has Acute Admission wards and it also has a Psychiatric Intensive Care Unit known as a PICU.
Q. Can you help us that differs from the Linden Centre and the Crystal Centre, please?
A. The only difference is that it has an Assessment Unit but they're both mental health hospitals.
Q. Can you just summarise your role as a Service Manager, please?
A. Yeah, so I'm responsible for the inpatient services and also the health-based place of safety at the Linden Centre. So I would be responsible for looking after staff, thinking about admissions, transfers, attending meetings, recruitment.
Q. And how often in that role would you actually be in the wards.
A. I walk the wards every day. So I will be present on the wards to check in with the staff and also to speak with patients.
Q. And you report to an Associate Director; is that right?
A. That's correct.
Q. Are they also a nurse?
A. Yes.
Q. And above that, they report to a Director of Mental Health Urgent and Inpatient Services; is that right?

A. Yes.
Q. What's their clinical background?
A. They're a nurse as well. Mental health nurse.
Q. And to what extent, if at all, might you report or flag concerns above that level, so for example, directly to the Board? Would that ever happen?
A. Yeah, I have raised concerns, and also if members of the team are off on annual leave they'll have someone that's covering that may be above that banding so I would raise concerns.
Q. And was it easy for you to raise concerns if you wanted to?
A. Yes.
Q. I want to move on now, please, and ask you about the topic of assessments, please. And I'm going to start with what you say at 12 and 13 of your statement if you want to have that open in front of you.

You refer at paragraph 12 to when working on wards, admission decisions being communicated based on bed availability and you refer to the Bed Management Team.
A. *(The witness nodded)*.
Q. Who would the Bed Management Team be made up of?
A. So then, in terms of when it was NEPT or is it EPUT now, sorry, in terms of your question?
Q. I'll start with EPUT, please, if I can.

A. Yeah, so the Bed Management Team now consists of -- we have a Service Manager that manages flow, there's purposeful admission staff. We also have a consultant that's dedicated to flow, and then there's admin that work in the Bed Management Team, as well.
Q. Just pausing there, I think a Service Manager --
A. *(The witness nodded)*.
Q. -- are they a clinical role?
A. Yes.
Q. What would be their clinical background?
A. Registered Mental Health Nurse.
Q. And consultant, presumably you mean a Consultant Psychiatrist; is that right?
A. Yes.
Q. And then they're supported by an administrative team?
A. Yes.
Q. So that's at EPUT. Was it any different before to that, substantially, prior to EPUT?
A. Yes. So when in NEPT, they had staff that were of clinical background, sort of RMNs as well, but in SEPT it was more of an administrative role.
Q. In terms of that Bed Management Team, would they be able to overrule clinical decisions from the person who would assess someone?
A. No.

Q. So how did that interaction work?
A. So if somebody was assessed, so before being assessed, the Bed Management Team would be contacted to say that a person is due to have a Mental Health Act Assessment at this time, and then, once the Mental Health Act had happened, whatever the outcome of that assessment would be, then they would inform the Bed Management Team and a decision would be made of where that bed was available for them to be admitted to.
Q. So as I'm going to come on to, there were situations, weren't there, where somebody would be assessed as suitable --
A. Yes.
Q. -- but nevertheless there wouldn't be a bed available?
A. Yes.
Q. And so I'm going to come on and ask a bit more about that, but you're saying the availability would not influence the clinical decision as to whether they should be admitted, at least in theory?
A. Yes.
Q. And you refer at your paragraph 13, and as I've touched upon, and you say it there, that bed availability could impact admissions decisions?
A. *(The witness nodded)*.
Q. And you also refer, at 23, to over time a focus on

avoiding admission where safe to do so.

Can I just start by asking this: starting, really, with your period with EPUT, was there a shortage of beds, generally speaking?

A. Yes, and nationally there's been a shortage of mental health beds. And also I think our beds are discharge dependent, so when we declare our beds on our sitrep call that happens three times a day, those discharges are discharge dependent, so if they don't go ahead then that bed won't become available.

Q. Did that lead to pressure to discharge patients, in view of what you've just described?

A. No.

Q. Did it also lead to pressure at any stage not to admit patients?

A. No.

Q. In your experience, how frequently were there delays in admission solely based on bed shortages?

A. I think it would be very difficult for me to say an exact number but in my experience there has been delays in accessing beds in particular when we've sourced private beds, and by private providers. There's a referral process that you need to go through for that bed to be accessible, and that can delay that person accessing a bed. And then also having availability of

transport to be able to get that person there, which might not be local to Essex.

Q. Just trying to get a bit more of a feel for how much of a problem this is, is this something that is a problem daily, weekly, monthly? Can you help?

A. So I think obviously the demand of people needing to access beds is higher, and it is probably a daily conversation that we have around bed availability.

Q. What are the criteria -- when you've got a situation where there aren't enough beds, and there are more people than there are beds meeting the clinical criteria for admission, what criteria dictate whether someone is admitted?

A. So on the bed calls there would be a conversation around who requires a bed and that would be discussed, like I said, three times a day.

Q. Just pausing there, sorry, who would be discussing that?

A. So there's -- the way the bed call works now is that it's locality, so there would be a bed call for Mid and South Essex, a bed call for Northeast and then a bed call for Northwest and then at 12.30 as a Trust we come together to have a conversation around updates from that call and then there's one in the afternoon that is locality.

And then there's conversations that happen on those

calls around who's priority to access those beds, whether we need to seek approval for access to private beds, and to think about what we can do to mitigate the risk of people remaining in the community that may need a bed.

Q. But just again, in terms of the criteria that are being used, because obviously people have to make a decision, don't they --

A. Yeah.

Q. -- that some people are going to get admitted to a bed --

A. *(The witness nodded)*.

Q. -- others who may be assessed and need one, aren't?

A. *(The witness nodded)*.

Q. Are there a set of published criteria that are used or is that just based on discussions you have?

A. So the Trust would have a flow and capacity policy that would support our decisions that are made in discussions that happen during those bed calls.

Q. Is that a public document or not?

A. I don't know if that's public or not.

Q. Just moving on, then, to situations where a patient can't be admitted, and you've described, I think you mentioned alternatives. One of the alternatives might be the Home Treatment Team; is that right?

A. Yes.
Q. And would you accept that even with the Home Treatment Team, that there still remains a risk to the patient if they've been assessed as needing to be admitted but aren't?
A. Yes.
Q. And would it be right, then, that that creates a pressure, an additional pressure on the Home Treatment Team?
A. Yes.
Q. Were they always available as an alternative to admission?
A. In my experience, the Home Treatment Team have supported people that have needed admission in the community and have been available.
Q. And in your experience have they been resourced properly to do that in view of that demand?
A. From what I have experienced, yes.
Q. Can I ask this: what was the procedure if a patient or their nearest relative felt that they weren't safe in the community? So say they'd been assessed as clinically suitable for admission but there's no bed and concerns are raised. What would happen then?
A. So there would be a Crisis Management Plan put in place and advice sought. So it could be that they could go to

A&E for further support. I mean, now we've got the Basildon Urgent Care Unit and patients can go there as well. But there's other support in place if family need to contact.

Q. Would you agree A&E is perhaps not the most suitable place for someone?

A. Yes, I would agree.

Q. So less than ideal?

A. Yes.

Q. Just moving on, but still focusing on admissions, in your roles after 2018, so your management roles, Matron, Service Manager, what's your experience been of service outcome monitoring?

A. Sorry, can you repeat the question.

Q. So after 2018, in your management roles, what's your experience been of service outcome monitoring?

A. So from even before being a manager, we were informed around what our key performance indicators are and we've had clinical dashboards in place and we've had performance reports sent. So I was aware of the ins and outs of that before my management role but obviously more exposed when I became a Band 7 and then throughout my management career around what goes behind those KPIs as well, and what the outcomes are and, I guess, the why to why we do things.

Q. Just giving a specific example, there are situations where patients can't be admitted due to lack of bed availability?
A. *(The witness nodded)*.
Q. And so there's a delay --
A. *(The witness nodded)*.
Q. -- of some sort? How are the outcomes of that monitored at EPUT?
A. So they would be monitored via the Bed Management Team in terms of who's waiting for a bed and how many people have been admitted.
Q. What about -- so they'd monitor the numbers, presumably?
A. Yes.
Q. But what about the actual outcome on an individual basis? Would they collect information as to what the outcome was in respect of an individual patient who had, say, a delayed admission? Is that something that would --
THE CHAIR: I think he's talking about what actually is the effect of that on somebody's presentation and illness? What monitoring is done of how this affects the patient?
A. In terms of waiting for a bed?
THE CHAIR: And being in the community, patient care, what does that mean for patient care? Is that something that is ever assessed?

A. So obviously if the patient is supported by the Home Treatment Team then there would be ongoing assessments, and I know that when I worked under the Home Treatment Team that that would definitely be something that I would, as my practice, check in and making sure that that person is supported and make sure they're updated with where or if the bed is available. But I don't know --

THE CHAIR: Of any system-wide assessment?

A. Yeah.

THE CHAIR: Thank you.

MR COKE-SMYTH: So as I understand it, just to summarise, if I can, the numbers would be monitored in terms of --

A. Yeah --

Q. -- (overspeaking) --

A. -- I'm assured that -- I know that the numbers are monitored in terms of around who is waiting for beds.

Q. But the actual individual outcome in respect of an individual patient, as you understand it, is not something that's routinely monitored?

A. I'm not sure if it's routinely monitored.

Q. And just because I'm talking about situations where they can't be admitted where there's a delay.

A. *(The witness nodded)*.

Q. I want to move on and, please, ask you about another

aspect of admission, or assessment. And that's what you deal with at paragraph 16 of your statement, where you deal with assessment. And you say that family members and carers can be involved with consideration of confidentiality and consent.

And you explain in that paragraph how that works.

I just want to ask you a few more questions about the detail of that process.

Would you agree that even if a patient doesn't consent to information being shared with family members, that doesn't stop information being sought from them?

A. No.

Q. Does that routinely happen in practice?

A. Yes.

Q. And can I just ask, what's the process that ensures that that happens?

A. So obviously if the patient is being detained or having a Mental Health Act Assessment, then the next of kin would be contacted as part of that. But also, if they're going down the informal route, then the views and the wishes of the family would be taken on board, as well, and, like I said, in terms of being able to listen to families. If the person isn't consenting, it's very difficult to share, but we do listen to what their concerns are.

Q. You've used the word "listen to their concerns". Can I just be very clear. When they don't consent, do you positively seek information from the family?
A. Yes.
Q. And is there any form or part of the notes that prompt you to do that, or is that just common practice, as it were?
A. So as part of the inpatient process, as part of the admission, there would be information on the, like, ward review forms that would say patient or relative's wishes and views and as a part in the, like, the AMHP referral, the AMHP report, as well, that would capture that.
Q. And how confident are you that that's happening consistently across EPUT services? So situations where a patient may or may not consent, information being sought from the family on every occasion?
A. Well, I hope that that would be the practice. I don't think I could sit here and say hand on heart that a hundred per cent that's happening in all cases. Because I don't think that would be the right answer, because I can't give the assurance that every single case that is happening. I can give assurance that in my practice, I have done that.
Q. Is there any way in which you monitor that is happening in the staff that work for you?

A. So from an inpatient perspective, we would have those conversations as part of the MDT meeting, as part of the ward review, and that is something that I am very passionate about in terms of making sure we've got good engagement. So that's something that I would personally check for my areas that we have got that. And we've also got our Family Care Ambassadors that work on the wards as well that have regular contact with all of the patient's loved ones, whoever that may be.

Q. You also refer to family members being involved in care planning.

A. Yes.

Q. Can I just ask this: as a rough proportion, what proportion of patients, in your experience, tend to have family members involved in the care planning?

A. So for my areas, I would say, the majority of our patients currently have family involvement. I don't know the exact number. Obviously I cover quite a large number of wards, but I do know that we do have family involvement in our care plans, and even families that have drafted care plans that we've implemented.

THE CHAIR: You talked about the ambassadors. The ambassadors, will they help you to seek out information from families, or do they more engage in liaison, in terms of what's going on on the ward, and ... describe

it for me.

A. So the Family Ambassador role I think is very individual and unique to that particular family member on how they want that person to be engaged. So, for example, they could have regular text messages, phone calls, they can attend ward reviews. We have contact via email, we send them information. It's really around what that family member wants to have, in terms of the involvement.

THE CHAIR: So, in other words, the initiative comes from the family rather than the ward asking the ambassador to give -- get information about the patient?

A. So we will contact the family and introduce ourselves, sorry. And then we'll offer the support that's available and then it's either taken up or not.

THE CHAIR: Are you aware of Family Ambassadors proactively seeking information from families to inform there's care on the ward?

A. So I can hand on heart say that about my Family Ambassador, they are very proactive and they will engage and make regular contact. Obviously, I can't speak on behalf of the others but from what I've experienced, yes.

THE CHAIR: Thank you.

MR COKE-SMYTH: Just going back to the decision to admit, and in fact, sorry, before I do, you've told us about

you're very confident about information being sought from family members and you've described that happening now. What about historically? Has that always been the case or has that changed?

A. It hasn't always been the case. And I know that, as the service has evolved, it's one of the things that I've been very passionate around, having our thoughts around family first and having family engagement. But I know as a Trust that we haven't always done our best in terms of engaging with the family.

Q. And if you're able to help us as to when that change occurred, what do you say?

A. I don't think I could put a date or a time when it changed, because I don't think -- yeah, I can't give an exact date.

Q. Just in rough terms, we're obviously looking at EPUT after 2017.

A. Yeah.

Q. You've been a manager in some way, shape or form since 2018. Can you just give us a rough idea as to the year or the couple of years when you feel that started to change to what you've described now?

A. I would say in the past sort of three to four years.

Q. Before moving on to another area, in respect of decisions not to admit, if there was a decision not to

admit somebody, so they're assessed and they're not deemed to meet the criteria, would the patient's family or next of kin be consulted, in respect of that?

A. So in my experience, yes, that has happened.

Q. Does it always happen? Or again, is that something that has perhaps changed?

A. I would like to think that it has changed. Again, I don't think I could say a hundred per cent it has in all cases, because we're still learning. But I think that good practice would be that they would be contacted.

Q. So they should be contacted?

A. *(The witness nodded)*.

Q. But perhaps can't say that they always have been in the past; is that a fair summary?

A. Yes.

Q. And would their views be taken account of, in a decision to admit, or not?

A. In my experience, yes.

Q. I want to ask you about your experience of substance misuse. You deal with this at your paragraph 20. And you describe there substance misuse as having a significant impact when assessing someone.

A. *(The witness nodded)*.

Q. What would happen, I'm going to ask this in two parts

now and historically, but now, what would happen where someone presented, and because of some form of substance misuse, that precluded an assessment?

A. So we would wait until the patient had been declared medically fit for assessment and that would be joint led by if, for example, they were in A&E, we would have the emergency A&E department support with that, and then we would, as a liaison team go in and assess whether they are suitable for assessment.

But obviously out in the community, that would be a different assessment because you would need to risk assess the appropriateness of that assessment, and they may end up going down to A&E to be medically cleared if there was concerns around their physical health.

Q. So just sticking to A&E, does it follow, then, it wouldn't be right, for example, to say, "Sorry, you're under the influence of a substance, we can't assess you, we're going to send you home"?

A. So in my experience, if a patient have arrived, they will remain in the department until they're medically fit to be assessed.

Q. I think you're saying that's what should happen; is that right?

A. Yes.

Q. Would you accept in the past that hasn't always

happened?
A. Yes.
Q. Where a patient couldn't be assessed, and I think it's perhaps slightly easier if they're in A&E, it's a different situation, perhaps in the community, how would they be monitored, then, if, say, you can't assess them, they're under the influence, and you can't do the assessment? How would they be monitored following that?
A. Sorry, if they were in A&E?
Q. Not in A&E. So, for example, at home.
A. Yeah. So if they were at home and they were waiting to be assessed, then obviously depending on the support they had, so if they were under a community team, there would be community team support. Again, that could be Home First or with the local care co, and then, if needed to, you could contact the police for further support.
Q. Is there any sort of protocol or policy that deals with that sort of situation?
A. I think EPUT would have a policy regarding substance misuse.
Q. Are you aware of whether there is one or not?
A. I wouldn't be able to say yes a hundred per cent.
Q. You say, in terms of admission, and I'm just moving on to your paragraph 23, you say that over time, there was

a stronger focus on avoiding admission where safe to do so with greater utilisation of home treatment teams.

I think you've already told us that in your experience there was never a direction to reduce admissions by managers; is that right?

A. Yes.

Q. You've also told us about the Home Treatment Team but what about other Community Mental Health Teams or specialist teams in the community? Did they have enough resources to manage that change, in your experience?

A. So my experience would only be around the Home Treatment Team or when I worked in the community so I don't know whether I would be able to comment on whether they had the right resources or not, because I'm not sure.

Q. I want to move on now, please, to the part of your statement that deals with ward environment. And you set that out from your paragraph 25 onwards. You refer at paragraph 25 to ligature audits.

A. *(The witness nodded)*.

Q. And those are a tool for ensuring safety on the ward?

A. Yes.

Q. When were ligature audits introduced? Can you recall?

A. So when I was in SEPT, we had them in place there, which would have been from 2016. I'm unable to recall if they were in place in NEPT. And obviously then they carried

on in EPUT.

Q. You say carried on in EPUT, so obviously we can date EPUT as 2017.

A. *(The witness nodded)*.

Q. In 2017, were there ligature audits, or not at that point? Was it pre or post the merger?

A. So in SEPT we had them but in -- when I was working in NEPT obviously as a Band 5 I wouldn't have been involved in the ligature audits themselves. That would have been a Band 6 and above.

Q. Ligature audit is obviously quite an important part of managing safety on the ward.

A. *(The witness nodded)*.

Q. In your role as a Service Manager, how do you assure yourself that they're being done properly?

A. So my own assurance is that I will go and check them myself. I like to physically know what they look like. They're shared with us. So when the ligature audit takes place, we'll get a feedback from the Estates team, from the Risk team, and from the ward, but also we wouldn't wait for that audit to take place if there was an identified risk. But my own assurance is I physically go to the ward and check them myself.

Q. Is there any sort of system or structure that makes you do that as a Service Manager or is that just something

you do because you think it's important?
A. It's something that I have always done. Before I was a Service Manager, as a Matron, I would always go and visibly check for my own assurance and I would want to check. So we've got the ligature wallets, I would want to check that the items in there are correct as well. But yeah, it's for my own personal assurance.
Q. You also refer, at paragraph 25, to a practice developing over time, and improved recognition of neurodiversity in the context of the ward environment. What's your understanding of the requirements of autistic patients in general terms, in terms of the ward environment?
A. So obviously every patient that uses our services will have their own individual needs, and it's around ensuring that we can meet those needs. So it could be the lighting, for example. So before, the wards, we didn't -- we wasn't able to, like, dim the lighting it used to be constantly bright. We've now got sensory rooms that are available and also thinking about alarms on the ward, the alarms can be triggering for individuals. So making sure that if needed we've got ear defenders available to support with that, and having general awareness of what that person may need at those times as well.

Q. Are you familiar with Oliver McGowan training?
A. Yes.
Q. Have all staff on your wards had that training?
A. I would need to check the percentage of what -- how many staff have had them -- have completed the training, sorry. But yes, it is mandatory.
Q. And is that also routinely offered to bank and agency staff?
A. Yes.
Q. Moving on to therapeutic interventions. You refer to those at your paragraph 27, and you say that therapeutic value has changed over the years, and offer of therapeutic interventions has established with the development of the MDT.

Would you accept that historically there has been often an absence of therapeutic intervention --
A. Yes.
Q. -- on mental health wards?
A. Yes.
Q. To what extent today are patients encouraged to engage in therapeutic activities?
A. So on the wards -- and this is me speaking about the wards that I'm responsible for -- so we have a visual timetable, and also we have, like, whiteboards that will give a day-to-day of what activities are available, and

they will consist of OT staff, psychology. Also we've got our peer support workers that will come and do therapy groups, and also that can be offered on a one-to-one basis but also in a group, and it's very much led by patient choice.

So there's lots of different options, whereas previously it might just be there's the only group that's on that day and I think, as well, it's now a seven-day offer, whereas before, the therapeutic offer would be traditionally offered Monday to Friday but it's offered throughout.

Q. How often on a daily basis? Are we talking about one activity a day? More than one? What is there?

A. So there's activities in the morning, in the afternoon, and the evening. It's throughout. And often, like I said, we've also got staff available to offer one-to-one, as well, so if they need an intervention at that time, that can be offered. They don't have to wait for the set time for the group.

Q. And is there any way in which that's embedded, in terms of nurses or HCAs actually having to engage in that work?

A. So the therapeutic offer is by a separate team. So, like I said, in terms of it's made up with the OTs and the psychology and the peer support workers. So that's

separate to what the nurses then offer on top of that.
Q. So just focusing on nurses and healthcare assistants, do they all provide daily therapeutic engagement with patients?
A. Yeah, so they will offer patients one-to-one sessions, as well. That's part of their role for their allocation for the day.
Q. Is that aspiration or is that reality?
A. I think at times it's reality and at times it's aspirational, depending on the clinical presentation on the ward and other issues that may be occurring on the ward because the ward environment can be very variable at times.
THE CHAIR: Does the same apply to the set activities? You're talking at the moment about the one-to-one offer.
A. Yes.
THE CHAIR: But the set activities, morning, afternoon and evening. Are they sometimes not possible because of pressures on time, and staffing?
A. I think obviously there's things that we're not in control of. So unexpected sickness. But the team work across, so I'm really fortunate that they work across Linden Centre and Crystal Centre. So they will work together and look at what can be offered. So there's still a therapeutic offer on that day.

MR COKE-SMYTH: Another thing you refer to is psychological support. What are the psychological resources available in the units that you have managed? Has that always been available, in your experience?

A. So I think throughout my career there's always been vacancies within all teams across, but we're really fortunate to have all of our wards supported by psychology as we speak now.

Q. How far do vacancies still remain an issue, though, in terms of delivering that?

A. In terms of psychology, I wouldn't be able to comment on what their vacancies are. But obviously, if there were a shortage, then myself and the psychology lead would meet and we would have a conversation of what the therapeutic offer looks like and how we can support one another.

Q. You say in respect of the ward environment -- I'm looking at your paragraph 28 -- that ward environments contributed to recovery by providing structure and routine, and supporting engagement in therapeutic activities.

Would you agree that EPUT ward environments weren't always conducive to recovery?

A. Yes.

Q. So to just give an example, there have been dormitory

arrangements in some?
A. Yes.
Q. And would you accept that's not an ideal environment for inpatients?
A. Yeah.
Q. We've also heard evidence or received evidence, I should say, describing fixtures and fittings at Basildon Mental Health Unit as "dated". We've also heard evidence describing it as an "austere environment". Is that something you would recognise?
A. Yes.
Q. We also know that wards can be quite loud environments.
A. *(The witness nodded)*.
Q. Would you accept that can be particularly detrimental for neurodiverse patients?
A. Yes.
Q. I want to move on to the part of your statement that deals with treatment, please. Looking at your paragraph 36, you reference there:

"... risk management strategies including consideration of observation levels, de-escalation and behavioural strategies including care plans and Positive Behavioural Support Plans ..."

Just pausing there, what are positive behavioural support plans?

A. So they are individual to patients and they are sometimes a visual plan that's up on the patient's bedroom, and it will give examples of: if I'm feeling a particular way, please engage with me via X, Y and Z. So, for an example, I've nursed a patient who if they're feeling quite low they may put their hood up and that will be a sign that they actually need to have some engagement at that time. They might not be able to verbally say that but that will be a sign for us to know that that's how we need to engage. Or if a patient is particularly distressed, it might be that they've got a particular sour sweet that they need that we'll keep in a box for them that will provide support during that period for them.

So it's really individual to the person and it tries to focus on what positive interventions that we can do to help that person.

Q. Another document you refer to is the care plan.

A. Yes.

Q. And that's quite an important document in patient care; is that right?

A. Yes.

Q. And it's right to say that things like care plans in particular need to be up to date?

A. Yes.

Q. And you acknowledge I think in your statement that recordkeeping isn't always ideal --

A. Yes.

Q. -- it's fair to say. What processes do you have in place to mitigate the risks of poor, particularly poor care plans?

A. So the ward managers would meet with the qualified staff and as part of the supervision they would go through their individual allocations of the patients on the ward, and part of that is to review the records. So we would pull up the care plan and review that and look at the standard of that care plan.

We also have record keeping audits as well, but again, as my practice, I like to physically check care plans, as well. The Matrons also will check records, so there's lots of levels of assurance when thinking about what a good care plan should look like and the standard that we expect.

Q. Would it be right to say that accurate and complete care plans remains a challenge?

A. Yes.

Q. Turning, then, to some of the potential barriers to effectively treating patients, you deal with that from your paragraph 39. You say there were several barriers, and you deal there in particular to treating patients

with substance misuse issues.

I think you've already said that someone being under the influence of a substance isn't a reason to refuse them treatment or turn them away.

A. *(The witness nodded)*.

Q. So I'm not going to ask you about that but can I ask you this: how did you, and EPUT more widely, guard against substance misuse being treated as a barrier to mental health care? How did you stop that happening?

A. I don't think that we have stopped it from happening. I think that there's measures that we can put in place to prevent illicit substances potentially coming on the wards, but I think in my statement I'm referring to, you know, if a patient has been granted leave and has chosen to take illicit substances, then returning back to the ward can be the -- obviously they're unpredictable. How we may manage them through that at that time may be different to how we may have previously nursed that person.

Q. Did you observe or have you experienced individuals with substance misuse issues -- I'm not talking about assessment now, I'm talking about actual access to services -- being turned away from services, mental health services, because of an addiction? Is that something you have experienced?

A. Not in my experience.
Q. Is that something that happens?
A. I would like to think that it doesn't happen. I would be extremely upset if patients had been turned away that were asking for help. So I would hope that that doesn't happen.
Q. I'm going to move on now to a new topic. I'm conscious I think we've been going for about an hour so we're going to have a -- a bit less, we're going to have another 20 minutes until a break.
A. Okay.
Q. And I'm going to move on to transfer. And can I ask you, please, to turn to your paragraph 53. And you say there, last sentence:

"In my experience in the past, decisions have been made to transfer a patient without involving professionals within that person's care."

And I just want to understand a bit more fully what you mean by that.

Are you talking about a decision to transfer somebody without input from a clinician?
A. So in my sentence I'm talking about a patient that may be transferred between wards where, like, the community team have not been informed that that person may have moved. So, often, before we move to the locality model

we may have patients that may be living in the Chelmsford area but potentially nursed in Harlow, so there would be transfers that would happen but not all the key members of that person's care and treatment would have been informed of that happening until maybe they'd arrived at the receiving ward, and then been informed that they may be invited to a different ward review for example.

Q. So you're talking about an internal transfer?

A. Yes.

Q. Who would be the person making that decision?

A. So the decision could be made from the ward, it could be made by the RC or it could have been made by the Bed Management Team at that time. But that was my experience of people being moved and not key people being informed.

Q. So RC being the Responsible Clinician?

A. Yes, sorry.

Q. Bed Management Team with a nurse and a consultant?

A. Yes.

Q. So you're talking about a decision made by clinicians --

A. Yes.

Q. -- but not necessarily all of the relevant clinicians involved in a patient's care; is that right?

A. Yeah, and also that's been my experience, as well, when

patients have maybe transferred in to private hospitals that those relevant people haven't been informed of those decisions.

Q. And to what extent would things like nighttime transfers be avoided, or not?

A. So nighttime transfers have happened. It's something that I feel very strongly about that shouldn't be happening. You know, in my experience people have been woken up at 2, 3 o'clock in the morning to be moved, and for me, would I like that experience? Absolutely not. So why should we be offering that to anybody else? And I think that now the way the Bed Management Team, in terms of, if you like, the Flow and Capacity Team, and how we're managing our own internal transfers, that has improved, but sometimes it's not avoidable to transfer people in the middle of the night.

Q. Would family members, you've talked about members of the patient's treating team --

A. Yes.

Q. -- would family members always be involved or consulted in a decision to transfer?

A. Not always, no.

Q. Is that something that they should be involved with?

A. Yes.

Q. And so what can be done to change that?

A. So I think in the past, decisions have been made and people haven't been -- and I mean by "people" family members or loved ones haven't been informed. Now in my -- the way that I practise, I do ensure that we do communicate with the family to have that conversation before the transfer happens.
Q. You say at paragraph 54 that continuity of care was a key priority during patient transfers and was maintained through a number of structured processes. Do you see that?
A. Yes.
Q. Would you accept that that wasn't always successfully maintained?
A. Yes.
Q. And would you accept there are some fairly serious examples of that going wrong --
A. Yes.
Q. -- in EPUT?
A. *(The witness nodded)*.
Q. One example which I believe you're familiar with because you refer to this case in your statement, is that of Bethany Lilley?
A. Yes.
Q. And would you accept that that's one of those examples?
A. Yes.

Q. You say at your paragraph 58, in relation to the Basildon Mental Health Unit and the opening of the Thorpe Ward in 2018 and '19 that there were instances where patients arrived to the ward without prior notification or sufficient information relating to their transfer or admission?
A. Yes.
Q. So just to be clear, the right thing, what ought to happen is everybody ought to know about the patient.
A. Yes.
Q. They ought to know enough about their history.
A. *(The witness nodded)*.
Q. And they ought to be in a position to manage risk as a result.
A. Yes.
Q. And would you accept, then, that if they don't have the relevant information, that can create a very serious risk of harm?
A. Yes.
Q. And would you accept that the case of Bethany Lilley represented an example of that?
A. Yes.
Q. Just going back slightly, if I can, to the question of families in -- and their involvement. You say families and significant others were routinely informed of

transfers, but again, would you accept that didn't always happen?

A. Yes.

Q. And you accept it should always happen?

A. Yes.

Q. You touch on, at paragraph 56, issues of transfers from children's or young persons' to adult mental health services, are you aware of difficulties in securing specialised placements for those turning 18, so, for example, where they have autism or learning disabilities? Is that something that's an issue?

A. Yes.

Q. How are those cases managed?

A. So in terms of them needing specialist admission, that would be managed outside of the adult Bed Management Team. So if that was identified as part of their transition into adult services, that wouldn't be necessarily something that I would be involved in because that would need a different route in terms of accessing that bed. So if it was identified that someone who was turning 18 needed an adult acute bed or access to one of the PICU beds then that's something that I would then be contacted and involved in. But in terms of the specialist, that wouldn't fall under my remit.

Q. Is it right, then, that's something that's still an issue and a challenge?
A. I think nationally that's an issue and a challenge.
Q. You then also set out at paragraph 56 that following the death of Morgan-Rose Hart, Band 6 nurses on the acute adult wards receive specialist training for CAMHS transition.
A. Yes.
Q. And you say that happened in January 2024. Do you know what proportion of nurses completed that training?
A. So I know that the areas that I was responsible for, my Band 6s attended. I don't know how many, Trust-wide, would have attended that training.
Q. And it was completed in January 2024. Do you know if there's been refresher training since then for people who have joined after that date?
A. So in terms of -- I know this training was offered by an external company, but in terms of offering the transition training, that's something that has happened more in house rather than through an external company.
Q. So sorry, has there been a refresher since, or not?
A. Not from this company that was used.
Q. And what about internally? Has there been further training on this?
A. So internally, there's not a mandatory training for

this.

Q. And I think you say in your statement that you yourself haven't actually done that training. Is there a reason for that?

A. Just because at the time it was offered to the Band 6s across the acute wards, so I wasn't given the opportunity to do it. However, if I had have been, I would have taken it up.

Q. Would it probably assist you in your role as a Service Manager understanding the issue at a managerial level?

A. Yeah, because I'd be able to inform the staff what the expectations are of what that transition should look like and, I guess, as well, making sure that our patients have a positive transition from children's services to adult, as well, so it would be able to help.

Q. You state at your paragraph 57 that there are now more robust systems to ensure patients are informed of where they're being transferred to?

A. Yes.

Q. This is the patient, as opposed to the information being passed around them. But again, would you accept previously that has been an issue, of patients not being adequately informed of what's going on?

A. Yes.

Q. And you state that the systems for sharing clinical

information with treating Trusts has improved. Can you explain how?

A. So in terms of the process, so we would make -- if it's an internal transfer, there is a verbal handover, there's information that's sent. We do have a transfer handover that the team needs to follow to make sure that they've included all the information that's needed, and also having oversight on who's going where at the bed calls, as well. So thinking about who needs to be involved, who needs to be contacted, is there conversations that need to happen before the patient arrives as well, to make sure that that continuity of care happens.

It could be, for example, the patient has got section 17 leave and that needs to continue so the consultant needs to be contacted to make sure that they can still be granted leave, if they've got medical appointments and things like that. So trying to prevent any barriers once they arrive.

Q. Just coming back slightly, if I can, now to Bethany Lilley in 2018 and 2019. You deal at paragraph 58 with the time of the opening of the Thorpe Ward and you refer to identifying and raising concerns about the admissions process there.

A. Yes.

Q. Who -- I don't need a name but who, in terms of role, did you raise those concerns to?
A. So I raised that to my line manager, who also would have been Matron at the time. So that would have been my Service Manager. And I also raised it to the Bed Management Team who would have been in NEPT at that time, as well, around making sure that we have notification of who's coming.
Q. We know that Bethany Lilley died on 16 January 2019. Was it before or after that that you raised those concerns?
A. So I'd raised them before and obviously raised them after as well.
Q. So before --
A. Yes.
Q. -- before her death. What response did you receive?
A. So from my line manager they were very supportive and understood the concerns. It wasn't just me at the time that was raising the concerns; the consultant and the Ward Manager as well. So we were looking at what processes we could put in to make sure that transfers were safe, and also thinking about patient experience and trying to make that very positive for people that were arriving, because what I was worried about was that people were arriving at our door and us not having

notification may not give the greatest first impression of that person coming to our ward.

And also when I spoke to the NEPT Bed Management Team, they were understanding of the concerns that I had raised.

Q. Having raised those concerns, was any action taken prior to Bethany Lilley's death, do you know?

A. Not that I can recall.

Q. And do you know why that was?

A. No.

Q. Would you accept that that sort of issue is an urgent issue?

A. Yes.

Q. So does it follow perhaps there could have been a slightly quicker reaction on EPUT's behalf --

A. Yes.

Q. -- to those concerns?

A. *(The witness nodded)*.

Q. You're familiar, I understand, with the RCA report?

A. *(The witness nodded)*.

Q. Root cause analysis report.

A. *(The witness nodded)*.

Q. The internal report produced by the Trust following Bethany Lilley's death. To what extent do you feel the recommendations of that report reflected the concerns

that you identified?
A. I think it reflected all of my concerns.
Q. Did you play any part in the inquest into Bethany Lilley's death?
A. No, so I was on maternity leave at the time of the inquest.
Q. And as Service Manager more broadly, if there's a death of a patient on one of the units you're responsible for, what would your role be at an inquest?
A. So my role would be obviously supporting the wellbeing of the staff that are attending, but also it could be that I am potentially giving evidence or thinking about -- what I had previously done is around giving learning evidence and being a PFD witness as well.
Q. So that's -- so you'd be aware of, presumably, and have some involvement in inquest involving the death of a patient on one of the units you're responsible for?
A. Yes.
Q. What about deaths on other units that you weren't responsible for? What, if any, involvement might you have in those?
A. So if any incident occurs that results in a death, I would personally reach out to that team and offer support, and then any learning that comes from that incident is shared, and then learning from the inquest

following whatever recommendations that they may make. That's also shared as well. So that could be shared at our Inpatient Quality and Safety Meeting. Also, we have our Accountable Framework Meeting, as well, where lessons learnt are shared, but it wouldn't -- if there was identified lessons, it wouldn't have to wait until the inquest for that to be shared.

Q. So in theory at least, am I right that you ought to be aware of any patient who dies on an EPUT mental health unit --

A. *(The witness nodded)*.

Q. -- who has an inquest?

A. Yes.

Q. And in theory at least, you ought to be aware of any learning which arises from it?

A. Yes.

Q. And does the same thing apply to internal reports, things like SIs and RCAs involving other units?

A. So there would be, like, a summary of that report shared. I wouldn't necessarily be given the whole -- the whole report to read, but that would -- again, those reports may be shared at meetings.

Q. I think this is the last question before we break. Or last bit I want to deal with. So thank you for bearing with me.

You then deal in your statement, going back to the Bethany Lilley case, which you have knowledge of and you've talked about, you set out the recommendations from the RCA. Do you know by what date those recommendations have been implemented?

A. No.

Q. And just looking at those, I'm not going to read through them but it's perhaps worth just having a read through, just reminding yourself of those. Would you agree that, in fact, if we look at those recommendations, that they actually would have reflected reasonable practice, even in January 2019?

A. Yes.

Q. Just final question on this paragraph, at point (k) there's reference to training and use of the patient record system, not used in their locality. So there's two systems, Paris and Mobius?

A. Yes.

Q. Then it says, "All staff should be familiar with HIE." What does that stand for?

A. I don't think I'm going to get it right. But I want to say it's the Health Information Exchange.

Q. Just tell us --

A. I am not one hundred per cent sure on that.

Q. -- what is that?

A. So HIE was a system that was developed, so it could access both Mobius and Paris documents on there that staff would have a log-in for, and that would bring up relevant documents.
Q. Now you refer there to particularly consultants --
A. Yes.
Q. -- having access to that. What about the other end of the scale, healthcare assistants? Would they have access to that?
A. I can't recall whether they had access. The qualified staff had access to HIE. I'm not sure whether the support workers or healthcare assistants would have.
Q. And is that the case now, as well as at the time of this report?
A. Yes.
MR COKE-SMYTH: Thank you very much, that's all I have for the moment. I think we're going to take, if we can, Chair, a short break?
THE CHAIR: Fifteen minutes.
Fifteen minutes, thank you.
MR COKE-SMYTH: Thank you.
(3.33 pm)
(A short break)
(3.53 pm)
THE CHAIR: Mr Coke-Smyth.

MR COKE-SMYTH: Thank you, Chair.

I'm going to move now on to leave, absconsion, and AWOL. You deal with this in paragraph 64 of your statement. And you say there that all patients are risk assessed prior to leave taking place by the nursing team.

Would it be more accurate to say all patients "should be" risk assessed?

A. Yes.

Q. Because, in reality, that doesn't always happen, does it?

A. Yes.

Q. And in fairness, you do say at your paragraph 69, in your experience the process of patients being risk assessed and signed out for leave hasn't always been appropriate.

A. Yes.

Q. And can I just ask you this: what is the challenge in ensuring that happens? What is it that prevents that from happening as it should, in your experience?

A. I think it's very difficult to pinpoint it to one thing. Each time it's happened, it's been for individual reasons. It could be that the staff thought that they had been risk assessed by somebody else and that hasn't been effectively communicated, or potentially they've

just been let out and again, there's not been great communication within the team.

Sometimes the feedback I've had is that staff have not had the time to do it or they felt under pressure for the patient to leave if they're late for maybe an appointment that they've been waiting for. But it's varied across, when I've looked at those incidents, it's not taken place.

Q. Is it, in your view, a cultural issue or a systemic issue?

A. I think, in my view, it could be a bit of both, to be honest.

Q. You've set out at paragraphs 72 and 73 measures post-incident where a patient has gone AWOL or they've absconded. Would you accept that --

THE CHAIR: Absent without leave.

MR COKE-SMYTH: Forgive me. Thank you, Chair.

THE CHAIR: You only need to say it once, but I think --

MR COKE-SMYTH: Yes. Absent without leave.

You describe reviews and safety measures and risk management after each of those incidents. Would you accept that, despite that happening, this is still a problem? It still happens, doesn't it?

A. Yes.

Q. And again, you refer in your statement to AWOL incidents

always involving appropriate liaison with the police, but again, would you accept that's the aspiration but not always the reality?

A. Yes.

Q. And again, is that also the case with incidents being promptly reported by the nursing team? It should happen, but again it doesn't always happen, does it?

A. Yes.

Q. And do you recall in your role as a Service Manager receiving the PFD in January 2023 for in the case of Jayden Booroff?

A. Yes.

Q. And it's right that it identifies -- so it's PFD, Prevention of Future Deaths, it's a report from the coroner following the inquest that they write?

A. Yes.

Q. And you recall that, identifying that there was a lack of understanding by EPUT staff about the difference between a detained person absconding from a ward and a person going AWOL?

A. Yes.

Q. And it also raised a concern about how that information was communicated to emergency services?

A. Yes.

Q. So you received that information. So looking at all

that together, do you accept it's an area for improvement?

A. Yes.

Q. I want to ask now about safeguarding, and that aspect of your statement. At paragraph 76, you give an example where you talk about an inappropriate relationship between a staff member and a patient?

A. Yes.

Q. You talk about the Trust response to that, and the Trust investigation. Was that matter reported to the police?

A. Yes.

Q. And would that happen as a matter of course?

A. Yes.

Q. Is that dealt with by a policy or is that something that happened as a result of your judgement?

A. No. So any incident that involves that sort of nature of safeguarding, we would contact the police. And then I did that myself for that incident.

Q. And what was -- why was it reported to the police? What was it that triggered that report?

A. The person who was involved wanted to report it to the police themselves as well due to the nature of the safeguarding, and I was concerned about their level of distress while doing that and had offered to do it on their behalf, and they sat there and we did it together.

Q. What happens in a situation where the patient doesn't want to make a complaint to police, but they may be -- they may not be qualified to consent to any relationship? What happens there?
A. Then we can report that on their behalf.
Q. Would you report that on their behalf?
A. Yes, and I have.
Q. To the police?
A. Yes.
Q. And on this occasion was the member of staff that you referred to there reported to the NMC?
A. No, this member of staff wasn't a qualified member of staff.
Q. But they -- they weren't a nurse?
A. Sorry.
Q. So they weren't a nurse?
A. No, they weren't a nurse.
Q. So not registered, not governed by a professional regulatory body?
A. Yes.
Q. Had they been, would they have been reported?
A. Yes. And I have done that.
Q. Was there referral to DBS?
A. I would need to check that with HR. That's not something that I would do within my role.

Q. You also say, at your paragraph 143 --
A. Sorry, did you say one --
Q. 143, that sometimes -- you may not need to look at it, it's just that you refer to some patients reporting sexual safety concerns.
A. Yes.
Q. So I think that's something that you say happens. Can you just help us, how frequently does that occur?
A. So in my experience, obviously I do have knowledge of it happening. I don't know whether I would be able to say an exact number of how many times that has happened. I don't know if that would be best answered by someone from the Safeguarding Team.
THE CHAIR: Can you just give us an idea? I mean, you know, five times, ten times, 100 times, in your experience?
A. So in my experience I would say it's under ten, but obviously not a hundred per cent sure on the numbers.
MR COKE-SMYTH: Is that your time post-2018 as a manager and above?
A. Yes.
Q. Or is that Matron and above, or Ward Manager and above, I should say?
A. Yes.
Q. Moving on then, please, to clinical records. I've asked some questions about care plans but I want to ask some

more questions about records more broadly.

You talk at your paragraph 85 about the Mobius system and you say that:

"Where concerns regarding electronic record systems have been raised, for example temporary staff not having a log-in to the system, support was provided by providing guest log-ins for staff so that they could access clinical records and minimise interruption to patient care."

Just pausing there, presumably, for the wards to run safely, everybody working in them needs to be able to have access to the records.

A. Yes.

Q. So would you agree that would include not just nurses but HCAs?

A. Yes.

Q. And that would need to be permanent and temporary staff?

A. Yes.

Q. In terms of HCAs, would they routinely have access to clinical records?

A. Yes.

Q. How would that work?

A. So everyone has their own personal log-in to the clinical record system and then they would be able to search the patient that had been admitted on the ward

and be able to access the notes. Also their -- our HCA support workers on the ward would be responsible for writing clinical records, as well, so they would need access to be able to put their entries in.

Q. What about if they're just temporary?

A. Yes, they have access as well. So our flexible workers, so in terms of our bank staff, they will have access for that, as well, and we will check that their access is up to date as part of them being on the ward.

Q. So just summarising then, today you're confident that all staff on the ward from temporary HCAs all the way up to Ward Managers will all have access to clinical records?

A. Yes.

Q. Is it right that hasn't always been the case?

A. Yes.

Q. And is it right that previously there's been a situation where HCAs haven't had access?

A. Yes.

Q. And particularly temporary HCAs?

A. Yes.

Q. Do you know when that changed?

A. I don't think I could say an exact date. However, I know that from when I've been in post, that I've made sure that that is something that all of our new starters

have. So a part of their induction is that we would set them up with access to the clinical records and make sure they've had their training to use the clinical records so that they're confident before having to write entries.

Q. Would you acknowledge that historically that has been a problem?

A. Yes.

Q. That lack of access?

A. Yes.

Q. And it has created risk?

A. Yes, it has, yeah.

Q. You've acknowledged, in your statement, I think, shortcomings, issues with recordkeeping. I just want to drill down, if I can, into the reasons for that. What typically is the most common reason for shortcomings in recordkeeping in your experience as a manager?

A. So I think, in my experience as a manager, having been on a ward and done care plans myself, and that's one of the things that I made sure that I did from when I was a Ward Manager, was around, you know, having that protected time to sit down with the patient and make sure that the patient had involvement in their care plan and then keeping that up to date.

So some of the issues have been when named nurses

have been on leave, for example, and then not arranged adequate cover, to make sure that those documents are updated in the timeframe set.

When we've had vacancies across the wards in inpatient in particular, you can see that that does have a knock-on effect on the clinical records being updated in a timely manner. And then I guess, as well, thinking about clinical demand at the time.

Q. What about things like copying and pasting?

A. Yeah, so I have witnessed copy and pasting and I've seen that in care plans.

Q. And what would be the response to that, from management at EPUT to, to a copy-and-pasted care plan? How would that be dealt with with the staff member?

A. So my expectations would be that the Ward Manager would have a conversation with that person around the appropriateness of that and the expectations of how we expect our care plans to be. My expectations of care planning is extremely high, in that should not happen. It does happen. And then if that continues to happen, then we can think about what other supportive measures we need to put in place for that person, whether it's additional bespoke training, whether we need to think about their current caseload on the ward or what can we do differently to help that person. And again, it's

very individualised to the staff that have taken that place.

I've also -- I've written directly to staff and done management advice letters when I've done *ad hoc* audits to say: look, this is what I've found, this is not my expectations. And I've also had conversations with HR around recordkeeping and the standard that we expect.

Q. I'm just being reminded that we need to slow down slightly for the --

A. Sorry.

Q. -- for the note to be taken?

A. Yeah.

Q. So I'll try and remind you and I'll pause you if you're going too fast.

An important principle of clinical records is that they obviously should be accurate.

A. Yes.

Q. And they should normally be taken at the time?

A. Mm-hm.

Q. As a practice, are clinical records by ward staff, in your experience, always made contemporaneously?

A. No.

Q. And it's right, isn't it, that if they're not made contemporaneously, that the right thing that you should do as a clinician is make that clear?

A. Yes.
Q. Because if you don't, somebody looking at it is going to assume it's made at the time?
A. Yes.
Q. And would you agree that can be very serious if you're talking about something like an observation, for example?
A. Yes.
Q. And would you accept that's been a significant problem at EPUT?
A. Yes.
Q. What assurances can you give, going forward, that staff are going to keep contemporaneous records?
A. So obviously we've got our audits that are in place that will review that, but I think also it's really important that if we're not doing that, that the staff feel empowered to be transparent about that and let us know and we can address that. Because what I don't want to encourage is for that to happen and people not feel empowered to speak up. And for us to hold our hands up and say yes, we have got it wrong but this is how we're going to rectify it and these are the things that we need to put in place.
Q. Do you think there might be some aspect of a fear culture amongst staff?

A. I think so. But I feel like that's something that we have -- I say "we "-- we've worked really hard to shift. It's not something that you can shift overnight, change in culture, but I think it's something that we're working towards, and I know that in my experience and in my current role that I have had people that have been extremely transparent and honest and held their hands up, and we have had those conversations. So I do feel assured that it is moving in the right direction.

THE CHAIR: But it's still an ongoing issue?

A. Absolutely.

MR COKE-SMYTH: Just moving on to a slightly related matter in respect of records, but I did ask you about care plans --

A. Yes.

Q. -- earlier. And would you accept that often initial care plans can be brief and generic?

A. Yes.

Q. And not tailored to an individual patient?

A. Yes.

Q. You then deal with risk management plans and observations at paragraph 94 to 98.

Of your statement. And you say:

"... in my experience, once agreed, risk management plans and observation levels are consistently

implemented and adhered to."

Again, would it be fair to say that that's the expectation, perhaps more than necessarily the reality?

A. Yes.

Q. And again, in fairness to you, you do say at 98 that:

"... there are instances where the unpredictability of the inpatient setting presents challenges that cannot always be anticipated or fully mitigated."

And you say:

"... efforts are ... made to maintain patient safety and meet observation requirements ..."

Also in respect of observations, one purpose of observations is obviously for patient safety.

A. Yes.

Q. But is it right that there is also potentially a therapeutic engagement aspect?

A. Yes.

Q. And that's also an important part of observations?

A. Yes.

Q. So you'd agree it's not a case of just ticking a box on a form; you'd expect the person to engage with the patient?

A. Yes.

Q. Again, would you accept that historically that hasn't been something that's always been done well?

A. Yes, and when I have seen that, I have challenged that, because one of my passions is around engagement, and my teams will know that I will question, if they are sitting, they're not engaging, because again, I can't imagine how I would feel if someone was just sitting there not having anything to say. So it's something that I do champion across the wards that it's really important that we continue to engage with our patients.

Q. So other than you as a manager or Service Manager saying that, what are the systems in place that makes that happen?

A. So the Ward Managers will do walk around checks. Obviously the most important person we get feedback from is the patient. So we will often ask them what has their engagement been like? "What have you done?", on this person's observations, and then, if it's not up to the standards that we would expect, obviously we'll speak to those individuals as well, but I think there's not an audit tool that can measure the level of engagement. I think it's the person's voice that would say the most who's having that person on their obs.

Q. And in terms of making sure it's happening, is part of the problem staffing? Is it due to the staffing mix? Is that something you find harder with temporary staff as opposed to permanent staff? Where are you finding

the problem?

A. So I think it's around staff confidence and understanding of what observations is. So I think it's really important that we explain the why we're doing something and the rationale behind that for people to really understand what it is we're asking of them, and the expectation is set.

So for me, it would be, you know, having a conversation with that patient and asking them what is it they'd like to achieve for the day? "Is it that, you know, you would like your shower at 10 o'clock?" We can make sure if it's a female or a male, "Who would you like on your obs at those times?"

But I think sometimes it's making sure your staff are confident with those skills and they're skilled accurately. So, like for us, we've got engagement boxes on the ward where you can just grab them, and it's got like games, colouring books, puzzles, things like that, so it can start those conversations off, which again I think is really important. But also, the staff go through observation and engagement training as well, and we also have support from our psychology team that offer training around engaging with patients, as well.

So it's in-person because I think there's real value to having people in the room and listening and

understanding, and I've also done away-days. I've done what bad engagement looks like and we've given examples of that, and then showing what good engagement looks like as well, because I know that not everyone learns like me and I'm a very visual learner, so sometimes that can help in terms of what the expectations are of what we want to happen on our observations.

Q. One of the things that can impact observations is staffing levels?

A. Yes.

Q. You obviously need enough staff to be able to conduct a certain level of observations; is that right?

A. Yes.

Q. It's also right that you are often faced with staffing pressures?

A. And so I think obviously we've got our baseline, which is rostered for across all the wards, but there's things that are out of our control that we can't predict. Like, when I've mentioned earlier about unexpected sickness, those things will have an impact on the ward, but I think since us working within the MDT model and having support from our AHP colleagues, we can look at what those shortfalls are and it doesn't always have to rely on the nursing team to provide support with those, those patients.

Q. So just help me. Where you, for example, don't have enough nurses because of sickness, or say you don't have enough HCAs because of sickness, how is the risk mitigated in respect of observations?
A. So our Ward Managers are supernumerary, so they're not in the numbers, and they can step into the numbers. I will do that, as well. And also, the Matrons will do that. And we will look across, as well, like I've said, I'm really fortunate to have two sites that work collaboratively together. So even though one ward might be short, it could be that one of our wards is overstaffed due to maybe observations being reduced, and we can move staff around to mitigate those risks.
Q. So can I just understand this, how much are -- the potential failings or issues to do with observations not being carried out properly, how much is that to do with staffing and how much is it to do with culture, as it were? So where observations are not being done properly, what is the main cause of that? Is it staffing? Is it culture? Is it something else?
A. I would say it's potentially a mix between the two, of staffing and of culture.
Q. I want to move on and ask about the part of your statement that deals with engagement. You deal with that at paragraph 120 onwards.

Now, before I deal with that, I just want to come back to an aspect of your evidence earlier, and you told us that family engagement has increased in the last three to four years. Can I just ask you this: what do you attribute that change, that improvement, in family engagement to?

A. I feel that's to do with lessons learnt from where we've not got it right. I also think, again it's one of my passions, that I want to make sure that the families feel heard. It's also around us dealing and looking at lessons learned around complaints, as well. And how can we make sure that that's embedded and I think, you know, having at the forefront of our minds around thinking around family first and, like I said, the work that we've done around shifting that culture and thinking differently, and how would we like to be nursed if we were in the service, as well.

Q. Has there been any particular policy or driver from the Senior Management above you in respect of family engagement?

A. So we do talk about family-first focus and that has come from the directors and I think, as well, when you're thinking about Trust-wide lessons learnt, that is also being driven down by the seniors.

Q. And has there been any -- you've described the change,

has there been any actual change in the system or the structure to embed family engagement in the last three or four years?

A. I think obviously following the Family Care Ambassadors, that had changed the structure because obviously we have dedicated people in those roles now, but before that, I don't think I could say a hundred per cent it had been dedicated.

Q. What about in terms of the record, so, for example, I was asking you before about the assessment and presumably there's some sort of form or record that people have to go through when they carry out an assessment. Has there been any change to that to prompt family engagement that you're aware of?

A. So from an inpatient point of view, as mentioned before, the ward review form does have that section in it, and that needs to be completed before that form can be signed off.

Q. And just so we understand, the Family Ambassador role, it's right, isn't it, that's in fact as of January 2025?

A. Yes.

Q. So relatively recent?

A. Yes.

Q. Thank you. Just going back to your statement, please. You refer to the serious incident prompting this review

or change of approach. Can you just tell us what sort of issues arose that caused you to revisit this issue of family engagement?

A. So when I returned back from maternity leave and my brief had changed to being at the Chelmsford site, there was a relative that had asked to meet with me, and was really unsatisfied with the lack of communication that they had received for their wife's care. And that meeting was very difficult to sit and hear that, and it made me want to do things differently. I couldn't unhear what I had heard. It made me feel very upset that that was the standard of care that had been provided and I wanted to do better and I also made that relative a commitment that I was not going to not deliver on. And that was that I would make change and that I would ensure that things improved.

And obviously that's not just done to me; that takes me and my team, but I think having that conversation and hearing how they felt really -- yeah, I can't explain the impact that that had on me, and wanting to do different.

Q. You speak for yourself and the impact that's had on you.

A. Yeah.

Q. Obviously there's lots of other people involved in this issue.

A. Yes.
Q. What would you say to the families listening to your evidence to offer them assurance that things have changed in the way you say?
A. I think I can only, you know, give my word that things have changed, and that hopefully the positive feedback that we have received and the compliments and the fact that staff are engaging with families does give the families that are listening the assurance that we are really hearing what has gone wrong and that we are doing different, and, you know, if they hadn't have spoken up, we wouldn't be making positive changes.
Q. Moving on to the topic of safety and just coming back, if I can, to ligature risk, and audits. I'm just looking at paragraphs 137, 138, if you have those.
A. Sorry, 137 and 138?
Q. And 138.
A. Thank you.
Q. And you say you're aware, at paragraph 138, "aware that changes have been implemented as a result of serious incidents", and you reference work taking place to make wards safer for patients.

Were you aware that EPUT was prosecuted by the HSE in respect of environmental risk from ligatures?
A. So I have some awareness of that.

Q. And obviously you refer there to changes following serious incidents, so ligature points being addressed following incidents. Can I just ask you this: are you able to offer any insight, from a staff perspective, for why it appears that EPUT have been so slow to reduce ligature risk?
A. I think it's very difficult to answer because I've only ever worked in that Trust. So having not known how other Trusts respond in a responsible, different manner, I don't know. However, the experience I've had is that when there's been a concern raised, I've felt that that has been dealt with in whichever -- whichever manner that might be. But I think also, it's very difficult when there's like Trust-wide work that needs to be done that may appear slow -- so, for example, when we needed to change all of our doors, it might be that I might have felt that maybe my service was more of a higher priority than another service, but, you know, going back to your question, I think it's very difficult for me to say whether they are slow or not to -- because I've only ever known how they've responded.
Q. A perspective that many have, looking in --
A. Mm-hm.
Q. -- particularly families, is that it looks as if an incident happens and EPUT reacts, and they fix that?

A. Mm-hm.
Q. It doesn't look often from an outside perspective like things are being proactively addressed.
A. *(The witness nodded)*.
Q. Do you have anything you can say or respond to in respect of that perception?
A. I can completely understand how they have seen that because that is exactly how it looks. But I think, as well, there's often a lot of work that is happening in the background that's maybe not spoken about that maybe families might not know that is happening, and then it happens. But I can completely understand how it would appear as reactive.
Q. You deal at 138 with the incident in respect of Abbigail Smith.
A. Yes.
Q. And you refer to work being done. Can you just help us, what work -- so this was an incident where Abbigail Smith was a patient on Galleywood; is that right?
A. Yes.
Q. And she was able to barricade a door and self-strangulate. And then there was an incident in the garden at The Lakes, you describe there, when a lady died having ligatured using a door handle and you say there was a lot of work done in the gardens and in

relation to door handles following that incident. What work was done in the garden?

A. So for the one at The Lakes, the door handle was changed so it was changed to a different door handle which was then ligature reduced, but also we then had works done around our furniture and ligature points in our garden area, because they're quite -- so on my wards I'm really fortunate to have quite big, open spaces, which will need additional work to make those areas that are identified risk safer.

Q. And when was that work carried out?

A. I don't think I can give you an exact date, but when I had returned from maternity leave, so around 2022, a lot of those works were happening or had happened, but I obviously wouldn't be able to say because I wasn't here at the time.

Q. Just moving on to another topic in your statement, it's under the heading of "Ligature audits" but I want to ask you if I can, about your paragraph 145 because you refer there to mixed- and single-sex wards and the issue of sexual safety.

You told us about an incident involving a patient earlier which was reported. You told us that was reported to the police. But can you just help us, in general terms, what are the channels available to

patients to report sexual assaults or inappropriate sexual behaviour?

A. So on all the -- so on all the wards -- and I can say that they're on my wards, my areas -- there's posters up around sexual safety information, and also it's included as part of the welcome pack, as well.

So there's contact details in there which the patients can make contact with if they don't wish to speak to somebody on the ward. We also do talk about sexual safety in our community meetings, and it's something that we will discuss within the MDT around sexual safety and if there's any incidents of that, that will be shared within our team meetings and also escalated through the appropriate channels.

Q. And on the ward, obviously the people have contact with the patients, the most are going to be the HCAs and the nurses, just asking about the HCAs for example, do they have training about how to deal with reports of sexual assault?

A. Yes.

Q. What would they be told?

A. They would be told that they would need to escalate that concern to the nurse in charge. Our Safeguarding Team are available, as well, so they could call them and have a conversation around the concerns that a patient had

raised. Also if they felt that they couldn't speak to anybody else, there's additional staff that are available for them to raise concerns.

Q. Is there a protocol or a policy that sets out the process for dealing with those sorts of allegations?

A. Yes.

Q. And where's that kept?

A. So that would be kept on the intranet.

Q. So if you're an HCA, how would you find out about that? How would you know what to do?

A. So you would be informed as part of your induction of where the policies and procedures are kept. Also, all of our staff have an induction, as well, and obviously it's covered as part of the safeguarding training, as well, which all staff have to do as mandatory.

Q. I want to move now to the part of your statement that deals with technology and particularly Oxehealth.

You refer to your role in piloting the use of Oxehealth technology; is that right?

A. Yes.

Q. Can I just firstly ask you this: what is your opinion as to the effectiveness of Oxevision in the care of patients on inpatient units.?

A. So I think in terms of monitoring the physical health care it's good and also in terms of supporting with

monitoring the sleep patterns, it's good.
Q. What about its limits? What would you say its limits are, in your view?
A. I think obviously the limits would be potentially when staff have misused Oxehealth.
Q. And when you say misused, do you mean, for example, relying on Oxehealth, or I'll use the term "Oxevision" --
A. Yeah.
Q. -- instead of carrying out their own observations?
A. Yes.
Q. And would you accept that has been a problem?
A. Yes.
Q. Because the reality is Oxevision shouldn't be a replacement for observations?
A. Yeah, it shouldn't be a replacement for the in-person checks.
Q. And in terms of the piloting of it, am I right that at the time of the pilot you were a Service Manager of the Hadleigh Unit?
A. Yes.
Q. And you provided feedback in respect of Oxevision?
A. *(The witness nodded)*.
Q. So does it follow that that feedback would have related to the Hadleigh Unit?

A. Yes.
Q. During the pilot, were clinical staff using it encouraged to identify problems or difficulties with the technology?
A. Yes, so when the technology was rolled out on the ward, we had additional support from the Oxevision company to be present, and any concerns to be raised and addressed with them as they arrived.
Q. Were there staff concerns?
A. So there were staff concerns raised in terms of -- obviously it's a new technology, how do we use it? What if it goes wrong? We had concerns raised in -- particularly on Hadleigh around the wi-fi issue, which is not an uncommon issue on the Basildon site. But there was concerns raised around that and how that would work.
Q. And just looking at your statement, you use the term "piloting", just looking at your paragraph 148, and you also talk about, in the same paragraph, "rollout".
Might it be seen to be more of a phased implementation than a pilot?
A. So when we were informed, that was the language that was used, that we were piloting on Hadleigh. So that's why I used that. And then -- and then we were informed it was then to be rolled out across the Trust. But at the

time, it -- that was how it was explained to us.
Q. You say that you were unable to recall if you did or didn't feed back any concerns during the pilot.
I think, does that relate to your concerns?
A. Yes, so obviously during the pilot we were obviously in the Covid pandemic, and I was pregnant at that time so my -- I was very -- it was very difficult for me at times to be on Hadleigh Unit, given the nature of the ward and also being pregnant. So all that I raised was what was escalated to me, which is what I had raised at the time, but I'm unable to recall if there was anything else.
Q. And what about from staff below you? Do you recall there being any actual concerns or issues, not at how to use it, but at the principle of using it, as such?
A. Not that I can recall. Unfortunately, at that time, my recollection is more around managing the Covid pandemic.
Q. In terms of training and the use of Oxevision, would you accept that there were issues or have been issues with staff not being properly trained?
A. Yes.
Q. Moving on, then, to a different aspect in respect of Oxevision, I want to ask you about the issue of consent, please.
A. Yes.

Q. You deal with this at paragraph 153. You say that:

"I have experienced patients not wishing to consent to Oxehealth and this has been turned off."

And you say when providing information to patient and their families, sometimes they've asked for it to be turned off.

Would you agree that informed consent is a key consideration with Oxehealth and Oxevision?

A. Yes.

Q. Would you agree that for consent to be informed, it requires information to be given to patients and their families?

A. Yes.

Q. Do you think that patients and families have always adequately been informed about what Oxevision is and what it does?

A. No, they haven't.

Q. And can you confirm, just looking at the consent-taking process, would patients explicitly have been told that Oxevision cameras would be recording them 24/7?

A. I don't think that I can offer that assurance, having had patients' and family members' feedback that that's not been the case, so I would say that that hasn't always been explained.

Q. Would you agree it should have been?

A. Absolutely it should have been.
Q. Sometimes in healthcare people are given information leaflets about a procedure or about a technology. Was anything like that provided in respect of Oxevision?
A. Yeah, so we did have posters up in the patients' bedrooms and information available to be given out.
Q. You said "available to be given out", but would you accept that's different to sitting a patient down at the beginning, or their family, and giving them something --
A. *(The witness nodded)*.
Q. -- and saying "this is what you need to know --
A. Yes.
Q. -- do you consent, having read it?".
A. Yes.
Q. Would you accept that that didn't happen?
A. Yes.
Q. Can I ask this: what process would be followed surrounding consent if a patient didn't have capacity?
A. So the process should be that it's documented and agreed within the MDT whether the Oxevision would need to remain on or off, and that should be reviewed.
Q. And what about family members? Would they always have been consulted if a patient didn't have capacity to consent?
A. They should have always been consulted. I don't know

whether that is the case.

Q. Again, do you think it would be the case that they wouldn't always have been consulted when a patient -- (overspeaking) --

A. I would say yes, given the feedback that I've had.

Q. You say at paragraph 154 that:

"I have personally had concerns raised from patients who have been paranoid who have believed they are being watched and listened to, also have supported them with turning it off and also the same for patients that have experienced trauma."

A. Yes.

Q. That's obviously a valid concern, isn't it --

A. Yes.

Q. -- in view of the use of cameras? Do you think it was perhaps foreseeable that installing remote camera-based monitoring in bedrooms could exacerbate paranoia, psychosis, distrust, or -- sorry, distress or mistrust?

A. Yes.

Q. Just before I move on to my final topic, at paragraph 159 you deal with CCTV and you say that patients have been told that CCTV doesn't record in their bedrooms. Would they have been told that Oxevision would record in their bedrooms?

A. They should have been. They should have been told that.

Again, given my previous answers, I don't think that's always been the case.

Q. And given those answers, do you think it wouldn't have always been the case that staff would have been aware of the need to communicate that?

A. Yes.

Q. Moving on to culture and management. At your paragraph 197 you say:

"In my experience 'therapeutic nihilism' has been a factor in the teams I have managed. This has been present within the inpatient but I've also witnessed this within the community."

Firstly, what do you mean by therapeutic nihilism?

A. So the staff haven't seen any improvement with the patients that may have been given medication and treatment on the ward.

Q. And what's the result of that? So they don't see an improvement, and what does that lead to?

A. So I think when you work in mental health, one of the things that you really want to see is your patient come through and recover, and you want to see that journey of them being better and support them along that journey, and sometimes there's a -- there's patients that come in that may present the same from point of admission, and that that could be the same presentation for months.

And it's really difficult for the teams to see the hope of that person recovering and the impact that has when you're not able to hope.

Q. And do you think that that perhaps disproportionately, affected the care of patients who repeatedly, for example, self-harmed or absconded or tried to kill themselves?

A. Yes.

Q. What would you do as a Matron or Service Manager to combat that?

A. So one of the things that I do in my current practice is that I will engage with the team, especially if I feel that there is signs of compassion fatigue within that team. I will speak with the consultant, I will speak with the leads, and I will go and look at what additional support mechanisms we can put in place, so whether that's additional reflective practice, additional support from psychology, think about meeting with the patient and trying to see what their goals are that they want to achieve, meeting with the family, and really trying to look at how we can instill that hope and what we can do differently and yeah, thinking about what is in the best interests of that patient to get them better.

Q. Would you agree there's still work to do to address

that?
A. Yes.
Q. You deal with the question of internal investigations, and that's something that will happen, certainly happen following a patient death.
A. Yes.
Q. And you describe having been involved in those and being made aware of recommendations. I asked you previously, I'm going to ask you again, because I know it's a case you're familiar with, the case of Bethany Lilley.
A. Mm.
Q. There was obviously an internal investigation by EPUT. There was also an independent report commissioned by Duncan and Johnston. Were you aware of that?
A. Yes.
Q. Sorry, not commissioned by, produced by Duncan and Johnston?
A. Yes, I was aware of that. However, that was shared with me obviously once I'd returned back from maternity leave, so in terms of the timeline that I would have known about that a lot later after it had happened.
Q. Were you made aware of the criticisms that report made about EPUT's own internal investigation report?
A. Yes.
Q. Was there learning as a result of that?

A. Yes.
Q. Was that disseminated to you?
A. Yes. My director at the time sat me down and discussed all of the findings.
Q. Good and poor practice. You deal with that from paragraph 210. You've described witnessing a staff member falling asleep. How common is that, in your experience?
A. It has been featured throughout my whole career within working within the different Trusts, that this has happened.

I would say that it's less common now than previous years in the last, sort of, three years. Yeah, I think there's been a lot of supportive measures put in place now to combat that.
Q. There could also be an issue in respect of mobile phones --
A. Yes.
Q. -- on wards. What's the mobile phone policy at EPUT on wards?
A. So staff should not be on their mobile phones whilst they're completing or performing observations.
Q. Completing or performing observations. What about when they're not, more generally?
A. So they shouldn't be, like, in the open spaces on their

phone. So, like, our -- so, like, our nursing offices, they've got all windows so people can see in and out. So they should be in, like, closed areas so, like, the staff rooms for example.

Q. So to summarise, mobile phones not allowed in public areas, are allowed in private areas not visible to patients?

A. Yeah.

Q. And for how long has that been the policy?

A. That has been in place since I have worked within the Trust, and it's always been you don't have your phone on you, you keep it in your bag. If there's a need for someone to contact you, then you can give the ward number. I mean, so it's all -- that's been in place since 2008.

Q. The final thing I want to ask you about is the Dispatches documentary.

A. Yes.

Q. You deal with that at the end of your statement. And you describe there that it made you feel sorry for patients. Why was that?

A. I think it was really upsetting watching the Dispatches programme and it made me feel extremely sorry that patients had received such treatment within our service, and it just isn't something that I would have expected

to have happened.
Q. Why did you feel like you had failed people?
A. I think you become a nurse because you want to help people and you want to do the best you can and I generally felt that having watched that, and that happened in wards that I was responsible for, I did feel that I had failed them.
Q. What concerned you most about what you saw in respect of the care in that documentary?
A. I think it all -- the whole documentary concerned me and I think the fact that staff felt that the way they were treating people was okay, and that that hadn't been escalated or people hadn't felt that they could speak up about what they'd seen.
Q. Was any action taken by way of disciplinary action or formal action against any of the staff as a result of that documentary?
A. I don't know because I wasn't involved in that process.
Q. What did you take away -- what lessons did you take away from the documentary?
A. So I think one of the lessons that I took and I've spoke about it previously is around if we're getting it wrong we need to hold our hands up and be transparent, and that if we have done something that we're concerned about, I really want staff to feel empowered to speak up

and not have the fear of potential consequences, and I think it made me want to be present with a purpose on the wards and speak to patients about their experience and understand what it is we can do differently, and what we need to be better at. And I think it's okay to acknowledge that there's still areas for improvement, and that shouldn't be seen as that we're failing; it's just that we need to think differently about what we're doing. And I think it -- yeah, it made me want to do more.

Q. One feature of the family evidence that the Inquiry has heard is a number of families have described EPUT as being defensive?

A. Mm-hm.

Q. Not being candid?

A. *(The witness nodded)*.

Q. How do you respond to that from a staff perspective? Can you offer any explanation why that might be perceived that way?

A. No, I mean I would be extremely sorry that that was their experience and that's not what I would expect from the Trust or from the staff when we work in such a caring environment.

MR COKE-SMYTH: Chair, I think now's the time where, if we may, we're going to take a ten-minute break before -- to

see if there are any final questions.

THE CHAIR: Ten minutes.

(4.53 pm)

(A short break)

(5.08 pm)

THE CHAIR: Mr Coke-Smyth.

MR COKE-SMYTH: Thank you, Chair.

I only have a few more questions, so hopefully we're just going to be a few more minutes.

You referred earlier in your evidence to ensuring that families are communicated with before transfers take place.

A. *(The witness nodded)*.

Q. Presumably that would apply equally to transfers out of area?

A. Yes.

Q. You also gave evidence earlier that those under the influence of drugs or alcohol who are held -- about those who are held at A&E or who attend A&E under the influence of drugs or alcohol, who need to be assessed under the Mental Health Act, do you know what steps would be taken to ensure that they're kept safe while they're waiting for an assessment at A&E?

A. So the liaison team that are based at our A&E departments, obviously they would be monitoring and

supporting with any additional needs and that person can also be nursed on a one-to-one as well, if there's a significant risk. But obviously A&E is a public place, as well, so there is still the risk of that person being able to leave.

Q. And say a person does leave, they haven't been assessed, would EPUT take any steps to try to follow up to assess that patient, to either contact them or --

A. Yeah, and we would also contact the police to inform them that they've left the department without being seen, and the risks, especially as they've been referred in for a Mental Health Act the risk would be considered as higher, so we would do that and also we would make contact, or attempt to make contact with that person, as well, and if appropriate, contact relevant loved ones to let them know that that person has left the department without being seen.

Q. You gave evidence earlier about the procedure for dealing with an allegation of a sexual assault. Are there policies that deal with patient-to-patient relationships on inpatient wards?

A. Yes.

Q. And how would you respond if you became aware of a relationship between patients on an inpatient ward?

A. So obviously we would contact the Safeguarding Team. If

there was an incident, then that also would need to be Datix-ed, there would be a conversation with the MDT as well which would include whether or not it would be appropriate for those patients to remain on the same ward. It could be that if there's a significant risk, that we may need to think about whether they remain on the ward, and if needed to, potentially one of those patients could be moved if the risk was deemed serious enough.

But all of that would need to be documented.

Q. You gave evidence about staff falling asleep on occasion. You described that now being less common. What do you think the reason for that is?

A. So I think, in terms of the Trust reviewing the observation and engagement policy and now the number of -- so -- sorry, the number of hours of observations that one individual can do is less. In my areas I can give assurance that we do wellbeing checks for our staff that are on observations. So those staff that -- so during the day the ward managers will go round and just check people, how they're feeling, if they're alert, do they need a break? Is it that we need to think about observations being potentially maybe half-hourly obs if they're intense?

Also, we've got our Clinical Site Managers that work

out of hours, they work nights and weekends, as well, they're Band 7, and they also do the same checks, as well. So I feel like there's a lot of support in place.

We also do ask the question at handover if there's any concerns that staff do want to raise. So it could be that there's things that have happened outside of our control, maybe they've not had adequate sleep, I don't know, maybe a child's been sick. There's things that we would need to know to support that person whilst they're at work.

MR COKE-SMYTH: Thank you very much, Ms Cawston. Those are all the questions I have.

Chair, do you have any questions?

THE CHAIR: I have no further questions, thank you very much. Can I thank you very much indeed for coming to give evidence.

THE WITNESS: Thank you.

THE CHAIR: It's very much appreciated.

THE WITNESS: Thank you.

MR COKE-SMYTH: Thank you, Chair, and I believe we're going to resume tomorrow at 10.00 am.

THE CHAIR: 10.00 am tomorrow.

(5.13 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X