

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

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

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

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

21 **STUART ALAN AYRIS (affirmed)**

22 **Questioned by MS HARRIS KC**

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

1 A. Yeah, Stuart Alan Ayris.

2 Q. Mr Ayris, you've provided two witness statements to the
3 Inquiry.

4 A. Yeah.

5 Q. One some time ago dated 21 February 2025, and another
6 more recent statement dated 4 June 2026?

7 A. Yeah.

8 Q. You have a copy, I hope, of both of those statements in
9 front of you.

10 A. Yeah.

11 Q. You signed both of those statements?

12 A. Yeah.

13 Q. And each of them bears a statement of truth.

14 A. Yeah.

15 Q. Now, I'm going to pause you for a moment because you're
16 nodding --

17 A. Oh, sorry.

18 Q. -- but it may be for transcript purposes we'll need you
19 to say, "Yes," clearly.

20 A. Yes, sorry.

21 Q. No, no, it's my fault, I should have said. Thank you
22 very much. If you just speak clearly and say, "Yes".

23 A. Yes.

24 Q. Have you had an opportunity to read both of your
25 statements recently?

1 A. Yes.

2 Q. Is there anything you wish to correct in either of those
3 statements?

4 A. No.

5 Q. Do you stand by those statements?

6 A. Yes, I do.

7 Q. I think, as you're aware, both of those statements in
8 full will form your evidence to the Inquiry --

9 A. Yeah.

10 Q. -- along, of course, with the answers to the questions
11 you give today.

12 I've got a message to ask you to speak up.

13 A. Oh okay, sorry.

14 Q. We've just begun and I know it can be a bit
15 nerve-racking but if we just both remember to speak
16 clearly.

17 A. Yeah, will do.

18 Q. Thank you, Mr Ayris.

19 You are now retired, but for around 27 years,
20 I think, you were a Registered Mental Health Nurse.

21 A. That's right, yes.

22 Q. And from 2002 until you retired in 2024, you worked for,
23 firstly, North Essex Partnership NHS Foundation Trust
24 and then, when it merged, you worked for EPUT?

25 A. Yes, I did, yeah.

1 Q. Now, there is, it may seem an obvious thing to say,
2 a distinction. Because until that merger, you were
3 working for I think we should just use the shorthand
4 NEPT?

5 A. Yes.

6 Q. And then after the merger you worked for EPUT?

7 A. That's right, yeah.

8 Q. During the course of your giving evidence -- this is for
9 me as well -- can we try and make clear as best we can
10 the periods of time that you're referring to so that we
11 make sure that we draw the distinction between when you
12 were employed by NEPT and when you were working for EPUT
13 after the merger?

14 A. Yes, yeah.

15 Q. Thank you. In terms of your experience and where your
16 different positions when you were working for EPUT,
17 I think the easiest thing for us to do is have look at
18 what you put in your statement and I'm going to ask if
19 paragraph 4 of your witness statement could be put up on
20 the screen, please. Hopefully you've got that as well.

21 A. Yeah.

22 Q. It's really so we can orientate ourselves with where you
23 were during that 22-year period.

24 We start off pre the 22 years. October 1997 to
25 April 2002 you worked as a staff nurse at Warley

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

4 A. Yes, that's right.

5 Q. So that was before you joined NEPT?

6 A. Yes.

7 Q. But that was your first position?

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

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

12 A. It is, yes.

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

16 A. Yes, I did.

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

18 A. It was, yes.

19 Q. An adult Psychiatric Intensive Care Unit?

20 A. Yes.

21 Q. There you were employed by NEPT --

22 A. Yes, I was.

23 Q. -- as it then was.

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

1 A. That's right, yeah.

2 Q. And you were there for a period of six years?

3 A. Yes.

4 Q. Again, that was an Adult Acute Admissions Ward?

5 A. It was, yeah.

6 Q. And that was NEPT?

7 A. It was.

8 Q. From March 2009 to October 2009 -- and we'll hear about

9 how you moved to this position a little bit later in

10 your evidence -- you worked on the Trust Safeguarding

11 Team and had various responsibilities.

12 Just in a sentence, what was your role on that team?

13 A. I was a best interest assessor which is basically

14 assessing people who were placed in various units around

15 the county who it was felt there was deprivation of

16 liberty issues. So I would go and see the person, and

17 do a report on their circumstances, and their capacity.

18 Q. So you were undertaking assessments but would it be

19 right to say you had limited or less direct patient

20 contact?

21 A. Yes, yes.

22 Q. You've written in your statement "within EPUT", but in

23 fact that was NEPT as well, wasn't it?

24 A. Yes, I've never really took account of when the changes

25 occurred to be honest.

1 Q. That's all right, that's why we will make it clear by
2 doing this exercise.

3 A. Yes.

4 Q. From November 2009 to June 2014 you worked as a team
5 manager at the Maldon Community Health Team in Essex?

6 A. That's right.

7 Q. That was community-based care there?

8 A. Yes, it was.

9 Q. And we'll come again in your evidence to how you
10 interacted with inpatient units and some of the working
11 between community teams and inpatient units, but that
12 was your providing mental health care in the community?

13 A. Yes, it was, yes.

14 Q. From June 2013 to July 2016, you were back on the ward?

15 A. I was, yes.

16 Q. This time you were a Charge Nurse at the Ardleigh Ward
17 at The Lakes?

18 A. Yes.

19 Q. From August 2016 to May 2019 you explain that you worked
20 as a bank nurse on various teams including the Access
21 and Assessment Team, the Mental Health Liaison Team
22 conducting emergency psychiatric assessments at
23 Colchester Hospital. Now, this period crosses with the
24 merger.

25 A. Right, okay.

1 Q. So is it NEPT into EPUT then, at that stage?

2 A. I believe so, yeah.

3 Q. And is that largely community based again?

4 A. Yes, it is. The assessments weren't in people's homes

5 but they were in a unit alongside The Lakes, and the A&E

6 liaison team that was doing assessments in Colchester

7 General Hospital, yeah, so it was assessing patients who

8 were based in the community but not assessing them in

9 their own homes.

10 Q. May 2019 to March 2021, you worked as a Community

11 Psychiatric Nurse in the Psychosis Team in Holmer Court

12 in Colchester?

13 A. Yes.

14 Q. So again, a community-based role?

15 A. Yes, yeah.

16 Q. From March 2021 to March 2022 you went travelling?

17 A. Yes, I did.

18 Q. April 2022, you were back again and from then until

19 January 2023 you work as a bank nurse as a Community

20 Psychiatric Nurse in the Specialist Mental Health Team

21 in the Gables in Braintree. Again, Gables provides

22 outpatient services and outreach; is that right?

23 A. Yeah, I was a Community Psychiatric Nurse with

24 a caseload of patients I would see in the community.

25 Q. So again a community role?

1 A. Yes, yeah.

2 Q. Then the final period of time we have is July 2023 to
3 August 2024 when in fact you were at the same job but in
4 a permanent position?

5 A. Yeah, that's right.

6 Q. -- (overspeaking) -- all right.

7 So what I wanted to do by looking at your witness
8 statement was identify, firstly, where it was NEPT and
9 where it was EPUT and, secondly, that there are quite
10 significant periods where you're working in the
11 community rather than an inpatient setting.

12 A. Yeah.

13 Q. And again, whilst before we leave this page, if we look
14 at number 5, your experience is solely with adults?

15 A. Yes, it is, yeah.

16 Q. Thank you. You can take that down now.

17 I don't ask you necessarily to look at your witness
18 statement but I'm going to give the references as we go
19 along in case you'd like to. You also explain, by way
20 of your experience and background, that for about half
21 of your career, half of your working time, you were
22 a trainer for the Ethical Care, Control and Restraint on
23 the Care Programme Approach and safeguarding. I'll come
24 back to that in just a moment, and you provided that
25 training for about 20 days a year; is that right?

1 A. Yeah, that's right.

2 Q. So that's paragraph 6 of your witness statement. As

3 I say, we'll come back to that in a moment.

4 At paragraph 8 of your first statement you set out

5 what you describe as your three key concerns in relation

6 to EPUT.

7 A. Okay.

8 Q. So it's paragraph 8. We'll come back to the

9 organisation in a moment but just let's look at your

10 concerns. Your first concern, you say, is EPUT's focus

11 on perception, how the organisation will look if

12 something tragic happened as opposed to making sure that

13 nothing tragic happened in the first place. And you say

14 this takes place -- I'll come back to that in

15 a moment -- at a point where patient care is overlooked?

16 A. Yeah.

17 Q. Your second concern is what you describe as a focus on

18 statistics --

19 A. *(The witness nodded)*.

20 Q. -- and blaming individuals when something went wrong for

21 systemic reasons?

22 A. Yes.

23 Q. And your third concern, you say, is a lack of care,

24 understanding, and compassion?

25 A. Yes.

1 Q. Now, you make reference to EPUT?

2 A. Yeah.

3 Q. And we've just been through your career and we can see

4 that a significant part of that was in fact when you

5 were employed by the predecessor organisation, NEPT. So

6 can I just ask you this: to what extent are those

7 concerns drawn from your experience, early experience,

8 say at the Linden Centre, and from the events following

9 the death of Benjamin Morris as opposed to your

10 experience overall?

11 A. I would say the majority is my concerns when I worked

12 for NEPT, yes, when I was at the Linden Centre, and in

13 the community at Maldon.

14 Q. And in the community, did you say, in Maldon?

15 A. Yeah, yes.

16 Q. Can I just ask you this, because you talk in the present

17 tense because you say, when you are talking about focus

18 on perception you say, "This takes place to the point

19 where patient care is overlooked."

20 Was it still a feature, then, of EPUT's approach at

21 the time you retired in 2024.

22 A. Yes, it was. In the team I was working in, yes, I

23 believe it was.

24 Q. Do you have any specific examples, later examples, let's

25 say, where EPUT focused on how something would look

1 rather than patient care?

2 A. Yeah, I mean, when I worked, for example, in the
3 community in Braintree, they had a system of grading
4 people's risks using red, amber or green as to regarding
5 if someone was rated as red, they would be an urgent
6 risk, and obviously down to green, maybe less of a risk.
7 Meetings would go on for two or three hours discussing
8 these ratings and to me they bore no reflection
9 whatsoever in the way those risks were then managed in
10 the community. So on paper it would seem that there was
11 a lot of attention paid to looking at people's risks but
12 in reality in terms of mitigating their risks, it just
13 didn't match up.

14 Q. Can I go back, then, to the Care Programme Approach
15 which was obviously in place for the majority of the
16 time you worked for NEPT and then EPUT, and your role as
17 a trainer. Now, this Inquiry has already heard evidence
18 about the Care Programme Approach, and we understand
19 that following a period of transition it was replaced by
20 the Community Mental Health Framework?

21 A. Yeah.

22 Q. Do you recall roughly when that transition or when that
23 was replaced?

24 A. No, I think it -- because there was a period of time
25 when I had kind of a year off then I was working as

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

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

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

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

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

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

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

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

3 Q. And you provided both, did you?

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

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

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

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

16 A. Sorry.

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

19 A. Staff.

20 Q. All staff, which levels of staff?

21 A. Yeah, all levels of staff.

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

23 A. Yes, it was, yeah.

24 Q. Was it assessed?

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

1 Q. Yes.

2 A. Yes, certainly the Control and Restraint was. The CPA
3 training was more about information giving.

4 Q. Were you assessed? Was it quality controlled?

5 A. Each year as a Control and Restraint trainer we have to
6 be assessed, yes. Yes, that was an annual revalidation.

7 Q. You made reference to safeguarding; was that different
8 or part of the same course?

9 A. Yeah, that was very much when there was still three of
10 us that were best interest assessors. When we didn't
11 have an assessment that day, we'd be asked to go along
12 and just support the person who was doing the training.

13 Q. In terms of safeguarding, how would you describe, then,
14 what safeguarding means in the context of inpatient
15 mental health care?

16 A. I think it's ensuring that patients' rights are upheld
17 within an organisational setting, making sure, in terms
18 of their dignity, their respect, that the law is
19 followed. Yeah, and that their voice is heard. And
20 that anything that needs to be reported on or be acted
21 upon, that process should take place.

22 Q. Can I just also ask you this, a slightly different
23 question: in terms of the CPA approach, obviously there
24 were policies and procedures in place and available.
25 When you worked at NEPT, was there any guidance by way

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

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

8 Q. A manual of sorts?

9 A. I think so, yeah.

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

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

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

22 A. No.

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

1 your statement is around the Linden Centre, isn't it?

2 And that's six years between 2003 and 2009?

3 A. Yes.

4 Q. But we will then go on to look at some of the

5 observations you can make through your community work.

6 A. Okay.

7 Q. And I think there's a short period of time on The Lakes,

8 but the majority of your evidence as I understand it --

9 you'll correct me when we go through -- is to do with

10 Finchingfield Ward?

11 A. Yes, it is, yes.

12 Q. Before we start on Finchingfield Ward, though, can we

13 begin with your first role for NEPT, which is at the

14 Christopher Unit.

15 A. Yeah, yeah.

16 Q. Now, you've already told us that you did your training

17 at the Barking and Havering Brentwood Trust.

18 A. *(The witness nodded)*.

19 Q. What other training, if any, had you received before

20 starting at NEPT?

21 A. It would have been whatever mandatory training was

22 available at the time. I remember at Warley Hospital we

23 did control and restraint training. I did a 998 course

24 which is about teaching and assessing and mentoring

25 students. And I can't remember what specific training

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

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

9 A. Yeah.

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

12 A. Yes, will do.

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

18 A. That's right, yes.

19 Q. Have I described it accurately?

20 A. Yeah.

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

22 "It had been identified that certain patients did
23 not always connect with all staff members and as such
24 a system was developed whereby nurses were rotated so
25 everyone was involved in different aspects of every

1 patient's care, for example, assessment, risk
2 assessment, and discharge planning."

3 A. That's right, yes.

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

6 A. It was, yes.

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

8 A. Yes.

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

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

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

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

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

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

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

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

1 member of staff did have contact with everyone.

2 MS HARRIS: So your nursing model, sorry, meant that when
3 somebody was away, they were just as familiar with
4 another member of staff.

5 A. Yeah, that's right, yeah. And also because each --
6 there were three diaries that we brought in, an
7 assessment diary, a risk assessment diary and
8 a discharge diary. So the -- say you're in the
9 Assessment Team, you would come into work, look at the
10 assessment diary and see this needed to be done or you
11 look in the risk assessment diary. So that way nothing
12 was missed. It wasn't all down to one member of staff
13 to kind of do everything.

14 Q. We'll come back to that in a moment because that's
15 something you then tried to put in place in
16 Finchingfield --

17 A. Yeah.

18 Q. -- on a larger scale and, as I said, you will explain it
19 in a moment, but just back to this model for a moment.
20 You talk about developing it. Was it a practice you'd
21 seen elsewhere? Was it a standard practice elsewhere?
22 Did you base it on something you'd seen or heard?

23 A. No, it was just something I'd kind of thought about over
24 a period of time, and wrote it up, and then presented it
25 to the manager of the unit, who said, "We'll give it

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

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

6 A. Yeah.

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

11 A. No. No.

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

15 A. Yeah.

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

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

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

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

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

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

14 A. Yeah.

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

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

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

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

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

1 A. Not under the model. The model was mainly directed in
2 terms of what staff would do.

3 Q. So that was a separate consideration?

4 A. Yeah, yeah.

5 Q. Were there any other particular changes that you
6 introduced in relation to the provision of nursing care?

7 A. Nothing specific, I don't think.

8 Q. Moving on, then, to the Linden Centre to Finchingfield
9 Ward. You were the Ward Manager. Your line manager was
10 a gentleman called Stuart McGough?

11 A. Yes.

12 Q. And he, in turn, had another line manager who we won't
13 name today.

14 A. Yeah.

15 Q. When you started in Finchingfield in October 2003, what
16 type of ward, was it?

17 A. It was an acute admissions ward.

18 Q. Mixed?

19 A. Yes.

20 Q. How many beds when you started?

21 A. When we started --think maybe 20 and I think in time
22 that was reduced to 18 because there was a short
23 corridor of single rooms that were then turned into
24 meeting rooms, I think.

25 Q. And it was next door to Galleywood Ward?

1 A. Yes.

2 Q. And what type of ward was Galleywood Ward?

3 A. That was acute admissions mixed ward. We just covered

4 different areas of -- geographical areas.

5 Q. So they were the same type of ward?

6 A. Yes.

7 Q. Same size?

8 A. I think so.

9 Q. Roughly?

10 A. Yeah, I think so.

11 Q. In your witness statement, in your first witness

12 statement at paragraph 10, you say that once you started

13 working there, you noticed that things were done

14 differently to how you had been trained or how you were

15 accustomed to doing things. You compare to Warley

16 Hospital. Are you also comparing to the Christopher

17 Unit?

18 A. The Christopher Unit and the acute admissions ward are

19 two very different approaches, so yeah, that would be

20 like comparing oranges and apples to a degree, but

21 there's certainly a comparison with the acute mixed ward

22 that I worked on at Warley Hospital to Finchingfield

23 Ward.

24 Q. So the most meaningful comparison --

25 A. Yeah.

1 Q. -- is the one with Warley?

2 A. Yes.

3 Q. What were the main differences then, between

4 Finchingfield and Warley?

5 A. Warley Hospital was -- it was much higher level of

6 intensity. I'd never -- to this day, I'd never met more

7 people -- people who were more in distress or higher

8 levels of aggression than I saw when I was at Warley

9 Hospital. We took patients from Barking and Dagenham so

10 it was a different socioeconomic area, and although it

11 was a very large hospital it felt like you were on

12 a standalone unit even though you were a big hospital

13 and I couldn't even tell you who the clinical manager

14 was when I worked there.

15 Q. At Warley?

16 A. Yeah, you just worked on the ward. Because of the

17 intensity there you only had four staff to, say, 24

18 patients. The real emphasis was you have to get to know

19 the patients; you have to get on with them, because you

20 are kind of quite vulnerable as a member of staff, and

21 you have to really be positive in trying to make

22 a difference each day. It was very much about engaging

23 with people.

24 Q. So how was Finchingfield different, then?

25 A. Going back to the Christopher Unit, when I was on the

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

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

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

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

16 A. Yeah.

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

18 A. Yeah.

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

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

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

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

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

13 A. Yeah.

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

16 A. Yeah.

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

19 A. Yeah, it was, yeah.

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

22 A. That's right.

23 Q. Were they resistant to it?

24 A. Yeah, they were.

25 Q. To what extent?

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

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

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

18 A. It did.

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

21 A. Yeah.

22 Q. Sorry, I'm paraphrasing.

23 A. Yeah.

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

1 A. That's right.

2 Q. Is that because those that were there when you arrived
3 were not, you thought, genuinely kind and open-minded
4 people?

5 A. I couldn't say in terms of whether they were kind and
6 open-minded people but certainly on the ward in the
7 roles they were in, I didn't feel they had the necessary
8 kind of positivity to do the job I wanted them to do.
9 I think you need to -- I need to differentiate between
10 what they were like as people and what they were like on
11 the ward.

12 Q. Understood, understood. It was how you wanted them to
13 be on the ward that was important?

14 A. Yeah, I mean, to be honest, almost everyone I've met
15 throughout my career were nice people. It didn't mean
16 they were always effective.

17 Q. It was my clumsy way of asking it, Mr Ayris, it's my
18 fault, but I think you've made it clear.

19 In terms of the model which you introduced, the
20 Three Teams Model, with the diary to make sure things
21 weren't missed, and we'll come on to, for example,
22 weekly reviews in a minute, you say that in your view,
23 the model worked and you base the fact on the -- you
24 base that on the fact that in the time you were there,
25 2003 to 2006, you say there was just one instance of

1 somebody taking their own life.

2 A. Yes.

3 Q. When you make that comparison, were you making that

4 comparison to other wards you worked on or other wards

5 you knew about or?

6 A. Yes, there were certainly more incidents on Galleywood

7 Ward who obviously didn't use the nursing model. But

8 I wouldn't put it entirely down to the nursing model, it

9 was the approach of the staff, the personalities of the

10 staff that did make a big difference as well.

11 Q. That's on your ward, you say?

12 A. Yeah.

13 Q. What about incidents of self-harm, were they reduced in

14 that period, do you think?

15 A. Again, not to do with the model, I don't think,

16 necessarily, more the approach we took if somebody did

17 self-harm, it was always about trying to learn and

18 understand why they did, but to see it as an act --

19 behavioural act, which was the case before, where people

20 would almost be punished for self-harming, where if

21 they'd been self-harming to regulate their emotions for

22 20 years and suddenly they do that on the ward to try to

23 kind of cope and they get everything taken out of their

24 room and put on observations, it's -- I didn't agree

25 with that.

1 Q. I'm going to ask you about your approach to that in just
2 a moment --

3 A. Okay, sure.

4 Q. -- because you're very specific about that in your
5 statement and about what you would describe, I think, as
6 a more positive approach to dealing with incidents of
7 self-harm.

8 A. Yeah, sorry.

9 Q. I promise I'll come back -- no, I promise I'll come back
10 to that in a moment.

11 Can I then ask you about admission to
12 Finchingfield --

13 A. Yeah.

14 Q. -- just picking up on one or two things you say in your
15 statement. When the patient was first admitted, a
16 72-hour care plan was put into place.

17 A. Yeah.

18 Q. It would cover observations, physical health,
19 medications, legal status and so on.

20 A. *(The witness nodded)*.

21 Q. Was there -- how were they put together? Was there
22 a form to fill in with set criteria?

23 A. It was just a standard care plan that you would print
24 out and then you would add in the different personal
25 details.

1 Q. Were families and patients involved at that time?
2 Sorry, family or patients involved at that time in the
3 72 --
4 A. In the compiling of the --
5 Q. Yeah.
6 A. No, they were just literally printed out from the
7 computer. They were just standard forms.
8 Q. But you didn't involve the --
9 A. No.
10 Q. Would you call it a tick-box exercise?
11 A. Yeah, absolutely. Yeah.
12 Q. And then a more personalised care plan would be
13 developed after --
14 A. Within the 72 hours period.
15 Q. Within the 72 hours.
16 You've talked about, in paragraph 15, how those more
17 personalised care plans should have been reviewed
18 weekly.
19 A. *(The witness nodded)*.
20 Q. I think that's where you say your nursing model meant it
21 was less likely that they would be missed?
22 A. Yes, because the named nurse would be responsible for
23 compiling the care plan with the patient and reviewing
24 it but not having to do the risk assessment for that
25 patient and the discharge plan, so they could focus very

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

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

8 A. Yeah.

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

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

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

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

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

23 A. Yeah.

24 Q. -- in terms of --

25 A. Yeah.

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

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

7 A. Yeah.

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

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

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

20 A. Monitored.

21 Q. -- observed --

22 A. Yeah.

23 Q. -- four times an hour?

24 A. Yeah.

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

1 A. Then it would be discussed during the shift and then
2 during the course of their shift it would be elevated to
3 a higher level of observation and then discussed with
4 the doctor.

5 Q. So how long after their arrival on the ward could that
6 happen if need be?

7 A. It could be immediate, if necessary, yeah.

8 Q. And how quickly could it be decreased?

9 A. I'm pretty sure that at the time when I first went to
10 Finchingfield Ward, the nurse in charge and the staff
11 could reduce the levels of observations, but over time,
12 that became the task that only the doctor could perform.
13 But yeah, to answer your question it could be just a
14 discussion at then decreased even just for a certain
15 period of time to see how things went, etc.

16 Q. You deal in your statement with how when you first
17 started in fact it was the nurse in charge of each shift
18 that was able to decrease and increase?

19 A. Yeah.

20 Q. But it later changed to being led by doctors in about
21 2005, 2006?

22 A. Yeah, roughly, yeah, I can't --

23 Q. Do you know what prompted that change?

24 A. I can only imagine -- I don't know specifically but
25 I can only imagine the levels of observations were

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

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

5 A. Yeah, yeah.

6 Q. You describe it as problematic.

7 A. Mm-hm.

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

10 A. Yeah.

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

13 A. It was, yes.

14 Q. Why was that?

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

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

1 A. No, they didn't, no.

2 THE CHAIR: No.

3 A. I think over time they did but you feel more comfortable
4 with those decisions if you know the patient better and
5 the more you know the patient, the more honest they will
6 be with you, generally.

7 THE CHAIR: What part do you think, then, that the doctor
8 should be playing in those decisions?

9 A. The doctor would generally see the patients once a week
10 maybe for 10 or 15 minutes. If a doctor was around, we
11 may have consulted the doctor, but I very much felt it
12 was the staff that were more aware of what the risks
13 were.

14 MS HARRIS: Did you raise your concerns or share this point
15 of view with anybody?

16 A. I don't recall.

17 Q. You also say in your witness statement that sometimes
18 you felt increasing observation levels was done with the
19 idea of protecting the Trust --

20 A. Yeah.

21 Q. -- rather than thinking about what was best for the
22 patient?

23 A. Yeah.

24 Q. What do you mean by that?

25 A. That -- I didn't see what good it did to have somebody

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

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

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

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

18 A. Yeah.

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

21 A. Yeah.

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

23 A. Yeah.

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

1 A. Yes.

2 Q. And if, as you say, higher observation levels were put
3 in place when they weren't really indicated, did you
4 find this affected the ability of staff or staffing
5 numbers to provide supervision for other patients for
6 other things?

7 A. Yeah, I think at the time the thing was where if you had
8 one person on a level 3 observation that was to be
9 subsumed in -- managed by the current staff numbers. So
10 if you had five on a shift, you could have one person on
11 level 3 observations. If you had more than one person
12 on level 3 observations, that would necessitate an extra
13 member of staff. And if you couldn't get that extra
14 member of staff it would take away from --

15 Q. From other activities --

16 A. Yeah.

17 Q. -- other therapeutic engagement for the other patients
18 on the ward?

19 A. Yeah, absolutely. The same as if you that lots of
20 patients on level 2 observations. If you had, say, 10
21 people on level 2 observations then that's two members
22 of staff that are tasked during that hour with doing
23 observations. So yeah, it would.

24 Q. Why do you think the Trust or NEPT, as it was then,
25 thought it needed the protection? You said you thought

1 it was being done for the protection of the Trust?

2 A. I can't speak for the Trust, I'm afraid.

3 Q. Fair enough. Okay, maybe I could ask it this way: why,

4 in your view, do you think it was being done for

5 protecting the Trust?

6 A. I think it was a way of having individuals accountable

7 for something that went wrong. So if somebody was on

8 level 2 observations that member of staff conducting

9 those observations would be accountable for what went

10 wrong if something did.

11 Q. Can I just ask you the flipside.

12 A. Yeah.

13 Q. Do you have any experience or did you ever perceive any

14 pressure to reduce observation levels because of

15 staffing numbers or staff workload?

16 A. No, no, on Finchingfield we had very few patients on

17 level 3 observations while I was there. If somebody's

18 risks increased we just tried to engage with them more

19 because I was always of the view that level 3

20 observations would -- could only be of detriment to the

21 patient. If you're paranoid or if you're depressed or

22 if you have got an urge to self-harm and the response to

23 that is to have some stranger following you around or

24 just looking at you, that's never going to help.

25 Q. My next question was going to be, do you consider this

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

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

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

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

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

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

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

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

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

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

16 A. Yeah.

17 Q. What do you mean by that?

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

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

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

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

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

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

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

16 A. Yeah.

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

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

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

23 A. Yeah.

24 Q. Or well received?

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

1 Q. In terms of clinical assessments on the ward, you give
2 information about this in paragraph 1 of your second
3 witness statement and I won't take you to that, but you
4 talk about informal assessments.

5 A. Mm-hm.

6 Q. You talk about there being a type of informal
7 assessment.

8 A. Yeah.

9 Q. Is that really reflecting the kind of daily interaction
10 between staff and patients?

11 A. Yeah, I've probably poorly phrased that. It was nothing
12 as grand as an assessment. It was just getting to know
13 the person.

14 Q. Were they documented at all?

15 A. Yeah, each shift the member of staff who was allocated
16 to that person on the shift would document the
17 engagement they had with that patient. Yeah.

18 Q. And if it was considered necessary, was it possible for
19 nursing staff to request a medical if they considered
20 a more formal assessment --

21 A. Yeah.

22 Q. -- they could request a more formal review?

23 A. Yeah, there would always be a doctor around that you
24 could call, call in, yeah.

25 Q. And what kind of things would trigger escalation to

1 a formal review?

2 A. It would general be maybe a deterioration in someone's
3 physical health or side effects from a medication, for
4 example, or if a patient wanted to go on leave, we would
5 call the doctor and the doctor would come and decide on
6 that.

7 Q. Would suicidal ideation or expressing a wish to die or
8 self-harm trigger such an escalation?

9 A. Not necessarily. It would depend, if -- because we
10 could raise the observations if we needed to. If it was
11 felt that some extra medication was needed then we would
12 call the doctor but we would manage a high level of risk
13 on the ward amongst the nursing staff.

14 Q. In terms of managing risk and assessing the risk, what
15 risk stratification system did you use on the ward in
16 Finchingfield Wald.

17 A. I can't remember the names, to be honest.

18 Q. Was it the Mobius?

19 A. No, it was something called HoNOS, I think, it may have
20 been. Again, it is an acronym, I couldn't tell you what
21 it meant but it was part of the CPA package.

22 Q. You deal in your first witness statement -- sorry, I'm
23 jumping about but I'm trying to draw them together --

24 A. That's okay.

25 Q. -- with physical health assessments which you have just

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

4 A. Yeah.

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

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

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

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

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

22 A. Yeah.

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

24 A. Yeah.

25 Q. At your paragraph 38 you say:

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

3 A. Yeah.

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

9 A. Yeah.

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

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

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

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

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

1 A. Yeah.

2 Q. -- and information you'd be in a better position to care
3 for those other issues as well as mental health?

4 A. Yeah, and certainly with autism as well, because the
5 general knowledge there was just so poor. And again,
6 I include myself in that.

7 Q. You've compared it already to Warley Hospital where you
8 said there was good facilities and good knowledge?

9 A. Mm, yeah.

10 Q. Other than Warley, have you seen differences in other
11 wards in which you've worked?

12 A. No.

13 Q. Or is that the prevailing issue?

14 A. Yeah. Prevailing issue, I believe, yeah.

15 Q. In relation to those with issues around drugs and
16 alcohol you say at your paragraph 37 that:

17 "Despite the fact that a significant proportion of
18 patients at the Linden Centre were admitted with
19 pre-existing drug and alcohol issues, there were no
20 permanent drug and alcohol workers attached to the wards
21 or the day hospital. I thought the approach to treating
22 those with drug and alcohol dependency was [and I'm
23 using your word here] terrible".

24 A. Yeah.

25 Q. What was so terrible about that?

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

8 Q. Did you say maligned?

9 A. Yeah, yeah.

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

12 A. Sure.

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

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

20 Q. And what about therapeutic options on the ward?

21 A. There was none.

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

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

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

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

11 A. Absolutely, yeah.

12 Q. -- of EPUT?

13 A. Yeah.

14 Q. So that the priority is given --

15 A. Yeah.

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

18 A. Yeah.

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

23 A. Yeah.

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

1 A. None at all.

2 Q. None at all?

3 A. No.

4 Q. And to what extent, in your experience, were Galleywood
5 and Finchingfield suitable for neurodivergent patients
6 at that time?

7 A. I don't think they were. Like I say, I include myself
8 in this. I had no real knowledge at all. I think, in
9 time, where was an online training module in terms of
10 autism but that was much further down the line.

11 Q. The Inquiry has heard evidence, I think, about training
12 that was introduced by the Trust, and when you say
13 online, are we talking about the Oliver McGowan
14 training?

15 A. Yeah.

16 Q. Was there a system in place for considering the
17 appropriateness of the ward environment for
18 neurodivergent patients at all?

19 A. No, not at all, as far as I was aware.

20 Q. In your experience, then, was neurodivergence ever
21 miscategorised as personality disorder or even just
22 troublesome or challenging behaviour, do you think?

23 A. It must have been, yeah. But like I say, my knowledge
24 was as poor as everybody else's in that it was only
25 through the Ben Morris kind of case that I became kind

1 of aware of it, to be honest.

2 Q. You have already expressed your concern about those with
3 autism or ADHD or some forms of personality disorder
4 being prescribed antipsychotic medication. Do you
5 consider that there was an overreliance on
6 pharmacological approaches to those types of patients?

7 A. Yes, yes.

8 Q. Do you think that the lack of specialism and knowledge
9 that you've described led to those patients being put on
10 the wrong care and treatment pathways?

11 A. Yes.

12 Q. Do you think it led to them potentially receiving
13 substandard or inadequate care?

14 A. Yes.

15 Q. Can you think of any specific examples where patients
16 were failed because of the lack of specialism?

17 A. The main example would be Ben Morris.

18 Q. It would be Ben. It may be that there weren't any
19 particular approaches but were some of the approaches
20 used possibly counterproductive, then?

21 A. I should imagine if someone is prescribed medication
22 that's unnecessary -- all medication carries with it
23 side effects, et cetera, and so yeah, if someone is
24 prescribed the wrong medication, it would have
25 a detrimental effect.

1 Q. Was the lack of specialism in comorbidities including
2 learning disabilities or neurodivergence something that
3 you ever raised with managers at that time?

4 A. No, I don't think I did. Certainly towards the end of
5 my time on Finchingfield we had three people admitted in
6 a short period of time who were suffering with early
7 onset dementia. We had absolutely no skills in managing
8 that, and for all sorts of reasons, that was the wrong
9 decision to place those people there. Incredibly
10 distressing for them, for the other patients, and for
11 the families and for the staff. And I raised that
12 continuously in my last few months at the Linden Centre.

13 Q. We didn't refer specifically to dementia in your
14 evidence but in your statement you -- I think you say
15 the same about lack of access to specialism?

16 A. Yeah.

17 Q. So specialist services for dementia, as well?

18 A. Yeah.

19 Q. Can I ask you a little bit about, then, the ward
20 environment, which also touches upon, I think, your
21 approach to self-harm. You say at paragraph 25 of your
22 witness statement that when you:

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

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

4 A. Mm-hm.

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

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

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

19 A. Yeah.

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

25 A. Mm-hm.

1 Q. -- effective, that's the words you used.

2 A. Yeah.

3 Q. And you say that -- and this is your paragraph 26:

4 "Our first question was 'Do you feel better?' or

5 'Did it help?' rather than immediately to medicate or

6 increase observation level or remove all items from

7 their room."

8 A. That's right.

9 Q. And you say:

10 "I don't think, however, that senior management were

11 fully in agreement and I don't believe our approach was

12 replicated on other wards."

13 A. Yeah, that's right yes.

14 Q. And again, you've already touched on this but do we take

15 from that that the preference of what was then NEPT

16 senior management was to increase observation levels or

17 to remove items?

18 A. Yes.

19 Q. And you disagreed with that approach?

20 A. Yes, I did, yes.

21 Q. Why did you disagree with that approach?

22 A. My views of self-harm are very much that it's an

23 expression of emotion, it's not a behaviour, it's not

24 a suicide attempt; it's the way someone has expressed

25 themselves. And there would -- often the person would

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

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

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

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

20 A. Yeah.

21 Q. -- rather than reaction of --

22 A. Absolutely.

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

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

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

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

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

13 A. Yeah.

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

15 A. Yeah.

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

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

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

1 consequence?

2 A. Yeah, I think it was certainly an abundance of caution.

3 But I think the patient would -- often felt they were

4 being punished because of it.

5 THE CHAIR: Then just to test your approach, do you think

6 there were occasions on which a patient continued to

7 self-harm because you had not taken away

8 -- (overspeaking) --

9 A. No, I don't remember any. I think the approach we took

10 was very refreshing for the patient, as well. They

11 would be relieved of the fact that we were saying "It's

12 not a bad thing you've done, this is how you've

13 expressed yourself, what's happening", you know, rather

14 than just a blanket approach of this is -- because

15 that's what they were used to.

16 MS HARRIS: Can I just pick up on the Chair's question

17 there?

18 A. Yes, of course.

19 Q. Which is -- you've talked about removal of razors but

20 can I just be clear, does that mean with your approach

21 there would have been occasions or there may have been

22 occasions where you would have left someone who

23 self-harmed with access to an item with which they'd

24 self-harmed or something else they could self-harm with?

25 A. No, absolutely.

1 Q. You'd remove the risk item?

2 A. Yeah, absolutely.

3 Q. In that sense, in the sense of the approaches described,
4 would you agree that you personally took something of a
5 permissive approach to self-harm?

6 A. No.

7 Q. Would you describe it as more of a positive approach,
8 rather than a permissive approach?

9 A. I don't agree, I would -- again, going back to being
10 a humane approach, I think it's an understanding of what
11 the person's going through and a collaborative approach
12 is how we can manage these instances if you feel like
13 that in the future.

14 Q. Was that collaborative, positive approach, however you
15 want to describe it, was that supported by NEPT's
16 policies or procedures or was this --

17 A. I don't recall --

18 Q. Were you out there, so to speak, with this approach?

19 A. I don't --

20 Q. An outlier?

21 A. No, I don't think so because the approach was about
22 kindness and compassion and engaging with the patient.
23 And if there was ever a policy against that, I haven't
24 seen it.

25 Q. Just in terms of practical steps, would giving a razor

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

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

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

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

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

24 A. Yeah.

25 Q. -- when they felt like --

1 A. Yeah, but that certainly doesn't mean it didn't happen.

2 Q. You say it didn't mean it didn't happen?

3 A. No.

4 Q. Okay. In terms of the environment more generally, and

5 I'll keep an eye on the time, if we maybe move a little

6 bit and then I know we have to break at a certain time,

7 I think for the transcriber but we have got a few more

8 moments.

9 A. Sure.

10 Q. In relation to the ward environment of Finchingfield

11 more generally you explain how it was initially quite

12 difficult to manage, there were dormitories sometimes

13 with six people in.

14 A. Yeah.

15 Q. It was difficult as a physical environment to manage,

16 I think you say.

17 A. Yeah.

18 Q. But ultimately you moved to shared rooms and then single

19 rooms?

20 A. Yeah.

21 Q. But that thought was given as to who to put together in

22 that shared room?

23 A. Yeah.

24 Q. You have already said in your evidence, and it's in your

25 witness statement at paragraph 44, that you always

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

3 A. Yeah.

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

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

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

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

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

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

19 Q. All right.

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

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

23 A. Yeah.

24 Q. Particularly on women who may have been abused?

25 A. Yeah.

1 Q. And when men may be intimidating --

2 A. Yeah.

3 Q. -- and you deal with that at paragraph 45.

4 You also say that while you were there the Linden

5 Centre became what you describe as increasingly

6 restrictive and evolved into something more like

7 a secure unit --

8 A. Yeah.

9 Q. -- you felt?

10 A. Yeah.

11 Q. In what way do you feel it became more locked up?

12 A. It was physically extra doors put in place. It used to

13 be just the door to Finchingfield and then you had the

14 reception and then out, and then there became a door in

15 between Finchingfield and reception and then another

16 entrance after reception. So yeah.

17 Q. Do you remember when those changes took place?

18 A. I think it was towards the end of my time there.

19 Q. But while you were there?

20 A. Yeah, certainly one of them did, but then I think when

21 I visited Linden Centre as -- from the community it

22 seems there was extra, yeah.

23 Q. So when you went back?

24 A. Yeah.

25 Q. And what were staff told about those changes and why

1 they were happening?

2 A. They just happened.

3 Q. Did they have an impact on inpatients that you saw, it

4 becoming more locked up?

5 A. I couldn't say, because people were locked up anyway.

6 Even though it's an acute admission ward, there was

7 still -- you still had to ask permission for a staff

8 member to let you through a door and then through

9 another door. So I think maybe the extra two doors

10 wouldn't have made much difference, really. It just

11 felt, as a member of staff, that you were walking into

12 a more secure --

13 Q. I understand. Did there remain a practical distinction

14 between the voluntary and involuntary patients on the

15 ward?

16 A. Not in terms of security.

17 Q. Did you raise concerns about the increased restrictions

18 and the fact that the unit felt more locked up?

19 A. Only amongst ourselves. I don't believe I raised them,

20 because the work was just done and then that was it. We

21 weren't consulted at all about anything like that.

22 Q. You also say in your statement, this is at your

23 paragraph 50, that:

24 "As the ward environment became more restrictive it

25 made people more likely to want to leave when they had

1 the chance."

2 A. Yeah, yeah.

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

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

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

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

17 Q. Did you ever authorise absconsion as leave
18 retrospectively?

19 A. No.

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

24 A. Okay.

25 Q. When you made your statement you were asked about

1 ligature risks on the ward --

2 A. Yeah.

3 Q. -- just dealing with ward environment. And you say that

4 the day after Benjamin Morris died, to which you've

5 already referred, which was Christmastime 2008 --

6 A. Yeah.

7 Q. -- you went to Galleywood Ward which is where he had

8 died?

9 A. Yeah.

10 Q. And you discovered the type of wardrobe door handle that

11 had been used?

12 A. Yeah.

13 Q. And you went back to Finchingfield Ward --

14 A. Yeah.

15 Q. -- in order to take them off in Finchingfield Ward?

16 A. Yeah.

17 Q. And you were told by your clinical manager, then your

18 line manager, which was Stuart McGough --

19 A. Yeah.

20 Q. -- that you were damaging -- or you would be damaging

21 Trust property --

22 A. Yeah.

23 Q. -- and it was a job for Estates?

24 A. Yeah.

25 Q. Did you in fact physically -- did you get to physically

1 take any of those handles off in Finchingfield?

2 A. Yeah, I had an electric screwdriver in the car and

3 I physically took them off.

4 Q. You had an electric screwdriver and you took them off?

5 A. Yeah, I took them off.

6 Q. And were you made to put them back on again?

7 A. Yeah, I refused to put them back on again.

8 Q. You refused to put them back on?

9 Did somebody else as far as you are aware?

10 A. Yeah, Estates put them on.

11 Q. Were they eventually removed?

12 A. I believe so, yeah, I can't remember, to be honest.

13 Because it wasn't long after that that I left the Linden

14 Centre.

15 Q. And to the best of your recollection, it was Stuart

16 McGough that --

17 A. I think so, yeah. I can't be for sure. It was someone

18 of a higher level.

19 Q. So it might not have been Stuart McGough --

20 A. Yeah.

21 Q. -- but another manager?

22 A. Yeah, yeah.

23 Q. Someone at a higher level to you?

24 A. Yeah.

25 Q. Is that the only time when you were on Finchingfield

1 Ward that a ligature risk was identified?

2 A. I don't know, there would be sort of regular I think

3 yearly inspections when -- (overspeaking) --

4 Q. I was about to ask you about those. Did those yearly

5 inspections take place as far as you remember?

6 A. Yeah, I think so, yeah. I mean, I was always aware of

7 again, when I found somebody hanging at Warley Hospital

8 after I'd been qualified a year, there was always --

9 that whole situation stayed with me and still does so

10 I was all always intent on -- I would always be

11 wandering around the ward just kind of making sure

12 things were okay and one of the things that I was

13 regularly doing was, if we had a toilet that was out of

14 order, which wasn't an infrequent thing, because it had

15 lots of people using it, the process was always -- the

16 sign would be put on it and the door would be locked and

17 I was always insistent that that door remain open

18 because if somebody wanted to harm themselves, nobody

19 would look inside a toilet that was out of order. So

20 it's --

21 Q. Did you consider, then, that your -- you've already

22 described how you wandered around the wards?

23 A. Mm.

24 Q. So we had the yearly inspections that you say you think

25 were taking place?

1 A. Yeah.

2 Q. But you considered that in addition to those inspections
3 you needed to be hypervigilant?

4 A. Yeah, absolutely.

5 Q. Were you that vigilant when you worked on other wards or
6 was it just Finchingfield you felt you needed to be
7 particularly vigilant about?

8 A. Certainly Ardleigh Ward, as well. Like I said,
9 a situation when I first -- sort of a year after being
10 qualified and that stayed it me, and like I say, still
11 does, so that vigilance never changed, wherever
12 I worked.

13 Q. More generally, whose responsibility was it, then, to
14 assess the environmental risks on the ward?

15 A. As a Ward Manager I would say it's my responsibility to
16 make sure the ward was safe.

17 Q. The time you were told, which you refused, you made
18 clear, to put the handles back on --

19 A. Yeah.

20 Q. -- did you escalate your concerns about that to anybody?

21 A. Yeah, certainly to Stuart McGough, yeah.

22 Q. Did you say to Stuart McGough?

23 A. Yeah.

24 Q. Or whoever the manager was --

25 A. No, I certainly spoke to Stuart McGough about -- about

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

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

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

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

9 A. Yeah.

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

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

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

23 A. Yeah, absolutely.

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

1 A. Sure.

2 Q. And it's around the question of razorblades.

3 A. Yeah.

4 Q. Firstly this: we talked about access to razors,
5 sometimes when razors were taken away.

6 A. Mm.

7 Q. Would there have been times when a request may have been
8 made by a patient for a razor and they would have been
9 allowed that razor unsupervised?

10 A. I'm sure it would have happened. It shouldn't have
11 happened but that doesn't mean it didn't happen --

12 Q. I mean perhaps for washing or -- for bathroom reasons or
13 things like that?

14 A. I don't specifically -- I don't recall, to be honest.
15 I mean, if there was somebody who was absolutely no risk
16 of self-harm and it wasn't in their make-up at all and
17 there was no risk there, it may have happened, yeah.
18 I can't recall specifically.

19 Q. So you can't recall but it may have happened?

20 A. Yeah.

21 Q. So maybe you won't be able to answer this question,
22 which is that if there were concerns around self-harm,
23 in respect of that patient --

24 A. Yeah, yeah.

25 Q. -- would that patient have allowed -- (overspeaking) --

1 A. They certainly should not have been, no.

2 Q. You say they should not have been?

3 A. No, no, definitely not.

4 Q. You also talked about taking razors away.

5 A. Mm-hm.

6 Q. But it's -- this is my fault, I didn't ask you

7 specifically about other potential items of risk --

8 A. Yeah, yeah, other items, yeah --

9 Q. -- in a room. So you've already told us on Galleywood

10 they took everything out --

11 A. Yeah.

12 Q. -- and you felt that was quite punitive?

13 A. Yes.

14 Q. On Finchingfield Ward would you take out other items,

15 for example, potential items that could be a potential

16 ligature or something of that nature?

17 A. Yes, absolutely, yeah.

18 And if there's a family photograph in a picture

19 frame, and it had a glass frame, we'd take the

20 photograph out, leave the photograph, and take the frame

21 and stuff like that.

22 Q. So you'd remove other items of risk?

23 A. Yeah.

24 Q. But what about items you can't remove, for example

25 headbanging is a particular form of self-harm?

1 A. Yeah, it is, yeah.

2 Q. How would you manage that in those circumstances?

3 A. That may have been one of those occasions where people

4 were put on level 3 observations for a period of time to

5 manage that level of distress and again to talk to the

6 person to bring down that level of distress and engage

7 with them. And medication, as well, maybe, on those

8 occasions.

9 Q. All right, thank you very much.

10 A. Okay.

11 Q. Let's pick up, then, with medication.

12 A. Sure.

13 Q. Because that was what I was going to ask you next

14 anyway. You've already alluded to it and at

15 paragraph 29 of your first witness statement you say

16 that -- you describe a culture of overly medicating

17 patients, in your view?

18 A. Yeah.

19 Q. And you say at paragraph 30 in your view the use of

20 night sedation was excessive and led to patients

21 becoming dependent on it?

22 A. Yes.

23 Q. And again, let's just be clear, we're talking about your

24 time on Finchingfield here --

25 A. Yes.

1 Q. -- it would appear from your statement.

2 Did you yourself witness patients being

3 over-sedated?

4 A. Yes.

5 Q. Did this include elderly patients?

6 A. In terms of the older adult -- in terms of the older

7 adults that were on the ward, yes, yeah.

8 Q. Sorry, maybe the word "elderly" was -- older adults.

9 A. Yeah, sorry.

10 Q. Would it have included patients that had other medical

11 conditions, renally impaired patients, for example?

12 A. I would assume that the doctors would have taken that

13 into account when they were prescribed but I can't be

14 sure.

15 Q. Are you aware of any instances where this

16 over-medication or this culture of over-medication led

17 to patients being harmed?

18 A. I think anyone is harmed if they take medication they

19 don't need to the levels that they need it (sic). My

20 big issue was that behaviours were medicated as opposed

21 to looking at why somebody behaved in a certain way.

22 I've always believed that if -- that people are allowed

23 to be angry, it's part of the human condition. And

24 certainly on the an acute admission ward, if you don't

25 want to be there, you're going to be angry. That

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

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

6 A. Yeah.

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

9 A. Yeah.

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

11 A. Yeah.

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

15 A. Yeah.

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

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

1 sleep?

2 Q. You also say at paragraph 31 of your witness statement
3 that you considered where would come a part when doctors
4 would ask patients -- these are your words -- what they
5 want to be on?

6 A. Yeah.

7 Q. And you considered that this abdicated professional
8 responsibility --

9 A. Yeah.

10 Q. -- and you think it was to avoid complaints. Can I just
11 ask you a couple of questions about that. Firstly, did
12 you raise that concern with anybody?

13 A. Yes, I did this was on Ardleigh Ward.

14 Q. Right, so this is The Lakes, is it?

15 A. Yes, The Lakes, yes.

16 Q. I'll continue asking you about it, though, even though
17 it's in the middle of our Finchingfield evidence.

18 Who did you raise it with?

19 A. The manager. The Ward Manager. And with the doctors.

20 Q. Why do you think -- you say you thought it was to avoid
21 complaints?

22 A. Yeah.

23 Q. What -- why do you think they were doing it or what was
24 your view?

25 A. When I went to Ardleigh Ward the overriding thing seemed

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

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

11 A. Yes, absolutely.

12 THE CHAIR: They know what they respond to --

13 A. Yeah.

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

15 A. Yeah, absolutely.

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

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

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

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

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

7 A. -- (overspeaking) --

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

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

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

13 A. Yes, it is absolutely.

14 THE CHAIR: And medication.

15 A. Yeah.

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

18 A. No, absolutely not, no.

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

22 A. Yes.

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

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

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

7 THE CHAIR: Thank you.

8 MS HARRIS: Thank you.

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

13 A. Yeah.

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

16 A. That's right.

17 Q. Did you ever escalate that --

18 A. Yeah, absolutely.

19 Q. Who to?

20 A. The Ward Manager.

21 Q. What was the outcome?

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

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

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

6 A. No.

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

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

18 Q. Not at NEPT or EPUT?

19 A. No.

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

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

1 THE CHAIR: The patients did feel?

2 A. Yeah.

3 MS HARRIS: So you're aware that patients felt that?

4 A. Yes, yeah.

5 Q. Do you agree -- do you consider, sorry, not agree, do
6 you consider over-sedation to be an abuse of position?

7 A. Yes.

8 Q. And degrading to patients?

9 A. Yeah, yeah, absolutely.

10 Q. You describe safeguards I think in place in relation to
11 rapid tranquilisation which is something different.

12 A. Yeah.

13 Q. Do you consider that there were insufficient safeguards
14 in place around sedation and over-sedating patients?

15 A. It's difficult to answer, I'm afraid. Yeah, I don't
16 know.

17 Q. What about systems in place to monitor whether staff
18 were over-sedating? Was that being monitored? Were
19 there systems in place?

20 A. Not specific staff. At each ward review they would look
21 at the medication card and see how many times -- it's
22 called PRN medication was given. There'd be
23 a combination of it being given by staff or asked for by
24 a patient. Sometimes patients wanted extra medication
25 if they were in distress.

1 Q. You say you recall that patients felt over-sedated?

2 A. Yeah.

3 Q. Would a record have been kept of those patients making

4 those complaints?

5 A. Yeah, any conversations that we had with patients would

6 be written up by that particular nurse in the nursing

7 notes.

8 Q. Would they be kept under review --

9 A. Yeah.

10 Q. -- if you'd certainly got a number of patients?

11 A. Yeah.

12 Q. And then what would happen?

13 A. You'd speak to the doctor in the ward reviews. And I'd

14 say the doctors on Finchingfield were good at listening

15 to the patient's view on that type of thing.

16 Q. Just moving on, if I may, to staffing. Again,

17 Finchingfield Ward, you talk about four members of

18 staff, I think two qualified and two unqualified you

19 say. This is paragraph 20 of your witness statement.

20 A. Yeah.

21 Q. What do you mean by "unqualified"? What do you mean by

22 unqualified?

23 A. Support workers, yeah.

24 Q. Because I think you said you didn't really distinguish

25 between the different grades --

1 A. No.

2 Q. -- because I think you said people were there to help
3 people.

4 A. Yeah, the qualified were qualified nurses and the
5 support workers were -- had no specific qualifications
6 for the role.

7 Q. What kind of responsibilities did the support workers
8 have?

9 A. General, to be around helping patients in terms of how
10 the ward worked, menial tasks like helping with making
11 beds if the patients weren't able to do that, keeping
12 the areas clean. That was kind of the basic task but
13 the personality of the person would make a massive
14 difference to the patients, as well. They'd always
15 spend time with the patients. They would generally be
16 the ones that would be in the day area and be visible
17 for the patients. And I don't think the patients often
18 knew the difference between -- because we didn't wear
19 uniforms back then.

20 Q. What training did the support workers have?

21 A. I think some of them did NVQ courses, you certainly
22 didn't need a qualification to get the job on the ward
23 but they did all the mandatory training that was
24 required of them and NVQ courses in care.

25 Q. And who was responsible for supervising them?

1 A. The qualified staff. Sorry, the nursing staff, yeah.

2 Q. You mention having no particular problems with staffing
3 on Finchingfield Ward?

4 A. Yeah.

5 Q. But you talk about understaffing at The Lakes,
6 I think --

7 A. Yeah, and on Galleywood Ward, yeah.

8 Q. And on Galleywood Ward?

9 A. Yeah.

10 Q. And you would describe bank and agency staff?

11 A. Yeah.

12 Q. What's the practical difference between bank and agency
13 staff?

14 A. Bank staff were generally -- a regular member of staff
15 can do extra hours on the nurse bank, and that's
16 generally what we would use, and also bank staff would
17 have to be interviewed by the Trust to be employed as
18 a bank member of staff, whereas an agency staff would
19 come from outside of the Trust.

20 Q. So bank were employed by the Trust?

21 A. Yeah.

22 Q. Agency weren't?

23 A. Yeah.

24 Q. Was there a particular process which the Trust used, as
25 far as you were concerned, to fill gaps with bank staff

1 before going to agency staff?

2 A. Yeah, I think -- I can only speak for Finchingfield

3 Ward --

4 Q. Of course.

5 A. -- is most of our shifts were filled up with staff that

6 wanted to do extra hours and on the occasion we couldn't

7 fill that, we had the numbers of different bank staff

8 that we'd phone up and say, "Can you do this shift" and

9 then there was a bank kind of administrative place where

10 we would phone up and say "We've covered this shift".

11 If we couldn't cover a shift, they would then try and

12 phone around to get the shift covered for us.

13 Q. So it would be overtime followed by bank, followed by

14 agency --

15 A. Yeah, there was no overtime it was still bank --

16 Q. No, you said extra hours, people doing extra hours?

17 A. Yeah, on bank.

18 Q. On bank?

19 A. Yeah.

20 Q. Okay.

21 A. Then if they couldn't be filled, then you'd have to ask

22 the clinical manager for admission to go to an agency to

23 get staff in.

24 Q. Can I ask about the impact of bank and agency staff.

25 A. Mm-hm.

1 Q. It may be the answer is different for the two of them
2 from what you're describing.

3 A. Yeah.

4 Q. So what impact does filling gaps with bank staff or
5 agency staff have on the quality and frequency of
6 observations or the engagement that you've already
7 described to us, or empathetic connection between staff
8 and patients? How does that play out on the ward?

9 A. On Finchingfield, like I said, the majority of the staff
10 member would do bank as well. So in essence it kind of
11 wasn't much difference to the patients. They didn't
12 know that person was doing an extra shift or whatever.
13 And if we had a bank member of staff that was really
14 good we would keep asking them to come back so then they
15 would get to know the patients on the ward.

16 In terms of agency staff, we didn't have much use
17 for them on Finchingfield, but my impression that when
18 they came was that they were there to do the hours and
19 they had no real interest in anything other than
20 finishing the shift.

21 Q. And I think you referred to understaffing at The
22 Lakes --

23 A. Yeah.

24 Q. -- which I know is later on?

25 A. Yeah.

1 Q. Did you have more agency staff at The Lakes then?

2 A. Yeah.

3 Q. And you say there was -- I don't want to put words in

4 your mouth -- a significant difference then --

5 A. -- yeah.

6 Q. -- in the care provided by agency staff to bank staff?

7 A. Yeah.

8 Q. Is that what I'm taking from this?

9 A. Yeah, both in terms of ability and interest, to be

10 honest.

11 Q. Can I ask you about transfers?

12 A. Yeah.

13 Q. Something else you refer to in your statement.

14 You refer to transfers and I think again we're

15 dealing with Finchingfield --

16 A. Yeah.

17 Q. -- mostly. You say the need would be determined by

18 a doctor.

19 A. Yeah.

20 Q. And it would be based on clinical need?

21 A. Yeah.

22 Q. And in your experience you say -- this is your

23 paragraph 23:

24 "It was usually when someone needed to move to

25 a more secure unit."

1 A. Yeah.

2 Q. And it was the Christopher Unit, I think, for the most
3 part?

4 A. Yeah.

5 Q. And you describe the process where two people would come
6 from the Christopher Unit?

7 A. Yeah.

8 Q. There would be a face-to-face assessment?

9 A. Yeah.

10 Q. You're -- you're -- I'm summarising but tell me if I've
11 got this wrong. Then you describe a tension because
12 sometimes the staff from the Christopher Unit would
13 determine that your ward was fine with the risk?

14 A. Yeah.

15 Q. You could contain the risk?

16 A. That's right.

17 Q. And you consider that that came about because of,
18 really, for a resource issue because there came a time
19 when the Christopher Unit was really the only secure
20 unit to refer to?

21 A. That's right, yes.

22 Q. And I think you've already told us it was small, would
23 you say six -- (overspeaking) --

24 A. At the time it was six or seven beds but I understand
25 that over the years it's grown, it's got an extra wing

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

3 Q. But at that time it was smaller?

4 A. Yeah, it was.

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

7 A. Yeah.

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

10 A. Yeah.

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

12 A. Yeah.

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

15 A. Yes, it was known.

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

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

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

25 A. Yes, it was, yeah.

1 Q. Did you ever escalate it as an overall and ongoing
2 concern?

3 A. I don't think so because it wasn't that frequent that we
4 had to refer someone to the Christopher Unit.

5 Q. Right. Did it persist, though? Did that problem, that
6 persist throughout your time there?

7 A. It did very much depend on the member of staff from the
8 Christopher Unit that did the assessment. It felt like,
9 different people had different thresholds for what they
10 felt was appropriate.

11 Q. Were you aware then, having escalated, of any attempt to
12 address the problem to bring the consistency in?

13 A. No, no, I don't remember anything being fed back.

14 Q. In terms of the Christopher Unit being the only secure
15 place to refer people, when -- was that -- did there
16 come a time when -- when did that become the position?

17 A. At a time when I was on Finchingfield, I'm quite sure
18 there was two other secure units, one in Harlow called
19 Shannon House and I think Maple or Cedar Ward in
20 Colchester. And they did both close down, one and then
21 the other, but I don't know what period of time that was
22 over. And there was a new secure unit built at the back
23 of Finchingfield called Edward House. Again, I'm not
24 sure when that was.

25 Q. And in terms of, then, of the -- you being limited to

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

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

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

12 A. Yeah.

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

15 A. Yeah.

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

17 A. Yeah.

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

20 A. Yeah, absolutely.

21 Q. But you were unaware of that?

22 A. Yeah, absolutely.

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

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

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

9 A. Yeah.

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

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

17 Q. And did you ever raise concerns about that?

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

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

22 A. Yeah, absolutely, yeah.

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

1 A. Yeah.

2 Q. All right. You refer to transfer decisions being doctor
3 led with little patient or family involvement?

4 A. Yeah.

5 Q. Why was that the case?

6 A. I think I'm referring there to the specific incident
7 from where I worked in the community and I had a patient
8 on a secure ward in Colchester.

9 Q. We'll come back to that in a moment in fact and
10 everybody found out about it after the event?

11 A. Yeah.

12 Q. Is that the incident you're referring to?

13 A. Yes.

14 Q. All right. But in terms of, then, patients and their
15 families to out-of-area transfers, were they informed
16 about those? Were patients and families involved in
17 that?

18 A. Yeah, they were, I don't remember there being many -- do
19 you mean by out of area by out of the Trust?

20 Q. Yes.

21 A. I don't remember there being many of them to be honest,
22 or any examples. Certainly, if they were, the families
23 should have been informed beforehand.

24 Q. Perhaps you would want to answer this question more
25 generally, but it may be that you can link it to

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

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

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

15 A. Bed availability, yeah.

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

20 A. Yes.

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

23 A. Yeah.

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

25 A. That's right, yeah.

1 Q. Did that apply to out-of-area placements, as well?

2 A. Yes.

3 Q. So the care coordinator should have been invited to

4 those --

5 A. Yeah.

6 Q. -- reviews as well?

7 And what was your understanding of the role and

8 oversight of a transferring Trust for the ongoing care

9 of patients in a receiving Trust?

10 A. I don't know, to be honest.

11 Q. Can you help us with any reasons, to the best of your

12 knowledge why care coordinators didn't attend the ward

13 reviews on the receiving units?

14 A. Not at the time. It may have been if they were told at

15 the last minute because a care coordinator will have

16 five or six appointments in their diary booked from the

17 week before. So often it would be difficult for them to

18 get to something if they've only got an hour's or

19 a day's notice, even.

20 Q. And this is where I think in your statement you do refer

21 to your experience from when you were a care coordinator

22 later on --

23 A. Yeah.

24 Q. -- and you talked about the patient that was moved to a

25 secure unit without your knowledge?

1 A. Yeah.

2 Q. Without the next of kin being informed?

3 A. Yeah.

4 Q. And you found out after the event?

5 A. Yeah.

6 Q. Did you complain about that?

7 A. Yes, I did, yeah.

8 Q. Can you just give us a time period for that?

9 A. That would have been probably within the first two years

10 that I was at Maldon Community Mental Health Team, so

11 that was 2009 maybe, 2010. Something like that.

12 Q. Did you receive any feedback from that complaint?

13 A. No, no.

14 Q. You also explain in your second witness statement that

15 there are different processes in place for communication

16 with a care coordinator after a transfer of a patient.

17 And it depends on, or it's determined by, whether they

18 went to North Essex-based facilities?

19 A. Yeah.

20 Q. Or South Essex-based facilities?

21 A. Yeah.

22 Q. And if it was a previous North Essex facility then you

23 could follow progress better because the records would

24 be on the Carebase or Paris system?

25 A. Yes.

1 Q. Have I understood this correctly?

2 A. Yes.

3 Q. But if a patient is transferred to a South Essex, what

4 was previously a SEPT facility --

5 A. Yeah.

6 Q. -- it was still the use of SystemOne --

7 A. Yes.

8 Q. -- which was a different system?

9 A. Yes.

10 Q. So you couldn't get information?

11 A. No.

12 Q. How -- until how recently did that persist?

13 A. I'm pretty sure it persisted until I retired.

14 Q. So when you retired in 2024 --

15 A. Yeah.

16 Q. -- there was still this anomaly between the two

17 systems --

18 A. I think so --

19 Q. And it depended literally on where you were sent.

20 A. Yes.

21 Q. So if you were in a North Essex facility everybody could

22 get better information about what was happening?

23 A. Yeah.

24 Q. All right. Can I ask you about staff attitudes. You

25 explain in your witness statement, first witness

1 statement at paragraph 39, that you'd heard a bit about
2 -- you'd heard something about difficulties with staff
3 attitudes during the courses that you
4 -- (overspeaking) --
5 A. Yeah.
6 Q. Is that the training you've already talked to us about?
7 A. Yeah.
8 Q. So what period of time are we talking about that you'd
9 heard about difficulties --
10 A. Kind of throughout the time I was the control and
11 restraining instructor. There was lots of space within
12 those four days of training or two days refresher
13 training where staff would sit down and just talk about
14 their own areas. Sometimes we would encourage that as
15 part of the course, but sometimes it would be during
16 breaks and stuff like that.
17 Q. So is it a kind of keeping one's ear to the ground?
18 A. Yeah.
19 Q. And you said you did training, I think you said, until
20 about 2015?
21 A. Yeah.
22 Q. And what kind of things were you hearing, then, about
23 staff attitude?
24 A. Basically it was more to do with the attitudes of their
25 managers. Predominantly people felt overwhelmed, they

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

10 Q. So you were --

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

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

14 A. Yeah.

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

17 A. Mm-hm.

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

21 A. Yeah.

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

1 A. Yeah, absolutely, yeah.

2 Q. And you insisted that the door remain open?

3 A. Yeah.

4 Q. That one person would stay in the office but all of the

5 others should be out on the ward?

6 A. Yes.

7 Q. But it didn't sit well with the staff?

8 A. No.

9 Q. What was their issue with it?

10 A. I think the issue was that they were having to engage

11 with the patients. I don't think it was something that

12 a lot of them wanted to do. They weren't happy at work.

13 THE CHAIR: Can I ask you about this, because this also

14 arises in relation to your nursing model --

15 A. Yeah.

16 THE CHAIR: -- which you described as existing staff being

17 resistant to --

18 A. Yes.

19 THE CHAIR: -- and not enjoying. Is that a case of learnt

20 behaviour? Is it a case of or was it a case of actively

21 not wanting to do the things you're suggesting? Or was

22 it just because they had been led to expect a different

23 thing of how they should work? What do you attribute

24 that resistance to these changes?

25 A. I think there's -- I think there's some learned

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

2 THE CHAIR: Yes.

3 A. And also, the hardest part of working on a ward is

4 engaging with the patients. It's very emotional, it's

5 very draining and it's very difficult and some people

6 either didn't want to do that or they had had enough of

7 doing that and they kind of just become enclosed. And

8 by shutting themselves in the office with their

9 colleagues it felt safer for them, and I was asking them

10 to break out of that, which was resisted.

11 THE CHAIR: So it was more, really, to do with their

12 willingness or their personality themselves.

13 A. Yeah. It was the individuals, yeah.

14 THE CHAIR: The individuals. Thank you.

15 MS HARRIS: Thank you, Chair.

16 Because you then go on to explain that senior

17 management introduced this concept of the PET time, the

18 Patient Engagement Time.

19 A. Yes.

20 Q. Where for one hour a day staff phones would be off, the

21 office door would be shut in the right way, with the

22 staff on the patient side, and staff were to dedicate

23 their time to patients.

24 A. Mm-hm.

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

1 way round?

2 A. Yes.

3 Q. They should have had a dedicated paperwork hour --

4 A. Yeah.

5 Q. -- and the rest of the time staff the staff should be

6 out. Does that mean, then, that for this PET time, with

7 this hour of PET time, that for the rest of the working

8 day, staff were able to use their personal mobile

9 phones?

10 A. Sorry, it wasn't their own phones, it was the office

11 phone.

12 Q. The office --

13 A. The office phone, yeah. Yeah, my argument was if you're

14 not engaging with the patients what are you doing with

15 your time? You know. So I told my staff to ignore that

16 completely and carry on doing what we were doing.

17 Q. When was it introduced? Do you remember?

18 A. It would have been towards the end of my time on

19 Finchingfield, I think.

20 Q. And who was responsible for determining that one hour

21 patient engagement time was enough?

22 A. That was just something that came down to us.

23 Q. Did you yourself, particularly in the beginning, observe

24 staff failing to engage, then, with patients?

25 A. Yeah, yeah.

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

1 A. Yeah. Patients -- there was always a big affinity on
2 the ward. I think because it was generally a reasonably
3 good atmosphere, if you can have one in those types of
4 places, and there was a lot of time that patients spent
5 with each other, yeah definitely.

6 Q. Sorry, just to make a distinction, so patients looking
7 after patients, anyway because of the atmosphere, but
8 did you ever observe patients looking after patients
9 because there was no one --

10 A. No.

11 Q. -- no staff to do it?

12 A. No, I don't recall an incident there. You would get
13 patients come to you and say, "So and so is upset" and
14 things like that, and then -- that kind of thing.

15 Q. We have touched on some of the differences between
16 Finchingfield and Galleywood. And in your statement at
17 paragraph 41, you use the phrase "a distinct divide"?

18 A. Yeah.

19 Q. Galleywood was managed by your colleague Rahma Saibon?

20 A. Yeah.

21 Q. And you said you tried to foster a general atmosphere of
22 positivity but you felt isolated --

23 A. Yeah.

24 Q. -- because she had been in post for years.

25 A. Yeah.

1 Q. Put shortly, what were the difference, then, in yours
2 and her management styles and approach?

3 A. In terms of -- obviously I've not worked for Rahma so
4 it's difficult to say how it felt to work there but
5 having gone on the ward and it was quite a dreary place.
6 There was -- almost every time one of us went to
7 Galleywood Ward, the office door was shut and a lot of
8 the staff were in the office. There'd be times where
9 we'd phone from Galleywood Ward for something, get no
10 answer and go over there and find staff in the office.

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

19 Q. Can I ask you about some of the specific differences, if
20 there were any.

21 A. Yeah.

22 Q. How did their approach to self-harm differ? Do you
23 know?

24 A. Yeah, it was very much a case of increasing
25 observations, then removing items -- stripping people's

1 rooms, yeah.

2 Q. So that's what you described as you thought the punitive
3 approach?

4 A. Yeah, yeah.

5 Q. What about their approach to level 3 observations?

6 A. They would almost always have somebody on level 3
7 observations, sometimes two people, sometimes three
8 people.

9 Q. How were the fact that there were differences overseen
10 and managed?

11 A. I think more or less every morning myself and Rahma and
12 the manager of the day hospital would have a meeting
13 with Stuart McGough in the mornings, and any issues that
14 we had to bring to him, we would. How issues on
15 Galleywood were managed, I wouldn't have been privy to.

16 Q. Sorry, it may be my fault in the way I asked the
17 question, but were there any concerns about the fact
18 that the two wards were doing things very differently?

19 A. I don't know. I don't know. We just carried on doing
20 the way I thought it should be done.

21 Q. And given that there were different approaches, it would
22 appear, from the two wards, were you ever given clinical
23 input for the correct approach for individual patients?

24 A. No, no.

25 Q. Were you ever concerned, on Finchingfield, that your

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

3 A. No, no.

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

6 A. Mm --

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

9 A. Yeah, yeah.

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

12 A. Yeah.

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

15 A. Absolutely, yeah.

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

18 A. Yes.

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

20 A. Yeah.

21 THE CHAIR: -- not the answer?

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

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

17 THE CHAIR: Thank you.

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

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

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

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

9 A. Sure.

10 Q. Can I just ask you about risk assessments.

11 A. Yeah.

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

19 A. Yeah.

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

21 A. Yeah.

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

25 A. Yeah.

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

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

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

21 Q. So no learning disseminated from any of this?

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

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

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

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

8 Q. Yes. As you --

9 A. Yeah.

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

11 Where were the books kept?

12 A. Just in my office on the ward.

13 Q. Did you ever chase for any feedback?

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

19 Q. And --

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

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

1 A. I don't know, certainly, my priorities when I was on the
2 ward was making sure people were safe and okay and that
3 the incident book wasn't on a high list of my daily
4 priorities.

5 Q. Discharge planning, sorry, I'm moving --

6 A. Yeah, it's okay.

7 Q. -- through quite quickly. You describe discharge
8 planning at the point of admission, which is at
9 paragraph 15 of your first witness statement.

10 A. Yeah.

11 Q. What are your views as to whether discharge planning at
12 the point of admission is effective and appropriate?

13 A. It is to a degree if you're looking at the situation the
14 person was in before they got admitted, but during
15 admission, other issues could come to light. And just
16 being on an acute admission ward, as you can imagine, is
17 a trauma in itself. So people can develop anxiety and
18 become distressed. So it is helpful to know from the
19 beginning what needs to happen for somebody to be
20 discharged but other issues can come into play during
21 the course of the admission.

22 Q. What's your view as to the impact that early discharge
23 planning has on patients?

24 A. It is difficult because some patients actually wanted to
25 be in hospital and asked to be there voluntarily and

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

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

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

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

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

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

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

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

10 A. I personally not, no.

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

13 A. Yeah.

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

16 A. Yeah.

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

21 A. Yeah.

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

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

1 Q. So there may have been one --

2 A. Yeah.

3 Q. -- but you just don't remember --

4 A. Yeah, I can't say that things like that didn't happen,

5 no.

6 Q. Okay. And we know that certainly when you started it

7 was a ward with -- a mixed-sex ward with a range of

8 ages.

9 A. Yeah.

10 Q. Are there any cohorts of individuals that you consider

11 to be most vulnerable or at risk of sexual exploitation

12 and abuse?

13 A. Yeah --

14 Q. -- (overspeaking) --

15 A. Usually young females. Yeah, the young females on the

16 ward, yeah.

17 Q. Were you ever made aware specifically of anyone being

18 particularly vulnerable to sexual exploitation or abuse?

19 A. I can't remember, sorry.

20 Q. Is that something that may have happened --

21 A. Yeah, yeah.

22 Q. -- but 20 years have passed?

23 A. Yeah, yeah.

24 Q. If someone had -- if you had been made aware of that,

25 would additional measures have been put in place to

1 monitor them?

2 A. Yeah, yeah, absolutely.

3 Q. And if someone had disclosed to a member of staff that

4 they'd been sexually assaulted on the ward, should that

5 have been brought to your attention as well?

6 A. Oh absolutely, yeah, yeah.

7 Q. And what steps would have been taken to address that?

8 A. I would speak with the patient, get the family involved,

9 the police if necessary, and obviously my Clinical

10 Manager, yeah, that shouldn't happen.

11 Q. Do you ever recall that happening?

12 A. I don't, I'm afraid.

13 Q. Might it have happened?

14 A. Yeah, yeah, absolutely.

15 Q. In terms of additional measures to monitor them more

16 closely, what would they have been?

17 A. They would make sure that when the nursing staff were

18 allocated at the start of the shift that it would be a

19 female member of staff that they were allocated, making

20 sure there was sufficient females on the ward, and

21 making sure everybody was aware of the sensitivity

22 of it.

23 Q. You also say you don't recall any specific risk

24 assessment with regard to sexual safety, but you say it

25 would have formed part of the vulnerability part of the

1 risk assessment?

2 A. Yeah, I think so, yeah.

3 Q. You say that you are convinced more could have been

4 done?

5 A. Yeah.

6 Q. What --

7 A. In all areas of the management of the ward and the way

8 the ward ran, absolutely. In terms of the level of

9 understanding, level of knowledge --

10 Q. Does that include in relation to sexual safety and

11 wellbeing?

12 A. Yeah, absolutely.

13 Q. What steps do you think should have been taken?

14 A. I think there should have been training for staff as to

15 how to -- in those situations. Yeah. I don't believe

16 there was any.

17 Q. Moving on, again quickly, to the question of leave and

18 absconsions. In your second witness statement you

19 provide detail at paragraph 18 about arrangements for

20 leave, which you say would be discussed in

21 a multi-disciplinary ward review.

22 A. Yeah.

23 Q. And that family members would be spoken to before the

24 patient. You state that:

25 "During leave reviews, care coordinator or

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

4 A. Mm.

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

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

11 Q. What factors were considered during leave reviews?

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

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

25 A. Yeah, absolutely.

1 Q. What about factors such as recent self-harm attempts?
2 Would they be part of the discussion?

3 A. Yeah, that would all be part of the risk. Some people
4 would be more at risk, I felt, being on the ward, it was
5 the fact that they were on the ward that sometimes the
6 risk was heightened and it was the distress that may
7 lead someone to self-harm, but it was all discussed
8 because -- sorry, being a patient on a ward with another
9 19 people that were very distressed can cause kind of
10 anxieties that you wouldn't get at home.

11 Q. What was your view, then, of the continuity of care
12 available during periods of leave? And this might have
13 changed, of course, throughout your time working.

14 A. Yeah, it would depend if the care coordinator was
15 available to visit. Because what we tried to do was
16 have leave as part of the discharge process, not
17 somebody wants to go on leave for a couple of days and
18 then come back on the ward for a week. There needed to
19 be a purpose for leave and it needs to be towards
20 discharge. So you would involve the care coordinator
21 with that to visit while they were on leave to then
22 report back, speak to the family to see how it was
23 going.

24 Q. And you would get feedback, I think you say?

25 A. Yeah.

1 Q. Did you ask the patients if you could get feedback from
2 the family?

3 A. Um --

4 Q. Did you get their consent for that?

5 A. I think we would generally, yeah, yeah, yeah. That
6 would definitely be the process. And I think they would
7 understand, because we would try and explain as much as
8 we could to the patients what the processes were. And
9 that would have been part of it.

10 Q. You also refer to the importance of communication
11 between, as you say, the community and inpatient teams.

12 A. Mm-hm.

13 Q. With out-of-area patients, is -- how was that
14 communication expected to operate between the home
15 Trust's community team, if you like, and the inpatient
16 out-of-area Trust?

17 A. Yeah, it was really difficult. It was basically by
18 phone call, really, or email sometimes. You'd try and
19 find out what ward the person was on and you'd try and
20 find out when the ward reviews were, hopefully get given
21 a time for it and then you'd drive down to Basildon and
22 frequently I went down there and the review had either
23 finished or it had been postponed. Yeah, it was really
24 poor in terms of the patient's continuity.

25 Q. Did you observe out-of-area patients slipping through

1 the gaps?

2 A. Yeah, absolutely, yeah.

3 Q. And who would maintain overall responsibility, then,

4 during periods of leave?

5 A. In terms of ...?

6 Q. For the patient's care?

7 A. The ward.

8 Q. The ward?

9 A. Yeah, still the ward, yeah.

10 Q. Again, I'm going to move on quickly. Can I ask you

11 a little bit about clinical records. I think you

12 explain that when a patient was admitted to an inpatient

13 unit, the paper records would be created?

14 A. Yeah.

15 Q. We're going back now some time, aren't we, with your

16 evidence?

17 A. Yeah.

18 Q. But any existing file would have to be requested from

19 the records department which could sometimes take

20 a couple of days?

21 A. Yeah.

22 Q. Because this is the beginning, this is when you're

23 Christopher Unit in Finchingfield?

24 A. Yes, yeah.

25 Q. Does that mean that sometimes people were being assessed

1 on admission but without full access to records?

2 A. Yes.

3 Q. How often would that occur?

4 A. Certainly if people came in during the night or

5 weekends, yeah.

6 Q. I think you also explain, and we've picked up on it with

7 some of the transfers, that if a patient was coming in

8 from a SEPT service --

9 A. Yeah.

10 Q. -- there'd be no access to notes because they were using

11 SystemOne?

12 A. Yes, that's right.

13 Q. You also explain that paper nursing notes were filed

14 separately to medical notes?

15 A. Yes.

16 Q. And you don't recall a doctor ever requesting to see

17 nursing notes?

18 A. No. Maybe sometimes if they had a report to do but

19 certainly not as general -- because it was expected that

20 the nurses would feed back to the doctors what had

21 happened.

22 Q. So they would be reliant on others to provide them --

23 A. Yes.

24 Q. -- the information rather than seek it out for

25 themselves?

1 A. Yes, yeah.

2 Q. What impact do you think that had?

3 A. I think in a way it was not a particularly negative
4 because as a nurse you were able to tell the doctor
5 everything you felt you needed to tell them whereas
6 I think if they just looked in the notes you wouldn't be
7 convinced that they would maybe understand everything or
8 they might pick and choose certain things.

9 Q. So you weren't concerned that doctors were making
10 decisions without the relevant information?

11 A. No, I think it was more comprehensive because before
12 each ward review the nurse would give a rundown of how
13 the patient had been since the doctor had last seen
14 them.

15 Q. A slightly separate question. Did agency staff have
16 access to clinical records?

17 A. Yeah, because they would have to do -- write nursing
18 notes the same as anybody else.

19 Q. And what about records, again for out-of-area
20 placements, where systems may have been different?
21 How -- what was your experience of the access --

22 A. The most you could ever hope for was a Discharge
23 Summary, to be honest. You wouldn't get any up-to-date
24 stuff in between.

25 Q. You've given evidence and I won't ask you any questions

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

3 A. Yeah.

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

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

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

17 A. Mm.

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

20 A. Yeah, it's appalling, yeah.

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

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

24 A. Yeah.

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

1 information --

2 A. Yeah.

3 Q. -- in their records, were there barriers to staff

4 speaking out about that?

5 A. I was always very vocal so as far as I was concerned

6 there wasn't, no.

7 Q. To what extent were staff, certainly on the ward, able

8 to complete records contemporaneously?

9 A. Yeah, it was certainly possible, yeah.

10 Q. Again moving on, I want to ask about patient and family

11 involvement in care.

12 A. Okay.

13 Q. You describe a balance -- within your statement you

14 describe a balance shifting from what the doctor says

15 goes to doctors advocating for their patients and then

16 to a latter stage, which the Chair has already asked you

17 about, about whatever the patient wants, in order to

18 reduce --

19 A. Mm-hm.

20 Q. -- complaints.

21 A. Yeah.

22 Q. You've given examples of where you think, for example,

23 medication was changed too quickly without time for it

24 to --

25 A. Mm-hm.

1 Q. -- to settle in. What prompted the shift, do you think?

2 A. I don't know, because it -- because I'd never worked in

3 that part of the Trust before, I don't know how long

4 that had been a prevailing factor or whether it was

5 because of a certain incident. I didn't know. I just

6 very much noticed the difference.

7 Q. When was it, then, that the shift took place, do you

8 think?

9 A. I don't know. I was working in the community in Maldon

10 which was kind of the different end of the Trust, so --

11 Q. So it was when you were in the community?

12 A. Yeah.

13 Q. What was in place at a systemic level, do you think, to

14 ensure that patients' wishes were properly taken into

15 account into decisions that they disagreed with, if that

16 makes sense?

17 A. There was an advocacy -- had access to advocacy and

18 I'd like to think staff would have advocated for them,

19 as well. Certainly on Finchingfield that was the case.

20 I think less so on Ardleigh Ward.

21 Q. So on Finchingfield you'd have advocated for patients --

22 A. Yeah, and I often would say to patients, you know, you

23 know, encourage them to complain because often the

24 things they were complaining about, they would be things

25 I wasn't happy with either. And so I was often

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

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

4 A. Yeah, yeah.

5 Q. And were they able to obtain support --

6 A. Yeah.

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

9 A. Yes, yeah.

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

12 A. Yeah, yeah.

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

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

16 Q. Encouraged, you --

17 A. Yeah, absolutely. Yeah.

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

20 A. Yeah.

21 Q. What time are we talking about?

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

24 Q. So it was Linden Centre and The Lakes?

25 A. Yeah.

1 Q. To what extent do you consider care and family
2 involvement was encouraged and taken seriously, then?

3 A. On the ward, I don't think it was a priority. I think
4 it was a case of families were there to be informed of
5 events, meetings, et cetera, not to be learned from and
6 not to get information from. It was very much a one-way
7 kind of street. It was only when I started working in
8 the community, I just felt so ashamed in terms of the
9 fact of how it had been, because there was a patient on
10 the ward that I'd known very well on and off for
11 a number of years, they'd had extensive admissions. And
12 then when I became a care coordinator, I went to her
13 house and saw her wedding picture on the wall and it
14 suddenly struck me how much, you know, this person has
15 lived a life before they became a patient, and yeah,
16 from then it just -- it was a lightbulb moment for me
17 and yeah, I felt very ashamed of the way we'd not
18 engaged with people more.

19 Q. Obviously, there was policy and legislation in place
20 where care and family involvement was encouraged.

21 A. Mm-hm, yeah.

22 Q. What effort, do you recall, and you may have just
23 answered this question, did senior manager -- what
24 effort was made by senior management to assess whether
25 or not on the wards staff were complying with the

1 requirement to involve families?

2 A. I don't know. There was certainly no occasion where

3 I was told "This isn't good enough" or "You're not

4 engaging with the families enough." I don't believe it

5 was monitored.

6 Q. Can you recall any particular incidents -- as I say,

7 you've now worked in the community and realised --

8 A. Mm-hm.

9 Q. I think the words you use in your statement is it would

10 have made a massive difference if you'd known a lot more

11 about your patients?

12 A. Yeah.

13 Q. Can you recall any particular incidents where

14 information from family would have materially affected

15 a patient's wellbeing, or informed --

16 A. I can't think of specifics, no.

17 Q. And presumably this need to involve --

18 A. Mm-hm.

19 Q. -- families and obtain information from families applies

20 equally to decisions about safety on the ward?

21 A. Yeah.

22 Q. Leave?

23 A. Yeah.

24 Q. Discharge?

25 A. Absolutely.

1 Q. As it does in the community?

2 A. Yeah. I think we were so intent on getting to know the
3 patient that we didn't realise we were only getting half
4 the picture or two-thirds of the picture.

5 Q. Well, I was going to ask you that. Why were families,
6 carers and friends not systemically involved?

7 A. I don't know. It was -- when they came to visit,
8 certainly we would sit down, if they've got any issues
9 or anything, but there was no outreach to them. I think
10 the community, the care coordinator would have had much
11 more involvement with the families over time, so we
12 would get information from them to inform us. And
13 again, it was only -- because I didn't really know the
14 area. I'd come from East London way to work in
15 Chelmsford and I'd heard of these places that patients
16 lived and it's only when I worked in the Maldon
17 community I realised that some relatives were having to
18 travel 15 miles on public transport to get to see their
19 relative at the Linden Centre, and the fact that we
20 didn't welcome them or "Did you have a nice journey" or
21 "Do you want a coffee", looking back, that's all things
22 we should have done. Yeah.

23 Q. What specific changes did you effect yourself or observe
24 being affected to family inclusion as a result of your
25 experience in the community?

1 A. Me personally, where I had a caseload of patients,
2 I would spend as much time with the family as I can.
3 Sometimes more time with the family than the person.
4 Because these people are living lives, they're not
5 numbers or they're not a section-number, they're not
6 a room number. It was only when I was in the community
7 that that whole thing came clear to me. So, yeah.

8 Q. What do you then consider the main systemic issues or
9 structural barriers are that make effective family
10 involvement in inpatient care difficult to achieve?

11 A. I think they're very, very busy places. That's not an
12 excuse. That's kind of an explanation. They're
13 inherently chaotic. Things are changing all the time.
14 I don't know, sitting here, what can be done
15 differently. I couldn't honestly say.

16 Q. I will just ask you about serious incidents, please,
17 which is a slightly different topic.

18 A. Yeah.

19 Q. You say at paragraph 59 that following a serious
20 incident there was support for staff and patients.
21 I think there you're talking about restraint.

22 A. Yeah.

23 Q. Because you talk about the evidence you've already given
24 to the Chair, that it's not over. You've said, I think
25 today, that you'd have a cigarette, but you've said in

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

3 A. Yeah.

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

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

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

18 A. Yeah.

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

21 A. Yeah --

22 Q. -- come?

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

1 Q. At paragraph 59 onwards in your first witness statement
2 you describe your experience of the serious incident
3 investigation process?

4 A. Mm-hm.

5 Q. Can I ask you this: does that account primarily reflect
6 your experience at the Linden Centre?

7 A. Yes, yeah.

8 Q. You say there was half day of root cause analysis
9 training?

10 A. Yes.

11 Q. Who was that delivered to?

12 A. I think it was to managers.

13 Q. And was that one-off training?

14 A. Yes.

15 Q. Do you consider that was sufficient?

16 A. I think it's sufficient for me in terms of -- I was
17 quite confident in the reports that I was able to make,
18 to compile.

19 Q. You say that you were surprised there was no serious
20 incident response training such as the use of ligature
21 cutters and people were expected just, to use your
22 words, to "handle it"?

23 A. Yes.

24 Q. Did you ever raise that as a concern?

25 A. Yes, I did, and in time that became part of the control

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

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

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

10 Q. Halfway through you being the trainer?

11 A. Yeah, yeah.

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

14 A. No.

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

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

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

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

23 Q. And basic life support?

24 A. Yeah.

25 Q. What about intermediate live support?

1 A. No, as trainers we were trained in that.

2 Q. So the trainers were trained in intermediate

3 -- (overspeaking) --

4 A. Yeah. I think it may have been something the staff

5 could request to be trained in. I'm not sure.

6 Q. What about training provided to bank and agency staff?

7 A. I think bank staff had to do mandatory training before

8 their payroll number was triggered before they could

9 sort of come on to the ward. I don't know about agency

10 staff. The bank staff would attend the control and

11 restraint training as well.

12 Q. Any other training you think staff should have

13 been given in relation to responding to serious

14 incidents?

15 A. I think there should have been much more about

16 de-escalation about what should happen after the

17 incident. The control and restraint course was very

18 much a physical hands-on "This is how you do it" and

19 there wasn't enough emphasis as to how the patient feels

20 or what should happen afterwards.

21 Q. So that's restraint. What other serious incidents? Any

22 other training that you feel should have been provided?

23 A. I can't think of any.

24 Q. Okay. Were you ever involved in having to deliver bad

25 news to families?

1 A. Yes.

2 Q. Do you have any training about that?

3 A. No.

4 Q. In terms of incident reports, again, because of the
5 time, I shan't go into detail, but in your witness
6 statement, second witness statement at paragraph 74, you
7 say you received very little update or learning from
8 a higher level from some of the -- from any of the
9 reports that you wrote?

10 A. Yeah, yeah.

11 Q. And you don't recall getting any feedback as to whether
12 your recommendations were acted on?

13 A. That's right, yeah.

14 Q. And in fact you did, I think, a report -- or did you
15 review of the case of Glenn Holmes?

16 A. Yeah.

17 Q. In 2012?

18 A. Yeah.

19 Q. But have only recently discovered that some of the
20 recommendations were in fact implemented over --

21 A. Yeah, that's right, yeah.

22 Q. Did you ever raise concerns about not getting any
23 response to your reports?

24 A. No, no.

25 Q. Were you provided with any training on how to engage

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

3 A. No.

4 Q. -- or the review?

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

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

12 Q. That came in later on?

13 A. Oh, definitely, yeah.

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

16 A. I don't think it was.

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

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

21 Q. You'd do them at home?

22 A. Yeah, yeah.

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

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

1 Q. You just did them.

2 THE CHAIR: So you did them at home in your own time?

3 A. Yeah.

4 MS HARRIS: Can I ask you very briefly, then, about the

5 Serious Incident Report that you wrote in relation to

6 the case of Benjamin Morris, Ben Morris.

7 A. Yeah.

8 Q. We've already touched on the fact that you wrote that

9 report following his death just after Christmas in 2008.

10 You know that his mother is a Core Participant in this

11 Inquiry --

12 A. Yeah.

13 Q. -- and she has given evidence to the Inquiry already.

14 A. Yeah.

15 Q. And your evidence at paragraph 69 of your first witness

16 statement, to use your own words, is that you received

17 some pushback --

18 A. Yeah.

19 Q. -- from your manager, Stuart McGough, who told you Rahma

20 Saibon who you've already referred to, was unhappy

21 because it didn't paint Galleywood Ward in a good light?

22 A. Yeah.

23 Q. When were you told that?

24 A. It would have been after I'd written it. I can't say

25 when, specifically. I'd had feedback from a previous

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

3 Q. Sorry, a --

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

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

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

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

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

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

24 A. Yeah.

25 Q. -- the Trust?

1 A. I do, yeah.

2 Q. Did you raise any concerns with senior management
3 following the death of Benjamin Morris?

4 A. There was a lot of staff on Finchingfield that were very
5 unhappy. Two of them had been involved, I think, with
6 Ben before. So yeah, I did raise it with Stuart
7 McGough, yeah.

8 Q. You attended the inquest with Ben's mother?

9 A. Yes.

10 Q. You also explain in your second witness statement that
11 you were then replaced on Finchingfield Ward?

12 A. Yes, that's right.

13 Q. You were moved to do administrative work and audit work,
14 in effect?

15 A. Mm-hm.

16 Q. And you talk about the comment from the Director of
17 Nursing who said that you -- they'd had high hopes for
18 you --

19 A. Yeah.

20 Q. -- and you took it to mean that your career was over?

21 A. Yeah.

22 Q. You consider that following this report -- and I'm
23 moving quite fast because I'm mindful of the time --
24 that there was a serious of events that leave you
25 feeling punished for writing what you think was deemed

1 too negative a report?

2 A. Yeah, and generally I think at the period of time we

3 had -- I think I said before -- three patients on the

4 ward with early onset dementia and I was very vocal

5 about how I felt that was wrong and something -- these

6 people needed a better standard of care in a more

7 appropriate place. So I think in general I was a thorn

8 in the side, I guess, and I guess difficult to manage,

9 I would say, and not afraid to say what I thought to

10 people at various levels.

11 Q. You were subject to disciplinary action --

12 A. Mm.

13 Q. -- in relation to the yellow incident form books you've

14 told us about?

15 A. Yeah.

16 Q. Can you help us, what time period did the conduct that

17 was the part of the disciplinary action, when did that

18 relate to?

19 A. I --

20 Q. When was it said that you didn't -- you hadn't been

21 dealing with the yellow incident forms properly?

22 A. I thought it was somewhere sort of between January and

23 March.

24 Q. 2009?

25 A. Yes, yeah.

1 Q. Sorry, which year?

2 A. It was -- the time period when I wrote the report for

3 Ben Morris.

4 Q. So you wrote the report at the beginning of 2009?

5 A. Yeah, so I think it was some time after that.

6 Q. When did the conduct -- do you know when the conduct for

7 which you were disciplined first came to the attention

8 of the management?

9 A. No. No, I just remember coming in to work one day and

10 someone said, "Oh, Risk Management have taken all your

11 yellow books", and I actually thought, "Great, you know,

12 that's where they needed to go anyway for filing."

13 Yeah, and it was quickly after that I was told I was

14 going to be disciplined.

15 Q. What was the final outcome of your disciplinary

16 -- (overspeaking) --

17 A. Final written warning for three years. Yeah, and then I

18 was moved from Finchingfield Ward. I think the

19 phrasing, it was "putting staff and patients at risk"

20 which obviously was devastating to me because I had

21 spent my whole time making sure that didn't happen.

22 THE CHAIR: Was the move from Finchingfield Ward expressly

23 stated to be as part of the disciplinary --

24 A. No, I was told I needed a break from the ward, and

25 that I was going to be doing --

1 THE CHAIR: Who told you that?

2 A. It was the area director.

3 Then, yeah, I was replaced on Finchingfield Ward by

4 one of the Charge Nurses from Galleywood Ward which,

5 again, I found difficult.

6 MS HARRIS: You were then moved to work in the community.

7 A. Yeah.

8 Q. Can I just ask you a couple of questions, please, about

9 assessments in the community. You -- at paragraph 5 of

10 your witness statement, you say that assessments could

11 be classed as routine or urgent.

12 A. Mm-hm.

13 Q. Was there a protocol as to when that -- they would be

14 assessed as urgent?

15 A. Urgent would be assessment within 48 hours.

16 Q. Were there any circumstances in which immediate

17 assessment was mandated?

18 A. Yeah, we'd sometimes go and see people the same day,

19 yeah. We'd have meetings every morning with the team

20 where we'd look at all the new referrals that have come

21 in and look at what everyone's day looked like, yeah.

22 Q. Were there any measures that could be put in place

23 pending an urgent assessment?

24 A. Sorry, I don't understand.

25 Q. If you considered that somebody needed to be assessed

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

3 A. No, we would always get there.

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

6 A. I'm not aware of any specifics.

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

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

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

22 A. Yeah.

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

1 without its issues?

2 A. Yeah.

3 Q. And you provide an example I think from 2023 when
4 a colleague left a discharge planning meeting in tears
5 and the meeting continued in her absence.

6 A. Yeah.

7 Q. Did you ever report or escalate that incident?

8 A. Well, the manager of the team I worked in was part of
9 that meeting.

10 Q. What was the nature of the tension, then, between
11 inpatient and community teams?

12 A. It would generally be a disagreement about discharge,
13 because the inpatient wards certainly when I last
14 worked, were very few beds available. I had somebody
15 who was on a Community Treatment Order waiting six weeks
16 for a bed, and they should have gone in straight away.
17 So the inpatient wards very much wanted to discharge
18 people. But from the community side, it had to be
19 a safe discharge, and I think because of the
20 community -- the care coordinator would have a better
21 idea about what the person's requirements for safety
22 were in the community, whereas somebody might not pose
23 such a risk to stay on the ward but they would still
24 pose too big a risk to be in the community and it was
25 very much -- and certainly the one that you referred to,

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

4 Q. I think you describe the approach as disjointed.

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

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

17 A. Yeah.

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

22 A. Yeah.

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

1 A. At Ardleigh Ward.

2 Q. And at Ardleigh Ward?

3 A. Yeah, it was mainly Ardleigh Ward, yeah.

4 Q. At paragraph 32 of your second statement you say that

5 staff could raise concerns about a patient's care and

6 treatment to their Ward Manager --

7 A. Yeah.

8 Q. -- using a whistleblower policy. Did that ever happen

9 to you when you were Ward Manager? Did you ever receive

10 those complaints?

11 A. No, no.

12 Q. In terms of culture you describe a general culture of

13 detachment and superiority between senior managers and

14 senior ward staff towards patients. Did that extend to

15 dealings with the family as well, as far as you could

16 see?

17 A. I'm talking about meetings that I attended, like staff

18 meetings, and -- yeah, so.

19 Q. Do you think that the -- there was an impact of that

20 culture on patient care?

21 A. The meetings I went to and I have to say, I went to them

22 as infrequently as I could in the end because I felt it

23 was a waste of my time, I'd rather be with the patients

24 and the staff. And people would -- the senior managers

25 would talk about staff in a very derogatory way, and it

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

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

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

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

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

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

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

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

1 perception, you think, being important to the Trust.

2 A. Mm-hm.

3 Q. And you talk, for example, about when a CQC inspection
4 would be announced that in fact work would be done to
5 paint the walls?

6 A. Yeah.

7 Q. And I think you describe it as farcical.

8 A. Yeah.

9 Q. How widespread were your concerns about the culture and
10 the superiority, the farcical response to CQC and the
11 very few lessons being learned after serious incidents?

12 A. I mean my experience could only be from what I'd
13 experienced on Finchingfield Ward and in the community
14 and I ended up coming to the conclusion that I just need
15 to do the best that I can for patients. The Trust just
16 seemed to get bigger and bigger and bigger and I was
17 less aware of who was who. So I just concentrated on
18 doing what I could do on a daily basis to help people.
19 And the teams I worked in were the same.

20 Q. And that Trust getting bigger and bigger, do you
21 attribute that in particular to the merger?

22 A. Yes.

23 Q. You talk about the CEO of NEPT when you were working for
24 NEPT, having a domineering personality, and those he
25 employed reflected that attitude?

1 A. Yeah.

2 Q. Was that something that was felt, as far as you were
3 concerned, throughout the Trust?

4 A. Yeah, yes.

5 Q. And the culture you describe of "We know what we're
6 doing; the problem is down there"?

7 A. Yes.

8 Q. "Down there", do you mean the staff on the ground?

9 A. Yeah, absolutely.

10 Q. In your view, did this culture that you're describing
11 result in the -- a defensive approach to patient safety
12 incidents?

13 A. Yeah.

14 Q. And to the internal and external investigations --

15 A. Yes.

16 Q. -- as you've described?

17 A. Yeah.

18 Q. Are you able to give any examples of the culture of
19 blaming staff for systemic issues?

20 A. I can't think of any specific examples right now.

21 Q. Do you think the culture had an impact on staff
22 retention?

23 A. Yeah, I think people were coming to work afraid of
24 being -- of getting in trouble, and I think they've
25 began to feel that the less they engage with patients

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

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

6 A. Yeah.

7 Q. Did you raise concerns about the culture?

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

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

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

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

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

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

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

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

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

9 A. Yeah. It did happen, yeah.

10 Q. What about bullying by patients?

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

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

18 A. No.

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

22 A. Mm-hm.

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

25 "It was not unusual for staff, subject to

1 disciplinary action, to find themselves moved to other
2 areas within the Trust"?
3 A. That's right.
4 Q. What was your impression of why that happened?
5 A. I don't know. Certainly two of the staff that came to
6 Finchingfield Ward came from the Colchester area
7 following disciplinary. So I don't know why that
8 happened, yeah.
9 Q. Do you know the kind of things they were being
10 investigated for --
11 A. No.
12 Q. -- when they were being moved around?
13 A. No, no. I mean, what I would say is that they were very
14 good members of staff on the ward, and I would say they
15 were similar to myself in terms of not sitting back if
16 we thought things needed to change.
17 Q. So they'd also -- you have described yourself as
18 vocal --
19 A. Yeah.
20 Q. -- would you describe them?
21 A. Yeah.
22 MS HARRIS: That's all I'm going to ask for now.
23 Chair, do you have any further questions for
24 Mr Ayris?
25 THE CHAIR: No.

1 MS HARRIS: Mr Ayris, what will happen now is we will have
2 a short break --
3 A. Okay.
4 MS HARRIS: -- to see if there are any other questions,
5 I think for ten minutes. If you wouldn't mind staying
6 within the vicinity, we'll come back about 1.25.
7 A. Okay.
8 **(1.15 pm)**
9 (A short break)
10 **(1.25 pm)**
11 THE CHAIR: Ms Harris.
12 MS HARRIS: Thank you, Chair.
13 Mr Ayris, there's just a few more questions for you.
14 We won't be very much longer. The first is this: you
15 have already given evidence about the seven-day report
16 you wrote following Ben Morris's death at the end of
17 2008. You've already given evidence of how you went to
18 look at the handles in Galleywood Ward.
19 A. Yeah.
20 Q. You went back to start trying to remove them with your
21 electric screwdriver on Finchingfield Ward?
22 A. Yeah.
23 Q. And you said that you were told you mustn't do that, it
24 was damaging Trust property and it was a job for
25 Estates?

1 A. Yeah.

2 Q. And you said initially you thought it was a conversation
3 you'd had with Stuart McGough?

4 A. Yeah, I can't be --

5 Q. But then you said it might have been somebody else?

6 A. Yeah.

7 Q. You have also given evidence that after you wrote the
8 seven-day report you felt that you'd had, to use your
9 words, some pushback from Stuart McGough?

10 A. Yeah.

11 Q. Now, might that have been somebody else that gave
12 you the pushback?

13 A. Yeah, it could be, yeah.

14 Q. So it may not have been Stuart McGough?

15 A. No, I can't be specific.

16 Q. So can I just break it up?

17 A. Yes, of course.

18 Q. Are you -- what is your evidence about the pushback? Do
19 you recall getting pushback?

20 A. Yeah, I may have heard it from the person that
21 commissions the reports. I certainly heard it from
22 Rahma, as well.

23 Q. So you heard it from Rahma, you think?

24 A. Yeah.

25 Q. Possibly the person that commissioned the report?

1 A. Yeah.

2 Q. But it might not have been from Stuart?

3 A. No, I have to say Stuart McGough was always very kind
4 and very supportive to me.

5 Q. Okay, so he was always kind and supportive to you?

6 A. Yeah.

7 Q. All right, thank you. That was that one.

8 I asked you some questions around sexual safety. Do
9 you remember?

10 A. Yeah.

11 Q. Did you have any training on how to deal with, first of
12 all, any aspect of how to either monitor those who were
13 vulnerable or deal with complaints made when you were on
14 Ardleigh Ward?

15 A. No.

16 Q. I asked you some questions around the completion of
17 clinical records and whether or not staff were able to
18 complete them contemporaneously --

19 A. Yes.

20 Q. -- and I think you said they had the opportunity to?

21 A. Yes, yeah.

22 Q. Can I ask you one question further.

23 A. Mm-hm.

24 Q. To your knowledge, as far as you were aware, did nursing
25 staff or support workers usually complete their records

1 contemporaneously?

2 A. When I was on the Finchingfield, certainly, yeah.

3 Q. Were there times when you worked elsewhere where that

4 wasn't the case?

5 A. Yes.

6 Q. So where would that be?

7 A. That would have been on Ardleigh Ward.

8 Q. So they weren't -- they weren't contemporaneous on

9 Ardleigh Ward.

10 A. No.

11 Q. What was the situation?

12 A. It was where you'd come in and there'd be no report from

13 the previous afternoon or something like that.

14 Q. And what would you have to do in those circumstances?

15 Would it be your responsibility to chase that up, or how

16 was that dealt with?

17 A. As a Charge Nurse, I would, yes. And there were times

18 when I worked in the community where there was no entry

19 from the previous day on the ward, if I had a patient on

20 the ward.

21 Q. So if we understand your evidence correctly,

22 Finchingfield Ward, the records were contemporaneous --

23 A. Yes.

24 Q. -- and you say better kept?

25 A. Yeah.

1 Q. I know those weren't your exact words.

2 A. Yeah.

3 Q. Ardleigh, not so much?

4 A. No, I think the Carebase system was a lot easier in

5 keeping paper records, people were more likely to do it.

6 I think people did struggle with the Paris system

7 initially when it came in.

8 Q. So that was part of the Paris system

9 -- (overspeaking) --

10 A. Yeah, I think so.

11 Q. And the community, again you say there were gaps in the

12 records?

13 A. Yeah.

14 Q. Okay. You very candidly -- different subject -- you

15 very candidly included yourself when we -- when you gave

16 evidence about the lack of specialist knowledge --

17 A. Mm.

18 Q. -- particularly in relation to neurodivergent patients

19 back in 2006 or 2007 --

20 A. Yes.

21 Q. -- or around that time, certainly when you were at

22 Finchingfield?

23 A. Yeah.

24 Q. And then you mentioned later down the line, the online

25 training --

1 A. Yeah.

2 Q. -- the Oliver McGowan training?

3 A. Yeah, I did.

4 Q. Did you undertake that training?

5 A. Yes, I did. It was mandatory for everybody.

6 Q. Yes, but it was in terms of your departure --

7 A. Yes, I did.

8 Q. Once you'd received that, did you feel that you were

9 able better to address the issues that arose --

10 A. Certainly, yeah.

11 Q. -- in relation to neurodivergent patients?

12 A. Yeah, I mean, it was the tip of the iceberg, it was

13 a whole new thing for me, really, because there's loads

14 more to learn, but it did open my eyes to it, yes.

15 Q. Did you consider it useful?

16 A. Yeah.

17 Q. But you say there was a lot more you could learn about

18 it?

19 A. Yeah.

20 Q. All right. Can I take you back, sorry, again, to ... to

21 the removal of items from rooms following self-harm.

22 A. Mm-hm.

23 Q. Now, you described the approach about taking the item,

24 items of risk, I think?

25 A. Yeah.

1 Q. Can I just ask you one question beyond that which is if
2 someone had self-harmed by ligaturing?
3 A. Yeah.
4 Q. What would your approach be or what would the correct
5 approach be, as far as you were concerned? Would you
6 remove any potential ligature items in those
7 circumstances?
8 A. Yes, definitely.
9 Q. So I'm thinking hoodies?
10 A. Yeah.
11 Q. Bedding?
12 A. Yeah -- (overspeaking) --
13 Q. Curtains?
14 A. Yeah.
15 Q. Tights.
16 A. Yeah.
17 Q. All those types of --
18 A. Yeah.
19 Q. All right. You have already given evidence that in your
20 view those wards were not suitable for people with
21 dementia.
22 A. Yeah.
23 Q. You already talked about how traumatic that was both for
24 them and for others on the wards?
25 A. Yeah.

1 Q. What alternatives were there, then, for treating
2 patients with dementia when in a crisis?

3 A. There was the Crystal Centre which is next door to the
4 Linden Centre which was a ward for people suffering from
5 dementia on that ward but because of the age of these
6 people that were suffering with dementia they were put
7 on an adult ward as opposed to the -- so it was due to
8 their age as opposed to the appropriate care that they
9 could receive.

10 Q. So they were on your ward which you considered was
11 entirely inappropriate --

12 A. Yeah.

13 Q. -- given --

14 A. Because they were under 65.

15 Q. And finally this: you -- we talked a little bit about
16 over-sedation and the culture of over-sedation?

17 A. Mm-hm.

18 Q. And you dealt particularly with the question of
19 over-sedation on Ardleigh Ward.

20 A. Yeah.

21 Q. Did you raise that with management?

22 A. Yes.

23 Q. Who did you raise it with?

24 A. The Ward Manager.

25 Q. And what response did you receive?

1 A. He would speak to the doctor. That was --

2 Q. And did you get any feedback from that?

3 A. No, none at all.

4 Q. That was the last you heard of it?

5 A. Yeah.

6 Q. All right. On the question, then, of raising matters,

7 you said at the very end of your evidence, when I asked

8 you, had you raised concerns regarding the culture of

9 the senior management and senior staff at NEPT and/or

10 EPUT, who did you raise that with?

11 A. Just Stuart McGough. I talked to him a lot about how

12 I felt about how things were.

13 Q. So this was back at Finchingfield?

14 A. Yeah.

15 Q. So that's two thousand and --

16 A. Yeah.

17 Q. Between 2003 and 2009?

18 A. Yeah.

19 Q. Have you raised concerns about the culture of senior

20 management since, in your more recent employment?

21 A. No. My most recent employment, all my focus was just on

22 the people that I was looking after. I tried to keep

23 myself away from almost the other stuff, to be honest.

24 Q. And did you get any response from raising that

25 concern --

1 A. No.

2 Q. -- with Stuart McGough?

3 A. No, I think he was very good, very good listener.

4 I think a lot of it was, kind of, this is how I feel

5 about things but I wasn't necessarily expecting him to

6 do anything about it.

7 MS HARRIS: Thank you, Mr Ayris. That's all the questions

8 I have now. Just checking.

9 Chair, do you have any further questions?

10 THE CHAIR: I don't. Thank you very much indeed.

11 Can I thank you very much for your evidence. It has

12 been very helpful indeed. Thank you.

13 THE WITNESS: Thank you.

14 MS HARRIS: I think -- could we come back again at 2.15?

15 Thank you very much.

16 THE CHAIR: 2.15.

17 **(1.34 pm)**

18 **(The Short Adjournment)**

19 **(2.15 pm)**

20 **(Proceedings delayed).**

21 **(2.21 pm)**

22 MR COKE-SMYTH: Good afternoon, Chair.

23 We have this afternoon Ms Chloe Cawston. Can I ask

24 that you please start by telling the Inquiry your full

25 name.

1 THE WITNESS: It's Chloe Ann Cawston.

2 MR COKE-SMYTH: And I'm going to ask that you are now sworn
3 so that we can hear your evidence.

4 **CHLOE ANN CAWSTON (sworn)**

5 **Questioned by MR COKE-SMYTH**

6 MR COKE-SMYTH: Thank you.

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

10 A. Yes.

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

13 A. Yes.

14 Q. Is it dated 8 June 2026?

15 A. Yes.

16 Q. And is it signed by you?

17 A. Yes.

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

21 A. Yes.

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

24 A. No.

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

1 belief?

2 A. Yes.

3 Q. Now, that statement is going to stand as your evidence,
4 but I'm going to ask you some further questions arising
5 from it but please rest assured, if you don't mention
6 something or if I don't cover it, everything in that
7 statement will form part of your evidence.

8 A. *(The witness nodded)*.

9 Q. I want to start, please, just by dealing with your
10 background and your experience. And it may help if you
11 just have in front of you the paragraphs of your
12 statement that deal with that, so from paragraph 3 on
13 page 1, and it may help just to start to have that up on
14 screen, please.

15 So it's right that you began working in mental
16 health in 2008 for the North Essex Partnership
17 University NHS Foundation Trust or NEPT.

18 A. Yes.

19 Q. And that was as a bank staff member in 2008?

20 A. Yes, that's correct.

21 Q. That was at the Linden Centre; is that right?

22 A. Yes.

23 Q. Can I just ask this: was that as a healthcare assistant
24 or were you a nurse at that point? What was your actual
25 role?

1 A. That was as a bank support worker while I was doing my
2 training.

3 Q. And so you do your training and complete that in 2011?

4 A. Yes.

5 Q. So you're then qualified as a mental health nurse?

6 A. *(The witness nodded)*.

7 Q. And you then take up a role as a staff nurse on the
8 Christopher Unit, and that's still NEPT?

9 A. Yes.

10 Q. And then, 2016, you change Trusts and you move to the
11 South Essex University NHS Foundation Trust or SEPT, and
12 you then take on a community health team role; is that
13 right?

14 A. So in 2016 I worked in North Essex. That was part of
15 the community health team and then it was 2018 that I
16 moved to SEPT. Sorry, 2016 when I moved to SEPT on
17 Grangewaters Ward.

18 Q. Then also at SEPT and slightly later in 2016, you take
19 on your first management role as a Ward Manager on
20 Grangewaters Ward at Basildon Mental Health Unit; is
21 that right?

22 A. Yes.

23 Q. Then in terms of the timeline, it's right that the
24 merger between SEPT and EPUT happened in 2022?

25 A. Yes.

1 THE CHAIR: Sorry, SEPT and NEPT.

2 MR COKE-SMYTH: Sorry, SEPT and NEPT, forgive me, thank you,
3 Chair, SEPT and NEPT, 2017, and so you continue in that
4 role but you're now working for EPUT.

5 A. Yes.

6 Q. So any work after 2017 you're working for EPUT. And in
7 2018 you became a Matron at the Basildon Mental Health
8 Unit; is that right?

9 A. Yes.

10 Q. 2020, you then became a Service Manager covering
11 Basildon Mental Health Unit and the Linden Centre?

12 A. Yes.

13 Q. 2021, a period of maternity leave?

14 A. *(The witness nodded)*.

15 Q. Then back in 2022, still as a Service Manager at EPUT --

16 A. *(The witness nodded)*.

17 Q. -- now covering the Linden Centre --

18 A. *(The witness nodded)*.

19 Q. -- and the Crystal Centre?

20 A. *(The witness nodded)*.

21 Q. And what about the Basildon Mental Health Unit?

22 A. No, I'm only solely based in Mid Essex.

23 Q. Now, when I come on to ask about the various different
24 topics which you cover in your witness statement, can
25 I ask that you make it clear if you're referring to the

1 period before 2017?

2 A. *(The witness nodded)*.

3 Q. And if you are, if you identify which Trust you're

4 referring to because you obviously worked for both SEPT

5 and NEPT?

6 A. Yes, of course.

7 Q. I suspect most of your answers will relate to after

8 2017.

9 A. *(The witness nodded)*.

10 Q. If that's the case, we'll work on that basis, but if

11 you're talking about earlier, please make that clear.

12 A. Yes.

13 Q. It's also right that when we talk about your role as

14 a Service Manager you've only ever been a Service

15 Manager at EPUT; is that right?

16 A. That's correct.

17 Q. Can I just ask a few more questions about the role of

18 the Service Manager, please. Firstly, the locations

19 where you've been a Service Manager, so I think in 2020

20 you were a Service Manager at both Basildon Mental

21 Health Unit and the Linden Centre.

22 A. *(The witness nodded)*.

23 Q. And then later on, the Linden Centre and the Crystal

24 Centre. What type of unit is the Basildon Mental Health

25 Unit?

1 A. So that has a number of wards. So it has the Assessment
2 Unit, it has Acute Admission wards and it also has
3 a Psychiatric Intensive Care Unit known as a PICU.

4 Q. Can you help us that differs from the Linden Centre and
5 the Crystal Centre, please?

6 A. The only difference is that it has an Assessment Unit
7 but they're both mental health hospitals.

8 Q. Can you just summarise your role as a Service Manager,
9 please?

10 A. Yeah, so I'm responsible for the inpatient services and
11 also the health-based place of safety at the Linden
12 Centre. So I would be responsible for looking after
13 staff, thinking about admissions, transfers, attending
14 meetings, recruitment.

15 Q. And how often in that role would you actually be in the
16 wards.

17 A. I walk the wards every day. So I will be present on the
18 wards to check in with the staff and also to speak with
19 patients.

20 Q. And you report to an Associate Director; is that right?

21 A. That's correct.

22 Q. Are they also a nurse?

23 A. Yes.

24 Q. And above that, they report to a Director of Mental
25 Health Urgent and Inpatient Services; is that right?

1 A. Yes.

2 Q. What's their clinical background?

3 A. They're a nurse as well. Mental health nurse.

4 Q. And to what extent, if at all, might you report or flag
5 concerns above that level, so for example, directly to
6 the Board? Would that ever happen?

7 A. Yeah, I have raised concerns, and also if members of the
8 team are off on annual leave they'll have someone that's
9 covering that may be above that banding so I would raise
10 concerns.

11 Q. And was it easy for you to raise concerns if you wanted
12 to?

13 A. Yes.

14 Q. I want to move on now, please, and ask you about the
15 topic of assessments, please. And I'm going to start
16 with what you say at 12 and 13 of your statement if you
17 want to have that open in front of you.

18 You refer at paragraph 12 to when working on wards,
19 admission decisions being communicated based on bed
20 availability and you refer to the Bed Management Team.

21 A. *(The witness nodded)*.

22 Q. Who would the Bed Management Team be made up of?

23 A. So then, in terms of when it was NEPT or is it EPUT now,
24 sorry, in terms of your question?

25 Q. I'll start with EPUT, please, if I can.

1 A. Yeah, so the Bed Management Team now consists of -- we
2 have a Service Manager that manages flow, there's
3 purposeful admission staff. We also have a consultant
4 that's dedicated to flow, and then there's admin that
5 work in the Bed Management Team, as well.

6 Q. Just pausing there, I think a Service Manager --

7 A. *(The witness nodded)*.

8 Q. -- are they a clinical role?

9 A. Yes.

10 Q. What would be their clinical background?

11 A. Registered Mental Health Nurse.

12 Q. And consultant, presumably you mean a Consultant
13 Psychiatrist; is that right?

14 A. Yes.

15 Q. And then they're supported by an administrative team?

16 A. Yes.

17 Q. So that's at EPUT. Was it any different before to that,
18 substantially, prior to EPUT?

19 A. Yes. So when in NEPT, they had staff that were of
20 clinical background, sort of RMNs as well, but in SEPT
21 it was more of an administrative role.

22 Q. In terms of that Bed Management Team, would they be able
23 to overrule clinical decisions from the person who would
24 assess someone?

25 A. No.

1 Q. So how did that interaction work?

2 A. So if somebody was assessed, so before being assessed,

3 the Bed Management Team would be contacted to say that

4 a person is due to have a Mental Health Act Assessment

5 at this time, and then, once the Mental Health Act had

6 happened, whatever the outcome of that assessment would

7 be, then they would inform the Bed Management Team and

8 a decision would be made of where that bed was available

9 for them to be admitted to.

10 Q. So as I'm going to come on to, there were situations,

11 weren't there, where somebody would be assessed as

12 suitable --

13 A. Yes.

14 Q. -- but nevertheless there wouldn't be a bed available?

15 A. Yes.

16 Q. And so I'm going to come on and ask a bit more about

17 that, but you're saying the availability would not

18 influence the clinical decision as to whether they

19 should be admitted, at least in theory?

20 A. Yes.

21 Q. And you refer at your paragraph 13, and as I've touched

22 upon, and you say it there, that bed availability could

23 impact admissions decisions?

24 A. *(The witness nodded)*.

25 Q. And you also refer, at 23, to over time a focus on

1 avoiding admission where safe to do so.

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

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

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

13 A. No.

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

16 A. No.

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

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

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

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

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

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

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

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

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

25 And then there's conversations that happen on those

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

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

9 A. Yeah.

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

12 A. *(The witness nodded)*.

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

14 A. *(The witness nodded)*.

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

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

20 Q. Is that a public document or not?

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

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

1 A. Yes.

2 Q. And would you accept that even with the Home Treatment
3 Team, that there still remains a risk to the patient if
4 they've been assessed as needing to be admitted but
5 aren't?

6 A. Yes.

7 Q. And would it be right, then, that that creates
8 a pressure, an additional pressure on the Home Treatment
9 Team?

10 A. Yes.

11 Q. Were they always available as an alternative to
12 admission?

13 A. In my experience, the Home Treatment Team have supported
14 people that have needed admission in the community and
15 have been available.

16 Q. And in your experience have they been resourced properly
17 to do that in view of that demand?

18 A. From what I have experienced, yes.

19 Q. Can I ask this: what was the procedure if a patient or
20 their nearest relative felt that they weren't safe in
21 the community? So say they'd been assessed as
22 clinically suitable for admission but there's no bed and
23 concerns are raised. What would happen then?

24 A. So there would be a Crisis Management Plan put in place
25 and advice sought. So it could be that they could go to

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

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

7 A. Yes, I would agree.

8 Q. So less than ideal?

9 A. Yes.

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

14 A. Sorry, can you repeat the question.

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

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

1 Q. Just giving a specific example, there are situations
2 where patients can't be admitted due to lack of bed
3 availability?

4 A. *(The witness nodded)*.

5 Q. And so there's a delay --

6 A. *(The witness nodded)*.

7 Q. -- of some sort? How are the outcomes of that monitored
8 at EPUT?

9 A. So they would be monitored via the Bed Management Team
10 in terms of who's waiting for a bed and how many people
11 have been admitted.

12 Q. What about -- so they'd monitor the numbers, presumably?

13 A. Yes.

14 Q. But what about the actual outcome on an individual
15 basis? Would they collect information as to what the
16 outcome was in respect of an individual patient who had,
17 say, a delayed admission? Is that something that
18 would --

19 THE CHAIR: I think he's talking about what actually is the
20 effect of that on somebody's presentation and illness?
21 What monitoring is done of how this affects the patient?

22 A. In terms of waiting for a bed?

23 THE CHAIR: And being in the community, patient care, what
24 does that mean for patient care? Is that something that
25 is ever assessed?

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

9 THE CHAIR: Of any system-wide assessment?

10 A. Yeah.

11 THE CHAIR: Thank you.

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

14 A. Yeah --

15 Q. -- (overspeaking) --

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

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

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

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

24 A. *(The witness nodded)*.

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

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

6 And you explain in that paragraph how that works.

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

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

12 A. No.

13 Q. Does that routinely happen in practice?

14 A. Yes.

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

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

1 Q. You've used the word "listen to their concerns". Can
2 I just be very clear. When they don't consent, do you
3 positively seek information from the family?

4 A. Yes.

5 Q. And is there any form or part of the notes that prompt
6 you to do that, or is that just common practice, as it
7 were?

8 A. So as part of the inpatient process, as part of the
9 admission, there would be information on the, like, ward
10 review forms that would say patient or relative's wishes
11 and views and as a part in the, like, the AMHP referral,
12 the AMHP report, as well, that would capture that.

13 Q. And how confident are you that that's happening
14 consistently across EPUT services? So situations where
15 a patient may or may not consent, information being
16 sought from the family on every occasion?

17 A. Well, I hope that that would be the practice. I don't
18 think I could sit here and say hand on heart that a
19 hundred per cent that's happening in all cases. Because
20 I don't think that would be the right answer, because
21 I can't give the assurance that every single case that
22 is happening. I can give assurance that in my practice,
23 I have done that.

24 Q. Is there any way in which you monitor that is happening
25 in the staff that work for you?

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

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

12 A. Yes.

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

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

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

1 it for me.

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

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

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

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

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

23 THE CHAIR: Thank you.

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

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

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

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

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

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

18 A. Yeah.

19 Q. You've been a manager in some way, shape or form since
20 2018. Can you just give us a rough idea as to the year
21 or the couple of years when you feel that started to
22 change to what you've described now?

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

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

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

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

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

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

12 Q. So they should be contacted?

13 A. *(The witness nodded)*.

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

16 A. Yes.

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

19 A. In my experience, yes.

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

24 A. *(The witness nodded)*.

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

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

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

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

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

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

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

24 A. Yes.

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

1 happened?

2 A. Yes.

3 Q. Where a patient couldn't be assessed, and I think it's

4 perhaps slightly easier if they're in A&E, it's

5 a different situation, perhaps in the community, how

6 would they be monitored, then, if, say, you can't assess

7 them, they're under the influence, and you can't do the

8 assessment? How would they be monitored following that?

9 A. Sorry, if they were in A&E?

10 Q. Not in A&E. So, for example, at home.

11 A. Yeah. So if they were at home and they were waiting to

12 be assessed, then obviously depending on the support

13 they had, so if they were under a community team, there

14 would be community team support. Again, that could be

15 Home First or with the local care co, and then, if

16 needed to, you could contact the police for further

17 support.

18 Q. Is there any sort of protocol or policy that deals with

19 that sort of situation?

20 A. I think EPUT would have a policy regarding substance

21 misuse.

22 Q. Are you aware of whether there is one or not?

23 A. I wouldn't be able to say yes a hundred per cent.

24 Q. You say, in terms of admission, and I'm just moving on

25 to your paragraph 23, you say that over time, there was

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

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

6 A. Yes.

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

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

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

19 A. *(The witness nodded)*.

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

21 A. Yes.

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

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

1 on in EPUT.

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

3 EPUT as 2017.

4 A. *(The witness nodded).*

5 Q. In 2017, were there ligature audits, or not at that

6 point? Was it pre or post the merger?

7 A. So in SEPT we had them but in -- when I was working in

8 NEPT obviously as a Band 5 I wouldn't have been involved

9 in the ligature audits themselves. That would have been

10 a Band 6 and above.

11 Q. Ligature audit is obviously quite an important part of

12 managing safety on the ward.

13 A. *(The witness nodded).*

14 Q. In your role as a Service Manager, how do you assure

15 yourself that they're being done properly?

16 A. So my own assurance is that I will go and check them

17 myself. I like to physically know what they look like.

18 They're shared with us. So when the ligature audit

19 takes place, we'll get a feedback from the Estates team,

20 from the Risk team, and from the ward, but also we

21 wouldn't wait for that audit to take place if there was

22 an identified risk. But my own assurance is

23 I physically go to the ward and check them myself.

24 Q. Is there any sort of system or structure that makes you

25 do that as a Service Manager or is that just something

1 you do because you think it's important?

2 A. It's something that I have always done. Before I was
3 a Service Manager, as a Matron, I would always go and
4 visibly check for my own assurance and I would want to
5 check. So we've got the ligature wallets, I would want
6 to check that the items in there are correct as well.
7 But yeah, it's for my own personal assurance.

8 Q. You also refer, at paragraph 25, to a practice
9 developing over time, and improved recognition of
10 neurodiversity in the context of the ward environment.
11 What's your understanding of the requirements of
12 autistic patients in general terms, in terms of the ward
13 environment?

14 A. So obviously every patient that uses our services will
15 have their own individual needs, and it's around
16 ensuring that we can meet those needs. So it could be
17 the lighting, for example. So before, the wards, we
18 didn't -- we wasn't able to, like, dim the lighting it
19 used to be constantly bright. We've now got sensory
20 rooms that are available and also thinking about alarms
21 on the ward, the alarms can be triggering for
22 individuals. So making sure that if needed we've got
23 ear defenders available to support with that, and having
24 general awareness of what that person may need at those
25 times as well.

1 Q. Are you familiar with Oliver McGowan training?

2 A. Yes.

3 Q. Have all staff on your wards had that training?

4 A. I would need to check the percentage of what -- how many

5 staff have had them -- have completed the training,

6 sorry. But yes, it is mandatory.

7 Q. And is that also routinely offered to bank and agency

8 staff?

9 A. Yes.

10 Q. Moving on to therapeutic interventions. You refer to

11 those at your paragraph 27, and you say that therapeutic

12 value has changed over the years, and offer of

13 therapeutic interventions has established with the

14 development of the MDT.

15 Would you accept that historically there has been

16 often an absence of therapeutic intervention --

17 A. Yes.

18 Q. -- on mental health wards?

19 A. Yes.

20 Q. To what extent today are patients encouraged to engage

21 in therapeutic activities?

22 A. So on the wards -- and this is me speaking about the

23 wards that I'm responsible for -- so we have a visual

24 timetable, and also we have, like, whiteboards that will

25 give a day-to-day of what activities are available, and

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

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

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

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

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

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

1 separate to what the nurses then offer on top of that.

2 Q. So just focusing on nurses and healthcare assistants, do

3 they all provide daily therapeutic engagement with

4 patients?

5 A. Yeah, so they will offer patients one-to-one sessions,

6 as well. That's part of their role for their allocation

7 for the day.

8 Q. Is that aspiration or is that reality?

9 A. I think at times it's reality and at times it's

10 aspirational, depending on the clinical presentation on

11 the ward and other issues that may be occurring on the

12 ward because the ward environment can be very variable

13 at times.

14 THE CHAIR: Does the same apply to the set activities?

15 You're talking at the moment about the one-to-one offer.

16 A. Yes.

17 THE CHAIR: But the set activities, morning, afternoon and

18 evening. Are they sometimes not possible because of

19 pressures on time, and staffing?

20 A. I think obviously there's things that we're not in

21 control of. So unexpected sickness. But the team work

22 across, so I'm really fortunate that they work across

23 Linden Centre and Crystal Centre. So they will work

24 together and look at what can be offered. So there's

25 still a therapeutic offer on that day.

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

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

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

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

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

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

24 A. Yes.

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

1 arrangements in some?

2 A. Yes.

3 Q. And would you accept that's not an ideal environment for
4 inpatients?

5 A. Yeah.

6 Q. We've also heard evidence or received evidence, I should
7 say, describing fixtures and fittings at Basildon Mental
8 Health Unit as "dated". We've also heard evidence
9 describing it as an "austere environment". Is that
10 something you would recognise?

11 A. Yes.

12 Q. We also know that wards can be quite loud environments.

13 A. *(The witness nodded)*.

14 Q. Would you accept that can be particularly detrimental
15 for neurodiverse patients?

16 A. Yes.

17 Q. I want to move on to the part of your statement that
18 deals with treatment, please. Looking at your
19 paragraph 36, you reference there:

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

24 Just pausing there, what are positive behavioural
25 support plans?

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

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

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

19 A. Yes.

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

22 A. Yes.

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

25 A. Yes.

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

3 A. Yes.

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

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

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

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

21 A. Yes.

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

1 with substance misuse issues.

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

5 A. *(The witness nodded)*.

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

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

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

1 A. Not in my experience.

2 Q. Is that something that happens?

3 A. I would like to think that it doesn't happen. I would
4 be extremely upset if patients had been turned away that
5 were asking for help. So I would hope that that doesn't
6 happen.

7 Q. I'm going to move on now to a new topic. I'm conscious
8 I think we've been going for about an hour so we're
9 going to have a -- a bit less, we're going to have
10 another 20 minutes until a break.

11 A. Okay.

12 Q. And I'm going to move on to transfer. And can I ask
13 you, please, to turn to your paragraph 53. And you say
14 there, last sentence:

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

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

20 Are you talking about a decision to transfer
21 somebody without input from a clinician?

22 A. So in my sentence I'm talking about a patient that may
23 be transferred between wards where, like, the community
24 team have not been informed that that person may have
25 moved. So, often, before we move to the locality model

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

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

10 A. Yes.

11 Q. Who would be the person making that decision?

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

17 Q. So RC being the Responsible Clinician?

18 A. Yes, sorry.

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

20 A. Yes.

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

22 A. Yes.

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

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

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

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

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

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

19 A. Yes.

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

22 A. Not always, no.

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

24 A. Yes.

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

1 A. So I think in the past, decisions have been made and
2 people haven't been -- and I mean by "people" family
3 members or loved ones haven't been informed. Now in
4 my -- the way that I practise, I do ensure that we do
5 communicate with the family to have that conversation
6 before the transfer happens.

7 Q. You say at paragraph 54 that continuity of care was
8 a key priority during patient transfers and was
9 maintained through a number of structured processes. Do
10 you see that?

11 A. Yes.

12 Q. Would you accept that that wasn't always successfully
13 maintained?

14 A. Yes.

15 Q. And would you accept there are some fairly serious
16 examples of that going wrong --

17 A. Yes.

18 Q. -- in EPUT?

19 A. *(The witness nodded)*.

20 Q. One example which I believe you're familiar with because
21 you refer to this case in your statement, is that of
22 Bethany Lilley?

23 A. Yes.

24 Q. And would you accept that that's one of those examples?

25 A. Yes.

1 Q. You say at your paragraph 58, in relation to the
2 Basildon Mental Health Unit and the opening of the
3 Thorpe Ward in 2018 and '19 that there were instances
4 where patients arrived to the ward without prior
5 notification or sufficient information relating to their
6 transfer or admission?

7 A. Yes.

8 Q. So just to be clear, the right thing, what ought to
9 happen is everybody ought to know about the patient.

10 A. Yes.

11 Q. They ought to know enough about their history.

12 A. *(The witness nodded)*.

13 Q. And they ought to be in a position to manage risk as a
14 result.

15 A. Yes.

16 Q. And would you accept, then, that if they don't have the
17 relevant information, that can create a very serious
18 risk of harm?

19 A. Yes.

20 Q. And would you accept that the case of Bethany Lilley
21 represented an example of that?

22 A. Yes.

23 Q. Just going back slightly, if I can, to the question of
24 families in -- and their involvement. You say families
25 and significant others were routinely informed of

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

3 A. Yes.

4 Q. And you accept it should always happen?

5 A. Yes.

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

12 A. Yes.

13 Q. How are those cases managed?

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

1 Q. Is it right, then, that's something that's still an
2 issue and a challenge?

3 A. I think nationally that's an issue and a challenge.

4 Q. You then also set out at paragraph 56 that following the
5 death of Morgan-Rose Hart, Band 6 nurses on the acute
6 adult wards receive specialist training for CAMHS
7 transition.

8 A. Yes.

9 Q. And you say that happened in January 2024. Do you know
10 what proportion of nurses completed that training?

11 A. So I know that the areas that I was responsible for, my
12 Band 6s attended. I don't know how many, Trust-wide,
13 would have attended that training.

14 Q. And it was completed in January 2024. Do you know if
15 there's been refresher training since then for people
16 who have joined after that date?

17 A. So in terms of -- I know this training was offered by an
18 external company, but in terms of offering the
19 transition training, that's something that has happened
20 more in house rather than through an external company.

21 Q. So sorry, has there been a refresher since, or not?

22 A. Not from this company that was used.

23 Q. And what about internally? Has there been further
24 training on this?

25 A. So internally, there's not a mandatory training for

1 this.

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

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

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

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

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

19 A. Yes.

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

24 A. Yes.

25 Q. And you state that the systems for sharing clinical

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

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

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

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

25 A. Yes.

1 Q. Who -- I don't need a name but who, in terms of role,
2 did you raise those concerns to?

3 A. So I raised that to my line manager, who also would have
4 been Matron at the time. So that would have been my
5 Service Manager. And I also raised it to the Bed
6 Management Team who would have been in NEPT at that
7 time, as well, around making sure that we have
8 notification of who's coming.

9 Q. We know that Bethany Lilley died on 16 January 2019.
10 Was it before or after that that you raised those
11 concerns?

12 A. So I'd raised them before and obviously raised them
13 after as well.

14 Q. So before --

15 A. Yes.

16 Q. -- before her death. What response did you receive?

17 A. So from my line manager they were very supportive and
18 understood the concerns. It wasn't just me at the time
19 that was raising the concerns; the consultant and the
20 Ward Manager as well. So we were looking at what
21 processes we could put in to make sure that transfers
22 were safe, and also thinking about patient experience
23 and trying to make that very positive for people that
24 were arriving, because what I was worried about was that
25 people were arriving at our door and us not having

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

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

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

8 A. Not that I can recall.

9 Q. And do you know why that was?

10 A. No.

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

13 A. Yes.

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

16 A. Yes.

17 Q. -- to those concerns?

18 A. *(The witness nodded)*.

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

20 A. *(The witness nodded)*.

21 Q. Root cause analysis report.

22 A. *(The witness nodded)*.

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

1 that you identified?

2 A. I think it reflected all of my concerns.

3 Q. Did you play any part in the inquest into Bethany

4 Lilley's death?

5 A. No, so I was on maternity leave at the time of the

6 inquest.

7 Q. And as Service Manager more broadly, if there's a death

8 of a patient on one of the units you're responsible for,

9 what would your role be at an inquest?

10 A. So my role would be obviously supporting the wellbeing

11 of the staff that are attending, but also it could be

12 that I am potentially giving evidence or thinking

13 about -- what I had previously done is around giving

14 learning evidence and being a PFD witness as well.

15 Q. So that's -- so you'd be aware of, presumably, and have

16 some involvement in inquest involving the death of

17 a patient on one of the units you're responsible for?

18 A. Yes.

19 Q. What about deaths on other units that you weren't

20 responsible for? What, if any, involvement might you

21 have in those?

22 A. So if any incident occurs that results in a death,

23 I would personally reach out to that team and offer

24 support, and then any learning that comes from that

25 incident is shared, and then learning from the inquest

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

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

11 A. *(The witness nodded)*.

12 Q. -- who has an inquest?

13 A. Yes.

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

16 A. Yes.

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

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

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

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

6 A. No.

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

13 A. Yes.

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

18 A. Yes.

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

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

23 Q. Just tell us --

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

25 Q. -- what is that?

1 A. So HIE was a system that was developed, so it could
2 access both Mobius and Paris documents on there that
3 staff would have a log-in for, and that would bring up
4 relevant documents.

5 Q. Now you refer there to particularly consultants --

6 A. Yes.

7 Q. -- having access to that. What about the other end of
8 the scale, healthcare assistants? Would they have
9 access to that?

10 A. I can't recall whether they had access. The qualified
11 staff had access to HIE. I'm not sure whether the
12 support workers or healthcare assistants would have.

13 Q. And is that the case now, as well as at the time of this
14 report?

15 A. Yes.

16 MR COKE-SMYTH: Thank you very much, that's all I have for
17 the moment. I think we're going to take, if we can,
18 Chair, a short break?

19 THE CHAIR: Fifteen minutes.

20 Fifteen minutes, thank you.

21 MR COKE-SMYTH: Thank you.

22 **(3.33 pm)**

23 **(A short break)**

24 **(3.53 pm)**

25 THE CHAIR: Mr Coke-Smyth.

1 MR COKE-SMYTH: Thank you, Chair.

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

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

9 A. Yes.

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

12 A. Yes.

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

17 A. Yes.

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

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

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

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

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

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

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

16 THE CHAIR: Absent without leave.

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

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

19 MR COKE-SMYTH: Yes. Absent without leave.

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

24 A. Yes.

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

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

4 A. Yes.

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

8 A. Yes.

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

12 A. Yes.

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

16 A. Yes.

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

21 A. Yes.

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

24 A. Yes.

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

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

3 A. Yes.

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

8 A. Yes.

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

11 A. Yes.

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

13 A. Yes.

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

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

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

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

1 Q. What happens in a situation where the patient doesn't
2 want to make a complaint to police, but they may be --
3 they may not be qualified to consent to any
4 relationship? What happens there?
5 A. Then we can report that on their behalf.
6 Q. Would you report that on their behalf?
7 A. Yes, and I have.
8 Q. To the police?
9 A. Yes.
10 Q. And on this occasion was the member of staff that you
11 referred to there reported to the NMC?
12 A. No, this member of staff wasn't a qualified member of
13 staff.
14 Q. But they -- they weren't a nurse?
15 A. Sorry.
16 Q. So they weren't a nurse?
17 A. No, they weren't a nurse.
18 Q. So not registered, not governed by a professional
19 regulatory body?
20 A. Yes.
21 Q. Had they been, would they have been reported?
22 A. Yes. And I have done that.
23 Q. Was there referral to DBS?
24 A. I would need to check that with HR. That's not
25 something that I would do within my role.

1 Q. You also say, at your paragraph 143 --

2 A. Sorry, did you say one --

3 Q. 143, that sometimes -- you may not need to look at it,

4 it's just that you refer to some patients reporting

5 sexual safety concerns.

6 A. Yes.

7 Q. So I think that's something that you say happens. Can

8 you just help us, how frequently does that occur?

9 A. So in my experience, obviously I do have knowledge of it

10 happening. I don't know whether I would be able to say

11 an exact number of how many times that has happened. I

12 don't know if that would be best answered by someone

13 from the Safeguarding Team.

14 THE CHAIR: Can you just give us an idea? I mean, you know,

15 five times, ten times, 100 times, in your experience?

16 A. So in my experience I would say it's under ten, but

17 obviously not a hundred per cent sure on the numbers.

18 MR COKE-SMYTH: Is that your time post-2018 as a manager and

19 above?

20 A. Yes.

21 Q. Or is that Matron and above, or Ward Manager and above,

22 I should say?

23 A. Yes.

24 Q. Moving on then, please, to clinical records. I've asked

25 some questions about care plans but I want to ask some

1 more questions about records more broadly.

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

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

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

13 A. Yes.

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

16 A. Yes.

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

18 A. Yes.

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

21 A. Yes.

22 Q. How would that work?

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

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

5 Q. What about if they're just temporary?

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

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

14 A. Yes.

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

16 A. Yes.

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

19 A. Yes.

20 Q. And particularly temporary HCAs?

21 A. Yes.

22 Q. Do you know when that changed?

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

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

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

8 A. Yes.

9 Q. That lack of access?

10 A. Yes.

11 Q. And it has created risk?

12 A. Yes, it has, yeah.

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

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

25 So some of the issues have been when named nurses

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

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

9 Q. What about things like copying and pasting?

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

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

15 A. So my expectations would be that the Ward Manager would
16 have a conversation with that person around the
17 appropriateness of that and the expectations of how we
18 expect our care plans to be. My expectations of care
19 planning is extremely high, in that should not happen.
20 It does happen. And then if that continues to happen,
21 then we can think about what other supportive measures
22 we need to put in place for that person, whether it's
23 additional bespoke training, whether we need to think
24 about their current caseload on the ward or what can we
25 do differently to help that person. And again, it's

1 very individualised to the staff that have taken that
2 place.

3 I've also -- I've written directly to staff and done
4 management advice letters when I've done *ad hoc* audits
5 to say: look, this is what I've found, this is not my
6 expectations. And I've also had conversations with HR
7 around recordkeeping and the standard that we expect.

8 Q. I'm just being reminded that we need to slow down
9 slightly for the --

10 A. Sorry.

11 Q. -- for the note to be taken?

12 A. Yeah.

13 Q. So I'll try and remind you and I'll pause you if you're
14 going too fast.

15 An important principle of clinical records is that
16 they obviously should be accurate.

17 A. Yes.

18 Q. And they should normally be taken at the time?

19 A. Mm-hm.

20 Q. As a practice, are clinical records by ward staff, in
21 your experience, always made contemporaneously?

22 A. No.

23 Q. And it's right, isn't it, that if they're not made
24 contemporaneously, that the right thing that you should
25 do as a clinician is make that clear?

1 A. Yes.

2 Q. Because if you don't, somebody looking at it is going to
3 assume it's made at the time?

4 A. Yes.

5 Q. And would you agree that can be very serious if you're
6 talking about something like an observation, for
7 example?

8 A. Yes.

9 Q. And would you accept that's been a significant problem
10 at EPUT?

11 A. Yes.

12 Q. What assurances can you give, going forward, that staff
13 are going to keep contemporaneous records?

14 A. So obviously we've got our audits that are in place that
15 will review that, but I think also it's really important
16 that if we're not doing that, that the staff feel
17 empowered to be transparent about that and let us know
18 and we can address that. Because what I don't want to
19 encourage is for that to happen and people not feel
20 empowered to speak up. And for us to hold our hands up
21 and say yes, we have got it wrong but this is how we're
22 going to rectify it and these are the things that we
23 need to put in place.

24 Q. Do you think there might be some aspect of a fear
25 culture amongst staff?

1 A. I think so. But I feel like that's something that we
2 have -- I say "we" -- we've worked really hard to shift.
3 It's not something that you can shift overnight, change
4 in culture, but I think it's something that we're
5 working towards, and I know that in my experience and in
6 my current role that I have had people that have been
7 extremely transparent and honest and held their hands
8 up, and we have had those conversations. So I do feel
9 assured that it is moving in the right direction.

10 THE CHAIR: But it's still an ongoing issue?

11 A. Absolutely.

12 MR COKE-SMYTH: Just moving on to a slightly related matter
13 in respect of records, but I did ask you about care
14 plans --

15 A. Yes.

16 Q. -- earlier. And would you accept that often initial
17 care plans can be brief and generic?

18 A. Yes.

19 Q. And not tailored to an individual patient?

20 A. Yes.

21 Q. You then deal with risk management plans and
22 observations at paragraph 94 to 98.

23 Of your statement. And you say:

24 "... in my experience, once agreed, risk management
25 plans and observation levels are consistently

1 implemented and adhered to."

2 Again, would it be fair to say that that's the
3 expectation, perhaps more than necessarily the reality?

4 A. Yes.

5 Q. And again, in fairness to you, you do say at 98 that:

6 "... there are instances where the unpredictability
7 of the inpatient setting presents challenges that cannot
8 always be anticipated or fully mitigated."

9 And you say:

10 "... efforts are ... made to maintain patient safety
11 and meet observation requirements ..."

12 Also in respect of observations, one purpose of
13 observations is obviously for patient safety.

14 A. Yes.

15 Q. But is it right that there is also potentially
16 a therapeutic engagement aspect?

17 A. Yes.

18 Q. And that's also an important part of observations?

19 A. Yes.

20 Q. So you'd agree it's not a case of just ticking a box on
21 a form; you'd expect the person to engage with the
22 patient?

23 A. Yes.

24 Q. Again, would you accept that historically that hasn't
25 been something that's always been done well?

1 A. Yes, and when I have seen that, I have challenged that,
2 because one of my passions is around engagement, and my
3 teams will know that I will question, if they are
4 sitting, they're not engaging, because again, I can't
5 imagine how I would feel if someone was just sitting
6 there not having anything to say. So it's something
7 that I do champion across the wards that it's really
8 important that we continue to engage with our patients.

9 Q. So other than you as a manager or Service Manager saying
10 that, what are the systems in place that makes that
11 happen?

12 A. So the Ward Managers will do walk around checks.
13 Obviously the most important person we get feedback from
14 is the patient. So we will often ask them what has
15 their engagement been like? "What have you done?", on
16 this person's observations, and then, if it's not up to
17 the standards that we would expect, obviously we'll
18 speak to those individuals as well, but I think there's
19 not an audit tool that can measure the level of
20 engagement. I think it's the person's voice that would
21 say the most who's having that person on their obs.

22 Q. And in terms of making sure it's happening, is part of
23 the problem staffing? Is it due to the staffing mix?
24 Is that something you find harder with temporary staff
25 as opposed to permanent staff? Where are you finding

1 the problem?

2 A. So I think it's around staff confidence and
3 understanding of what observations is. So I think it's
4 really important that we explain the why we're doing
5 something and the rationale behind that for people to
6 really understand what it is we're asking of them, and
7 the expectation is set.

8 So for me, it would be, you know, having
9 a conversation with that patient and asking them what is
10 it they'd like to achieve for the day? "Is it that, you
11 know, you would like your shower at 10 o'clock?" We can
12 make sure if it's a female or a male, "Who would you
13 like on your obs at those times?"

14 But I think sometimes it's making sure your staff
15 are confident with those skills and they're skilled
16 accurately. So, like for us, we've got engagement boxes
17 on the ward where you can just grab them, and it's got
18 like games, colouring books, puzzles, things like that,
19 so it can start those conversations off, which again
20 I think is really important. But also, the staff go
21 through observation and engagement training as well, and
22 we also have support from our psychology team that offer
23 training around engaging with patients, as well.

24 So it's in-person because I think there's real value
25 to having people in the room and listening and

1 understanding, and I've also done away-days. I've done
2 what bad engagement looks like and we've given examples
3 of that, and then showing what good engagement looks
4 like as well, because I know that not everyone learns
5 like me and I'm a very visual learner, so sometimes that
6 can help in terms of what the expectations are of what
7 we want to happen on our observations.

8 Q. One of the things that can impact observations is
9 staffing levels?

10 A. Yes.

11 Q. You obviously need enough staff to be able to conduct
12 a certain level of observations; is that right?

13 A. Yes.

14 Q. It's also right that you are often faced with staffing
15 pressures?

16 A. And so I think obviously we've got our baseline, which
17 is rostered for across all the wards, but there's things
18 that are out of our control that we can't predict.
19 Like, when I've mentioned earlier about unexpected
20 sickness, those things will have an impact on the ward,
21 but I think since us working within the MDT model and
22 having support from our AHP colleagues, we can look at
23 what those shortfalls are and it doesn't always have to
24 rely on the nursing team to provide support with those,
25 those patients.

1 Q. So just help me. Where you, for example, don't have
2 enough nurses because of sickness, or say you don't have
3 enough HCAs because of sickness, how is the risk
4 mitigated in respect of observations?

5 A. So our Ward Managers are supernumerary, so they're not
6 in the numbers, and they can step into the numbers.
7 I will do that, as well. And also, the Matrons will do
8 that. And we will look across, as well, like I've said,
9 I'm really fortunate to have two sites that work
10 collaboratively together. So even though one ward might
11 be short, it could be that one of our wards is
12 overstaffed due to maybe observations being reduced, and
13 we can move staff around to mitigate those risks.

14 Q. So can I just understand this, how much are -- the
15 potential failings or issues to do with observations not
16 being carried out properly, how much is that to do with
17 staffing and how much is it to do with culture, as it
18 were? So where observations are not being done
19 properly, what is the main cause of that? Is it
20 staffing? Is it culture? Is it something else?

21 A. I would say it's potentially a mix between the two, of
22 staffing and of culture.

23 Q. I want to move on and ask about the part of your
24 statement that deals with engagement. You deal with
25 that at paragraph 120 onwards.

1 Now, before I deal with that, I just want to come
2 back to an aspect of your evidence earlier, and you told
3 us that family engagement has increased in the last
4 three to four years. Can I just ask you this: what do
5 you attribute that change, that improvement, in family
6 engagement to?

7 A. I feel that's to do with lessons learnt from where we've
8 not got it right. I also think, again it's one of my
9 passions, that I want to make sure that the families
10 feel heard. It's also around us dealing and looking at
11 lessons learned around complaints, as well. And how can
12 we make sure that that's embedded and I think, you know,
13 having at the forefront of our minds around thinking
14 around family first and, like I said, the work that
15 we've done around shifting that culture and thinking
16 differently, and how would we like to be nursed if we
17 were in the service, as well.

18 Q. Has there been any particular policy or driver from the
19 Senior Management above you in respect of family
20 engagement?

21 A. So we do talk about family-first focus and that has come
22 from the directors and I think, as well, when you're
23 thinking about Trust-wide lessons learnt, that is also
24 being driven down by the seniors.

25 Q. And has there been any -- you've described the change,

1 has there been any actual change in the system or the
2 structure to embed family engagement in the last three
3 or four years?

4 A. I think obviously following the Family Care Ambassadors,
5 that had changed the structure because obviously we have
6 dedicated people in those roles now, but before that,
7 I don't think I could say a hundred per cent it had been
8 dedicated.

9 Q. What about in terms of the record, so, for example,
10 I was asking you before about the assessment and
11 presumably there's some sort of form or record that
12 people have to go through when they carry out an
13 assessment. Has there been any change to that to prompt
14 family engagement that you're aware of?

15 A. So from an inpatient point of view, as mentioned before,
16 the ward review form does have that section in it, and
17 that needs to be completed before that form can be
18 signed off.

19 Q. And just so we understand, the Family Ambassador role,
20 it's right, isn't it, that's in fact as of January 2025?

21 A. Yes.

22 Q. So relatively recent?

23 A. Yes.

24 Q. Thank you. Just going back to your statement, please.

25 You refer to the serious incident prompting this review

1 or change of approach. Can you just tell us what sort
2 of issues arose that caused you to revisit this issue of
3 family engagement?

4 A. So when I returned back from maternity leave and my
5 brief had changed to being at the Chelmsford site, there
6 was a relative that had asked to meet with me, and was
7 really unsatisfied with the lack of communication that
8 they had received for their wife's care. And that
9 meeting was very difficult to sit and hear that, and it
10 made me want to do things differently. I couldn't
11 unhear what I had heard. It made me feel very upset
12 that that was the standard of care that had been
13 provided and I wanted to do better and I also made that
14 relative a commitment that I was not going to not
15 deliver on. And that was that I would make change and
16 that I would ensure that things improved.

17 And obviously that's not just done to me; that takes
18 me and my team, but I think having that conversation and
19 hearing how they felt really -- yeah, I can't explain
20 the impact that that had on me, and wanting to do
21 different.

22 Q. You speak for yourself and the impact that's had on you.

23 A. Yeah.

24 Q. Obviously there's lots of other people involved in this
25 issue.

1 A. Yes.

2 Q. What would you say to the families listening to your
3 evidence to offer them assurance that things have
4 changed in the way you say?

5 A. I think I can only, you know, give my word that things
6 have changed, and that hopefully the positive feedback
7 that we have received and the compliments and the fact
8 that staff are engaging with families does give the
9 families that are listening the assurance that we are
10 really hearing what has gone wrong and that we are doing
11 different, and, you know, if they hadn't have spoken up,
12 we wouldn't be making positive changes.

13 Q. Moving on to the topic of safety and just coming back,
14 if I can, to ligature risk, and audits. I'm just
15 looking at paragraphs 137, 138, if you have those.

16 A. Sorry, 137 and 138?

17 Q. And 138.

18 A. Thank you.

19 Q. And you say you're aware, at paragraph 138, "aware that
20 changes have been implemented as a result of serious
21 incidents", and you reference work taking place to make
22 wards safer for patients.

23 Were you aware that EPUT was prosecuted by the HSE
24 in respect of environmental risk from ligatures?

25 A. So I have some awareness of that.

1 Q. And obviously you refer there to changes following
2 serious incidents, so ligature points being addressed
3 following incidents. Can I just ask you this: are you
4 able to offer any insight, from a staff perspective, for
5 why it appears that EPUT have been so slow to reduce
6 ligature risk?

7 A. I think it's very difficult to answer because I've only
8 ever worked in that Trust. So having not known how
9 other Trusts respond in a responsible, different manner,
10 I don't know. However, the experience I've had is that
11 when there's been a concern raised, I've felt that that
12 has been dealt with in whichever -- whichever manner
13 that might be. But I think also, it's very difficult
14 when there's like Trust-wide work that needs to be done
15 that may appear slow -- so, for example, when we needed
16 to change all of our doors, it might be that I might
17 have felt that maybe my service was more of a higher
18 priority than another service, but, you know, going back
19 to your question, I think it's very difficult for me to
20 say whether they are slow or not to -- because I've only
21 ever known how they've responded.

22 Q. A perspective that many have, looking in --

23 A. Mm-hm.

24 Q. -- particularly families, is that it looks as if an
25 incident happens and EPUT reacts, and they fix that?

1 A. Mm-hm.

2 Q. It doesn't look often from an outside perspective like
3 things are being proactively addressed.

4 A. *(The witness nodded)*.

5 Q. Do you have anything you can say or respond to in
6 respect of that perception?

7 A. I can completely understand how they have seen that
8 because that is exactly how it looks. But I think, as
9 well, there's often a lot of work that is happening in
10 the background that's maybe not spoken about that maybe
11 families might not know that is happening, and then it
12 happens. But I can completely understand how it would
13 appear as reactive.

14 Q. You deal at 138 with the incident in respect of Abbigail
15 Smith.

16 A. Yes.

17 Q. And you refer to work being done. Can you just help us,
18 what work -- so this was an incident where Abbigail
19 Smith was a patient on Galleywood; is that right?

20 A. Yes.

21 Q. And she was able to barricade a door and
22 self-strangulate. And then there was an incident in the
23 garden at The Lakes, you describe there, when a lady
24 died having ligatured using a door handle and you say
25 there was a lot of work done in the gardens and in

1 relation to door handles following that incident. What
2 work was done in the garden?

3 A. So for the one at The Lakes, the door handle was changed
4 so it was changed to a different door handle which was
5 then ligature reduced, but also we then had works done
6 around our furniture and ligature points in our garden
7 area, because they're quite -- so on my wards I'm really
8 fortunate to have quite big, open spaces, which will
9 need additional work to make those areas that are
10 identified risk safer.

11 Q. And when was that work carried out?

12 A. I don't think I can give you an exact date, but when
13 I had returned from maternity leave, so around 2022, a
14 lot of those works were happening or had happened, but
15 I obviously wouldn't be able to say because I wasn't
16 here at the time.

17 Q. Just moving on to another topic in your statement, it's
18 under the heading of "Ligature audits" but I want to ask
19 you if I can, about your paragraph 145 because you refer
20 there to mixed- and single-sex wards and the issue of
21 sexual safety.

22 You told us about an incident involving a patient
23 earlier which was reported. You told us that was
24 reported to the police. But can you just help us, in
25 general terms, what are the channels available to

1 patients to report sexual assaults or inappropriate
2 sexual behaviour?

3 A. So on all the -- so on all the wards -- and I can say
4 that they're on my wards, my areas -- there's posters up
5 around sexual safety information, and also it's included
6 as part of the welcome pack, as well.

7 So there's contact details in there which the
8 patients can make contact with if they don't wish to
9 speak to somebody on the ward. We also do talk about
10 sexual safety in our community meetings, and it's
11 something that we will discuss within the MDT around
12 sexual safety and if there's any incidents of that, that
13 will be shared within our team meetings and also
14 escalated through the appropriate channels.

15 Q. And on the ward, obviously the people have contact with
16 the patients, the most are going to be the HCAs and the
17 nurses, just asking about the HCAs for example, do they
18 have training about how to deal with reports of sexual
19 assault?

20 A. Yes.

21 Q. What would they be told?

22 A. They would be told that they would need to escalate that
23 concern to the nurse in charge. Our Safeguarding Team
24 are available, as well, so they could call them and have
25 a conversation around the concerns that a patient had

1 raised. Also if they felt that they couldn't speak to
2 anybody else, there's additional staff that are
3 available for them to raise concerns.

4 Q. Is there a protocol or a policy that sets out the
5 process for dealing with those sorts of allegations?

6 A. Yes.

7 Q. And where's that kept?

8 A. So that would be kept on the intranet.

9 Q. So if you're an HCA, how would you find out about that?
10 How would you know what to do?

11 A. So you would be informed as part of your induction of
12 where the policies and procedures are kept. Also, all
13 of our staff have an induction, as well, and obviously
14 it's covered as part of the safeguarding training, as
15 well, which all staff have to do as mandatory.

16 Q. I want to move now to the part of your statement that
17 deals with technology and particularly Oxehealth.

18 You refer to your role in piloting the use of
19 Oxehealth technology; is that right?

20 A. Yes.

21 Q. Can I just firstly ask you this: what is your opinion as
22 to the effectiveness of Oxevision in the care of
23 patients on inpatient units.?

24 A. So I think in terms of monitoring the physical health
25 care it's good and also in terms of supporting with

1 monitoring the sleep patterns, it's good.

2 Q. What about its limits? What would you say its limits
3 are, in your view?

4 A. I think obviously the limits would be potentially when
5 staff have misused Oxehealth.

6 Q. And when you say misused, do you mean, for example,
7 relying on Oxehealth, or I'll use the term
8 "Oxevision" --

9 A. Yeah.

10 Q. -- instead of carrying out their own observations?

11 A. Yes.

12 Q. And would you accept that has been a problem?

13 A. Yes.

14 Q. Because the reality is Oxevision shouldn't be
15 a replacement for observations?

16 A. Yeah, it shouldn't be a replacement for the in-person
17 checks.

18 Q. And in terms of the piloting of it, am I right that at
19 the time of the pilot you were a Service Manager of the
20 Hadleigh Unit?

21 A. Yes.

22 Q. And you provided feedback in respect of Oxevision?

23 A. *(The witness nodded)*.

24 Q. So does it follow that that feedback would have related
25 to the Hadleigh Unit?

1 A. Yes.

2 Q. During the pilot, were clinical staff using it
3 encouraged to identify problems or difficulties with the
4 technology?

5 A. Yes, so when the technology was rolled out on the ward,
6 we had additional support from the Oxevision company to
7 be present, and any concerns to be raised and addressed
8 with them as they arrived.

9 Q. Were there staff concerns?

10 A. So there were staff concerns raised in terms of --
11 obviously it's a new technology, how do we use it? What
12 if it goes wrong? We had concerns raised in --
13 particularly on Hadleigh around the wi-fi issue, which
14 is not an uncommon issue on the Basildon site. But
15 there was concerns raised around that and how that would
16 work.

17 Q. And just looking at your statement, you use the term
18 "piloting", just looking at your paragraph 148, and you
19 also talk about, in the same paragraph, "rollout".

20 Might it be seen to be more of a phased
21 implementation than a pilot?

22 A. So when we were informed, that was the language that was
23 used, that we were piloting on Hadleigh. So that's why
24 I used that. And then -- and then we were informed it
25 was then to be rolled out across the Trust. But at the

1 time, it -- that was how it was explained to us.

2 Q. You say that you were unable to recall if you did or
3 didn't feed back any concerns during the pilot.
4 I think, does that relate to your concerns?

5 A. Yes, so obviously during the pilot we were obviously in
6 the Covid pandemic, and I was pregnant at that time so
7 my -- I was very -- it was very difficult for me at
8 times to be on Hadleigh Unit, given the nature of the
9 ward and also being pregnant. So all that I raised was
10 what was escalated to me, which is what I had raised at
11 the time, but I'm unable to recall if there was anything
12 else.

13 Q. And what about from staff below you? Do you recall
14 there being any actual concerns or issues, not at how to
15 use it, but at the principle of using it, as such?

16 A. Not that I can recall. Unfortunately, at that time, my
17 recollection is more around managing the Covid pandemic.

18 Q. In terms of training and the use of Oxevision, would you
19 accept that there were issues or have been issues with
20 staff not being properly trained?

21 A. Yes.

22 Q. Moving on, then, to a different aspect in respect of
23 Oxevision, I want to ask you about the issue of consent,
24 please.

25 A. Yes.

1 Q. You deal with this at paragraph 153. You say that:
2 "I have experienced patients not wishing to consent
3 to Oxehealth and this has been turned off."
4 And you say when providing information to patient
5 and their families, sometimes they've asked for it to be
6 turned off.
7 Would you agree that informed consent is a key
8 consideration with Oxehealth and Oxevision?
9 A. Yes.
10 Q. Would you agree that for consent to be informed, it
11 requires information to be given to patients and their
12 families?
13 A. Yes.
14 Q. Do you think that patients and families have always
15 adequately been informed about what Oxevision is and
16 what it does?
17 A. No, they haven't.
18 Q. And can you confirm, just looking at the consent-taking
19 process, would patients explicitly have been told that
20 Oxevision cameras would be recording them 24/7?
21 A. I don't think that I can offer that assurance, having
22 had patients' and family members' feedback that that's
23 not been the case, so I would say that that hasn't
24 always been explained.
25 Q. Would you agree it should have been?

1 A. Absolutely it should have been.

2 Q. Sometimes in healthcare people are given information

3 leaflets about a procedure or about a technology. Was

4 anything like that provided in respect of Oxevision?

5 A. Yeah, so we did have posters up in the patients'

6 bedrooms and information available to be given out.

7 Q. You said "available to be given out", but would you

8 accept that's different to sitting a patient down at the

9 beginning, or their family, and giving them something --

10 A. *(The witness nodded)*.

11 Q. -- and saying "this is what you need to know --

12 A. Yes.

13 Q. -- do you consent, having read it?".

14 A. Yes.

15 Q. Would you accept that that didn't happen?

16 A. Yes.

17 Q. Can I ask this: what process would be followed

18 surrounding consent if a patient didn't have capacity?

19 A. So the process should be that it's documented and agreed

20 within the MDT whether the Oxevision would need to

21 remain on or off, and that should be reviewed.

22 Q. And what about family members? Would they always have

23 been consulted if a patient didn't have capacity to

24 consent?

25 A. They should have always been consulted. I don't know

1 whether that is the case.

2 Q. Again, do you think it would be the case that they

3 wouldn't always have been consulted when a patient

4 -- (overspeaking) --

5 A. I would say yes, given the feedback that I've had.

6 Q. You say at paragraph 154 that:

7 "I have personally had concerns raised from patients

8 who have been paranoid who have believed they are being

9 watched and listened to, also have supported them with

10 turning it off and also the same for patients that have

11 experienced trauma."

12 A. Yes.

13 Q. That's obviously a valid concern, isn't it --

14 A. Yes.

15 Q. -- in view of the use of cameras? Do you think it was

16 perhaps foreseeable that installing remote camera-based

17 monitoring in bedrooms could exacerbate paranoia,

18 psychosis, distrust, or -- sorry, distress or mistrust?

19 A. Yes.

20 Q. Just before I move on to my final topic, at

21 paragraph 159 you deal with CCTV and you say that

22 patients have been told that CCTV doesn't record in

23 their bedrooms. Would they have been told that

24 Oxevision would record in their bedrooms?

25 A. They should have been. They should have been told that.

1 Again, given my previous answers, I don't think that's
2 always been the case.

3 Q. And given those answers, do you think it wouldn't have
4 always been the case that staff would have been aware of
5 the need to communicate that?

6 A. Yes.

7 Q. Moving on to culture and management. At your
8 paragraph 197 you say:

9 "In my experience 'therapeutic nihilism' has been
10 a factor in the teams I have managed. This has been
11 present within the inpatient but I've also witnessed
12 this within the community."

13 Firstly, what do you mean by therapeutic nihilism?

14 A. So the staff haven't seen any improvement with the
15 patients that may have been given medication and
16 treatment on the ward.

17 Q. And what's the result of that? So they don't see an
18 improvement, and what does that lead to?

19 A. So I think when you work in mental health, one of the
20 things that you really want to see is your patient come
21 through and recover, and you want to see that journey of
22 them being better and support them along that journey,
23 and sometimes there's a -- there's patients that come in
24 that may present the same from point of admission, and
25 that that could be the same presentation for months.

1 And it's really difficult for the teams to see the hope
2 of that person recovering and the impact that has when
3 you're not able to hope.

4 Q. And do you think that that perhaps disproportionately,
5 affected the care of patients who repeatedly, for
6 example, self-harmed or absconded or tried to kill
7 themselves?

8 A. Yes.

9 Q. What would you do as a Matron or Service Manager to
10 combat that?

11 A. So one of the things that I do in my current practice is
12 that I will engage with the team, especially if I feel
13 that there is signs of compassion fatigue within that
14 team. I will speak with the consultant, I will speak
15 with the leads, and I will go and look at what
16 additional support mechanisms we can put in place, so
17 whether that's additional reflective practice,
18 additional support from psychology, think about meeting
19 with the patient and trying to see what their goals are
20 that they want to achieve, meeting with the family, and
21 really trying to look at how we can instill that hope
22 and what we can do differently and yeah, thinking about
23 what is in the best interests of that patient to get
24 them better.

25 Q. Would you agree there's still work to do to address

1 that?

2 A. Yes.

3 Q. You deal with the question of internal investigations,
4 and that's something that will happen, certainly happen
5 following a patient death.

6 A. Yes.

7 Q. And you describe having been involved in those and being
8 made aware of recommendations. I asked you previously,
9 I'm going to ask you again, because I know it's a case
10 you're familiar with, the case of Bethany Lilley.

11 A. Mm.

12 Q. There was obviously an internal investigation by EPUT.
13 There was also an independent report commissioned by
14 Duncan and Johnston. Were you aware of that?

15 A. Yes.

16 Q. Sorry, not commissioned by, produced by Duncan and
17 Johnston?

18 A. Yes, I was aware of that. However, that was shared with
19 me obviously once I'd returned back from maternity
20 leave, so in terms of the timeline that I would have
21 known about that a lot later after it had happened.

22 Q. Were you made aware of the criticisms that report made
23 about EPUT's own internal investigation report?

24 A. Yes.

25 Q. Was there learning as a result of that?

1 A. Yes.

2 Q. Was that disseminated to you?

3 A. Yes. My director at the time sat me down and discussed
4 all of the findings.

5 Q. Good and poor practice. You deal with that from
6 paragraph 210. You've described witnessing a staff
7 member falling asleep. How common is that, in your
8 experience?

9 A. It has been featured throughout my whole career within
10 working within the different Trusts, that this has
11 happened.

12 I would say that it's less common now than previous
13 years in the last, sort of, three years. Yeah, I think
14 there's been a lot of supportive measures put in place
15 now to combat that.

16 Q. There could also be an issue in respect of mobile
17 phones --

18 A. Yes.

19 Q. -- on wards. What's the mobile phone policy at EPUT on
20 wards?

21 A. So staff should not be on their mobile phones whilst
22 they're completing or performing observations.

23 Q. Completing or performing observations. What about when
24 they're not, more generally?

25 A. So they shouldn't be, like, in the open spaces on their

1 phone. So, like, our -- so, like, our nursing offices,
2 they've got all windows so people can see in and out.
3 So they should be in, like, closed areas so, like, the
4 staff rooms for example.

5 Q. So to summarise, mobile phones not allowed in public
6 areas, are allowed in private areas not visible to
7 patients?

8 A. Yeah.

9 Q. And for how long has that been the policy?

10 A. That has been in place since I have worked within the
11 Trust, and it's always been you don't have your phone on
12 you, you keep it in your bag. If there's a need for
13 someone to contact you, then you can give the ward
14 number. I mean, so it's all -- that's been in place
15 since 2008.

16 Q. The final thing I want to ask you about is the
17 Dispatches documentary.

18 A. Yes.

19 Q. You deal with that at the end of your statement. And
20 you describe there that it made you feel sorry for
21 patients. Why was that?

22 A. I think it was really upsetting watching the Dispatches
23 programme and it made me feel extremely sorry that
24 patients had received such treatment within our service,
25 and it just isn't something that I would have expected

1 to have happened.

2 Q. Why did you feel like you had failed people?

3 A. I think you become a nurse because you want to help
4 people and you want to do the best you can and
5 I generally felt that having watched that, and that
6 happened in wards that I was responsible for, I did feel
7 that I had failed them.

8 Q. What concerned you most about what you saw in respect of
9 the care in that documentary?

10 A. I think it all -- the whole documentary concerned me and
11 I think the fact that staff felt that the way they were
12 treating people was okay, and that that hadn't been
13 escalated or people hadn't felt that they could speak up
14 about what they'd seen.

15 Q. Was any action taken by way of disciplinary action or
16 formal action against any of the staff as a result of
17 that documentary?

18 A. I don't know because I wasn't involved in that process.

19 Q. What did you take away -- what lessons did you take away
20 from the documentary?

21 A. So I think one of the lessons that I took and I've spoke
22 about it previously is around if we're getting it wrong
23 we need to hold our hands up and be transparent, and
24 that if we have done something that we're concerned
25 about, I really want staff to feel empowered to speak up

1 and not have the fear of potential consequences, and
2 I think it made me want to be present with a purpose on
3 the wards and speak to patients about their experience
4 and understand what it is we can do differently, and
5 what we need to be better at. And I think it's okay to
6 acknowledge that there's still areas for improvement,
7 and that shouldn't be seen as that we're failing; it's
8 just that we need to think differently about what we're
9 doing. And I think it -- yeah, it made me want to do
10 more.

11 Q. One feature of the family evidence that the Inquiry has
12 heard is a number of families have described EPUT as
13 being defensive?

14 A. Mm-hm.

15 Q. Not being candid?

16 A. *(The witness nodded)*.

17 Q. How do you respond to that from a staff perspective?
18 Can you offer any explanation why that might be
19 perceived that way?

20 A. No, I mean I would be extremely sorry that that was
21 their experience and that's not what I would expect from
22 the Trust or from the staff when we work in such
23 a caring environment.

24 MR COKE-SMYTH: Chair, I think now's the time where, if we
25 may, we're going to take a ten-minute break before -- to

1 see if there are any final questions.

2 THE CHAIR: Ten minutes.

3 **(4.53 pm)**

4 **(A short break)**

5 **(5.08 pm)**

6 THE CHAIR: Mr Coke-Smyth.

7 MR COKE-SMYTH: Thank you, Chair.

8 I only have a few more questions, so hopefully we're
9 just going to be a few more minutes.

10 You referred earlier in your evidence to ensuring
11 that families are communicated with before transfers
12 take place.

13 A. *(The witness nodded)*.

14 Q. Presumably that would apply equally to transfers out of
15 area?

16 A. Yes.

17 Q. You also gave evidence earlier that those under the
18 influence of drugs or alcohol who are held -- about
19 those who are held at A&E or who attend A&E under the
20 influence of drugs or alcohol, who need to be assessed
21 under the Mental Health Act, do you know what steps
22 would be taken to ensure that they're kept safe while
23 they're waiting for an assessment at A&E?

24 A. So the liaison team that are based at our A&E
25 departments, obviously they would be monitoring and

1 supporting with any additional needs and that person can
2 also be nursed on a one-to-one as well, if there's
3 a significant risk. But obviously A&E is a public
4 place, as well, so there is still the risk of that
5 person being able to leave.

6 Q. And say a person does leave, they haven't been assessed,
7 would EPUT take any steps to try to follow up to assess
8 that patient, to either contact them or --

9 A. Yeah, and we would also contact the police to inform
10 them that they've left the department without being
11 seen, and the risks, especially as they've been referred
12 in for a Mental Health Act the risk would be considered
13 as higher, so we would do that and also we would make
14 contact, or attempt to make contact with that person, as
15 well, and if appropriate, contact relevant loved ones to
16 let them know that that person has left the department
17 without being seen.

18 Q. You gave evidence earlier about the procedure for
19 dealing with an allegation of a sexual assault. Are
20 there policies that deal with patient-to-patient
21 relationships on inpatient wards?

22 A. Yes.

23 Q. And how would you respond if you became aware of
24 a relationship between patients on an inpatient ward?

25 A. So obviously we would contact the Safeguarding Team. If

1 there was an incident, then that also would need to be
2 Datix-ed, there would be a conversation with the MDT as
3 well which would include whether or not it would be
4 appropriate for those patients to remain on the same
5 ward. It could be that if there's a significant risk,
6 that we may need to think about whether they remain on
7 the ward, and if needed to, potentially one of those
8 patients could be moved if the risk was deemed serious
9 enough.

10 But all of that would need to be documented.

11 Q. You gave evidence about staff falling asleep on
12 occasion. You described that now being less common.
13 What do you think the reason for that is?

14 A. So I think, in terms of the Trust reviewing the
15 observation and engagement policy and now the number
16 of -- so -- sorry, the number of hours of observations
17 that one individual can do is less. In my areas I can
18 give assurance that we do wellbeing checks for our staff
19 that are on observations. So those staff that -- so
20 during the day the ward managers will go round and just
21 check people, how they're feeling, if they're alert, do
22 they need a break? Is it that we need to think about
23 observations being potentially maybe half-hourly obs if
24 they're intense?

25 Also, we've got our Clinical Site Managers that work

1 out of hours, they work nights and weekends, as well,
2 they're Band 7, and they also do the same checks, as
3 well. So I feel like there's a lot of support in place.

4 We also do ask the question at handover if there's
5 any concerns that staff do want to raise. So it could
6 be that there's things that have happened outside of our
7 control, maybe they've not had adequate sleep, I don't
8 know, maybe a child's been sick. There's things that we
9 would need to know to support that person whilst they're
10 at work.

11 MR COKE-SMYTH: Thank you very much, Ms Cawston. Those are
12 all the questions I have.

13 Chair, do you have any questions?

14 THE CHAIR: I have no further questions, thank you very
15 much. Can I thank you very much indeed for coming to
16 give evidence.

17 THE WITNESS: Thank you.

18 THE CHAIR: It's very much appreciated.

19 THE WITNESS: Thank you.

20 MR COKE-SMYTH: Thank you, Chair, and I believe we're going
21 to resume tomorrow at 10.00 am.

22 THE CHAIR: 10.00 am tomorrow.

23 **(5.13 pm)**

24 **(The hearing adjourned until 10.00 am the following day)**

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