Wednesday, 15 July 2026

(2.35 pm)

MS ONABANJO: Good afternoon.

WITNESS: Hi.

MS ONABANJO: I believe you have the wording of the affirmation?

WITNESS: I have.

MS ONABANJO: Can you read it, please?

STUART MCGOUGH (affirmed)

Questioned by MS ONABANJO

MS ONABANJO: Thank you. You've just said your name but can you state it in full for the record, please.

A. Yes, Stuart McGough.

Q. Thank you. And you've provided one witness statement to the Inquiry dated 22 May; is that correct?

A. It is.

Q. You have a copy of that statement in front of you. And have signed the final page.

A. Yes.

Q. And that final page bears a statement of truth.

A. It does.

Q. Have you had the opportunity to read that statement recently?

A. Yes.

Q. Do you have any corrections you wish to make?

A. I have one on paragraph 19, with regards to the wards' cleaning service, I said it was provided in house. I may be wrong on that. It may have been a commercial service brought in, but was still monitored by both their service and our service.

Q. Thank you. That's understood. So apart from that correction, can you confirm that the contents of your statement are true and accurate to the best of your knowledge and belief?

A. Yes.

Q. And are you content for that statement to stand as your evidence to the Inquiry?

A. Yes.

Q. I will now ask you some questions about your qualifications and experience. You set out your qualifications at paragraph 2 of your statement. That's on page 2.

A. Yes.

Q. When did you qualify as a Registered Mental Health Nurse?

A. 19 -- I think it was 1988 in the September.

Q. Thank you. And after the point that you qualified, I note that you had a number of roles across the country.

A. Yes.

Q. And then you say at paragraph 7 of your statement, which is on page 3, that you started working for the Mid Essex Partnership NHS Foundation Trust in August 1999; is that correct?

A. Yes. Sorry, I was just going to say all dates are approximate --

Q. Yes, understood.

A. -- because I haven't got any written record of any sort at all but that is my recollection.

Q. Thank you. I note that the Mid Essex NHS Foundation Trust merged with West Essex and North East Essex Mental Health Trust in 2001 to become the North Essex Partnership NHS Trust, which I --

A. Yes.

Q. -- I will refer to in the course of the hearing today as NEPT; is that right?

A. Yes.

Q. And the majority of my questions today will be --

A. Sorry, I can't hear you.

Q. I will try again. Can you hear me now?

A. I can hear you. Yes.

Q. The majority of my questions today will be --

A. Sorry, I can't -- the still is -- it's frozen. I can't hear you, or there's no movement on the camera.

Q. We will take a ten-minute break just to sort out the

technical issues.

A. Okay. No problem.

(2.39 pm)

(A short break)

(2.47 pm)

MS ONABANJO: Before we continue, may I remind you to please keep the pace slow to assist the transcribers in their work.

A. Right.

Q. When we last stopped, I noted that you started working for the Mid Essex Partnership NHS Foundation Trust in August 1999, and I noted that that Trust merged with two other Trusts in 2001 to become NEPT; is that correct?

A. Yes, correct.

Q. And the majority of my questions for you today will be about your time at the Linden Centre, from 2002 onwards. And at that time, the Linden Centre was run by NEPT.

A. Yes.

Q. I note also that the Essex Partnership University NHS Foundation Trust did not exist until nine years after you retired. And so your evidence today is about NEPT; is that right?

A. Yes.

Q. At paragraph 7 of your witness statement on page 3, you say that you started -- your first job within NEPT was

at New Ivy Chimneys Rehabilitation Unit; is that correct?

A. Yes.

Q. Do you recall whether that was an outpatient or an inpatient unit?

A. Inpatient unit.

Q. And do you recall what the purpose of the care provided by that unit was?

A. To provide rehabilitation so that patients could live more easily and meaningfully in the community, so we were actually preparing them to actually move out of our system to be independent.

Q. And what types of patients did you see at that unit?

A. I would say the majority of them had psychosis or the remnants of one -- the odd depressed one that was on the unit.

Q. Thank you. At paragraph 9 you say that approximately 18 months later you were asked to manage the Cherry Trees Day Hospital in Maldon. Would this have been around February 2001?

A. I would think so, yes.

Q. And you say you were brought in because there were issues with team cohesion and leadership.

A. Yes.

Q. Can you recall what factors were contributing to those

issues?

A. I'm sorry, I can't. My memory doesn't help me with that. I think there were -- had had problems with the people at work leading prior to that, and there was some unrest amongst the staff as to, I don't know, I think they'd lost trust within the management, and I was looking there to use my skills -- I sound bigheaded -- but to use my skills and, you know, get some, you know, show them that we could build up a trusting relationship at work. I have to say, at that time there was no issues regarding the treatment that the patients got. It was a day hospital, so we're a therapeutic, very therapeutic hospital.

Q. So is it your evidence that the leadership issues and the loss of trust in the leadership had no impact on patient care?

A. Not -- no, actually, even though we spent a lot of time building trust between me and them, something had happened to them that had, you know, they'd lost trust in the way that the unit was managed. But there was no -- in actual fact, I enjoyed myself taking part in therapy groups as well as actually acting as the manager.

Q. And when you say they lost trust, are you referring to the staff had lost trust in management?

A. Yes, I think so. Yes.

Q. Thank you. You were at Cherry Tree for 12 months before you became the Acting Clinical Manager at the Linden Centre. Does this mean you started work at the Linden Centre in around February 2002?

A. I think that would be about right.

Q. Then you say you became the Service Manager at some point, and that included responsibility for the Linden Centre and two community teams; is that right?

A. Yes.

Q. What was the difference between your roles as Acting Manager and Service Manager?

A. Well, the Acting Manager was a clinical manager, so I worked directly with just the team at the Linden Centre, or teams. A Service Manager, it was a bit more into the general management and having responsibility for community teams.

Q. Right. So as Acting Clinical Manager, you were responsible for the management of the wards at the Linden Centre, but as Service Manager, your role was broader and encompassed community teams?

A. That's right.

Q. And at the time where you were the Acting Clinical Manager or the Service Manager at the Linden Centre, were you the direct line manager for the Finchingfield

Ward and the Galleywood Ward?

A. Yes.

Q. Thank you. Before returning to questions about the Linden Centre, I want to ask you about your retirement. At paragraph 28 of your statement on page 8, you say that you retired on 31 December 2008, but because of accrued annual leave your last working day was approximately 16 December. Are you able to be more definitive about that last working day?

A. I can't, because the -- although my official leaving day was the 31st, with annual leave, bank holidays, things like that, it -- I finished working there before the end of my retirement date. And I believed that to be about 14 days. But I can't, you know, I can't be sure and exact what date I retired.

Q. Thank you. Did you ever work any bank or agency shifts at NEPT after you retired?

A. No.

Q. Do you remember whether you were replaced, somebody else replaced you as Service Manager?

A. I -- my recollection is that I wasn't aware of who was going to take over my post when I left.

Q. And do I take it from that, that the person who was going to replace you wasn't in post at the time that you left?

A. That's right.

Q. Thank you. I'll return to the topic of your retirement later when I ask you questions about the case of Ben Morris.

I will now turn to the Linden Centre and ask you about the wards. The Linden Centre had a number of services within it. There was the Finchingfield Ward and the Galleywood Ward and those were acute adult wards; is that right?

A. Correct.

Q. And you say there were mixed sex wards when you were there; is that right?

A. Correct.

Q. There was also a mother and baby unit?

A. And that was based in Galleywood, yes.

Q. Based in Galleywood?

A. Yes.

Q. And also the Tillingham Day Hospital?

A. That's correct.

Q. What services did that provide?

A. It provided therapeutic services to people that were living in the community and travelled in to the day hospital. We were quite fortunate that in the day hospital, the then manager had started a Clozaril clinic, which was a medication, Clozaril was

a medication which at that time was a last resort for people where other medication didn't work, and -- but could only be prescribed by an approved consultant. And the actual rules for having it, and, you know, if it went wrong, you know, lots of things could happen, and so they -- the Clozaril clinic monitored the blood levels, ensured they were returned to the manufacturer because only they would explore the bloods and come back with the medication prescription for it.

So that helped both the Tillingham Day Hospital in its group of patients that were on Clozaril that were coming in to the day hospital but also provided help to those on the wards so that the Clozaril levels could be monitored closely through our own facilities.

Q. Thank you. You also mention that there was the Cressing Ward at the Linden Centre, which later became a dedicated Crisis Intervention Team. In relation to all of these services, different wards and units at the Linden Centre, is it right that as Acting Clinical Manager you were managing all of these services?

A. Yes, as the Clinical Manager I was managing them, yes.

Q. At paragraph 12 you also mention that the Christopher Unit was on site. Were you responsible for the Christopher Unit when you were Acting Clinical Manager?

A. No.

Q. Were you responsible for it when you became Service Manager?

A. No.

Q. Thank you.

A. It was self-contained unit. It was a secure unit. Which -- the reason I mentioned it, probably not very clearly, was that it was a facility that if we had problems on the wards, we could refer the patient to the Christopher Unit for, you know, they would, in some cases, take the patient until the psychosis or whatever was happening had died down.

Q. Thank you. At paragraph 15 of your statement, you describe the rooms at the Linden Centre. And in terms of the individual patient rooms, you tell us that they were lockable and each patient had a keycard. You also say that some patients wedged their rooms open with towels. Were patients able to lock their rooms when they were inside them?

A. Yes, I believe they were.

Q. Can you remember whether there were any protocols in place in relation to patients locking themselves in their rooms?

A. Sorry, I can't remember any protocols.

Q. Would you agree that the ability of patients to lock themselves in their rooms posed a safety issue?

A. Well, every member of staff also had a keycard which locked all of the rooms, that -- there was -- the big problem with any kind of room with a door on it, wasn't necessarily the locking of it, which was there to make them feel more secure, but the actual problem could arise of barricading in that room, which would, you know, stop access. But all staff had key cards which would open the individual rooms.

Q. Thank you. I will now ask you questions arising out of your evidence about staffing at paragraphs 29 to 36 of your statement.

First, I'll ask you questions about the staff mix on the wards. Can you remember how many patients there were on each of Finchingfield and Galleywood Wards?

A. I think it was 24.

Q. Do you remember how many nurses would usually have worked on each ward?

A. No, not on each shift.

Q. What about healthcare assistants? Do you recall how many would have worked on each --

A. No, no. Sorry.

Q. Can you recall what training was mandatory for nurses at the time?

A. Some of them, obviously there was -- restraint and control was mandatory, fire training was mandatory.

That's where my memory fails me, unfortunately. I can't think of the others. But there would be more than that.

Q. At paragraph 36 of your statement, you say that Paul Keedwell did a review of staffing levels.

A. Yes.

Q. Do you recall why he was tasked to do this review?

A. I think it would have been budgetary led, initially, you know, the actual way the wards were staffed was really somebody thinking of numbers. There was no national guidelines about, you know, if you had -- how many patients you had and how many members of staff you should have. So Paul Keedwell undertook that project to actually determine the number of staff that was needed for a ward. And in all honesty, I can't remember whether it resulted in an increase or a decrease in staffing levels. But it, you know, it took him about 12 months, I would suggest.

Q. Do you recall whether, at the time, there was a concern about the adequacy of staff numbers on wards?

A. The acute wards were always in a state of flux. So your actual staffing requirements would change within 20 minutes. So if you were working on a minimum level of staffing, then, you know, if an admission was made and there was observation levels which were high, if there'd been a consultant review, again, the observation levels

had changed, for example, then you could end up in a situation where you didn't have sufficient numbers, at that point, to keep the wards safe. But at that point they would, you know, beg and steal people from different wards to ensure the balance was kept and that the patients were safe.

Q. So when you say at paragraph 35 of your statement that staff were very good at covering those situations where the staffing needs changed quickly, is that what you meant, that you could essentially borrow staff from other wards?

A. Yes, yeah. I think that the other thing, you could always -- if it was -- if it was before the nurse bank was formed, you would have to phone up agency staff. You know, the problem arises when you're borrowing staff, that they aren't going to finish their shifts at the same time as the ones, you know, that have come in to cover. So you would also be looking for agency staff to provide extra numbers for the rest of the day, rather than just, you know, for one shift. Does that make sense?

Q. It does. Was it always possible to get bank or agency staff at very short notice?

A. With agency staff it would be easier, because they had a larger group of people that were available. And

because those people lived in a very large area around from the Linden Centre. So they would -- could normally cover staff, if I remember right, although there may be, you know, a time gap where they would travel in from where they were to come and do a turn of duty.

Q. Thank you. Given your experience, are you able to give an opinion on how many staff you think are needed for a ward that has 20 people, for example?

A. No, but you never had enough. That was the general feeling: that there'd been that many government, what do you call them, notifications that -- it was about efficiency rather than about (unclear). It was more about efficiency of the service, you know, that you should be working better to make the inefficiencies -- to make what you had work.

Q. You say staff, staffing levels was insufficient, so there was never enough staff. Do you recall patient care being affected by understaffed shifts?

A. Well, I cannot remember a shift that would not have its sufficient staff on it. The rosters were actually filled -- were booked up to a month in advance, but, you know, you always had the problem that somebody would phone in sick on the morning and you'd be one down and then you'd have to start arranging for other staff. And the other thing that you have to bear in mind is that

you had trained staff who could do certain jobs; then you had untrained staff, nursing assistants, who could only -- could do the assisting of qualified staff. So it's not only about the numbers of staff, it's also about the actual mix of staff which was important, as well.

Q. When you say that there was never enough staff, what impact did that have?

A. I think the biggest impact, I think they always -- we always tried to cover the wards, and if I remember correctly, were very successful in that. My -- always my main concern was that we had members of staff on the ward who were caring for the patients who didn't have any history of the patient, sometimes didn't even know the layout of the ward. Certainly weren't as knowledgeable of the policies and procedures.

So I think you've got to see the whole thing with those limitations and excesses in line. So I think we did well to cover the wards, you know. If I can give you an example, when I went to the rehab unit with the manager, there wasn't enough staff to actually staff the unit for 24 hours a day, seven days a week. So we always had agency staff covering, you know, a period at each day and that was only 5.00 till 9.00 of an evening. So that could manage, you know, we'd cover that, but,

you know, the management of staff on an acute ward, you will never have enough staff. That was my feeling, anyway.

Q. Some of these points you make, you actually make them in paragraph 29 of your witness statement in relation to agency staff, about managers not being aware of the staff members who are coming on to wards or agency staff not being very familiar with the wards. So is your evidence then that there were times when, because of the use of agency staff, staff weren't able to provide an adequate standard of care for patients?

A. No, I don't think that would apply greatly. You always had the core basis of the staff there, so in actual fact the agency staff would follow the instructions of the qualified staff on the ward to ensure that patient safety.

Q. Could I take you to paragraph 30 of your statement?

A. 30, did you say?

Q. Yes.

A. 30.

Q. So you say the downside of using agency staff was that the managers were unaware of who that person would be, the agency staff may not know which ward they were allocated to, and they may not have the necessary current skill to care for patients in the area they were

allocated to.

And so my question to you is: is it -- do I take from that evidence that what you're saying is inadequate patient care could be an issue where agency staff are used?

A. Yeah, the, the problem arose with agency staff, there would be qualified RMNs or -- and it was normally qualified people through the agency staff who would have the core qualification, but they were sometimes allocated to an acute ward, but they'd spent I don't know how many -- well, perhaps they worked full time in their normal job in a dementia unit, for example. So they, you know, they were there under instructions of the permanent staff.

Q. Thank you. We've now been going for about half an hour. Would you like to take a break now?

A. No, I'm fine, thank you.

Q. Thank you.

At paragraph 29 of your statement, you refer to the Trust creating its own nurse bank. Do you recall when this happened?

A. I can't remember the dates, I'm sorry.

Q. The nurse bank helped to reduce the number of agency staff that were used on each shift.

A. Yeah, the agency staff was costing the Trust, if

I remember correctly, at one point, over a million pound a year, which was a very large expenditure, which also begs the question, in my head, that if you were spending that much on agency staff, why wasn't the money spent on additional staff? That's probably a very naive way for a manager to look at it, and I appreciate that. But that was the initial -- I remember it being said it was costing agency -- the agency bill was about over a million at one point.

Setting the nurse bank up meant that you got a lot more people from your own resource, staff resource. So they knew the patients, they knew the policies, procedures. They knew the layouts of the wards. They knew what was expected of them. So that was a positive side, and that was set up internally on the Linden Centre, initially, but it served the Trust-wide. But the -- it has its problems, in that where some staff would stay on the agency so therefore wouldn't get any work, but it also meant that the bank staff, also we had this -- at least to my thinking, we had this problem that, you know, the idea of staff getting two days off a week and six weeks holiday, up to six weeks holidays, was to allow them to recover. My main concern about nurse banks is that some of these people would take their holiday and work it, you know, as, you know, on

the nurse bank. Which in actual fact meant that they could be working weeks on end without actually getting, you know, any breaks or any time to themselves.

So that was always in the back of my mind that it could create problems and I kept a fairly close eye on that.

Q. At paragraph 34 you talk about the need to balance regulations on excessive hours with the use of bank staff and you concluded in that paragraph that:

"The need to ensure the safety of the ward and the care to the patients is always a challenge."

What was that challenge?

A. That challenge, to me, was -- if you were looking for a member of staff because, you know, circumstances had changed on the ward and you were looking for a bank staff to cover that ward, and if a bank member of staff said, "No, I can't work, you know, I've done me hours" kind of thing, the actual safety of the patient will always be -- take priority over the availability of the staff. And that is -- sorry.

Q. I was going to ask, in what way would safety take priority?

A. Well, if you had somebody on or had a number of people on, for example, close observations and you needed an extra member of staff to ensure that the patient was

observed correctly, and you wanted a bank member of staff on the unit, and that if the bank member of staff that was available hadn't, you know, hadn't had a day off for a week, the priority of the patient safety would always take prominence in the actual -- the getting the member of staff. And that's what would happen.

Q. And so the bank staff would work longer hours?

A. That's right. So it's all right me having things about, you know, taking proper breaks and days off, you know, on holidays, you know. But, you know, the priority of the patient, and that's -- the staff would have to take priority in these situations.

Q. In such situations, was there a risk that staff being over-tired would have a detrimental impact on patient care?

A. It could have.

Q. And in what ways would that manifest?

A. Well, perhaps they weren't as alert as they should be. You know, perhaps they weren't as sharp as they would normally be, wouldn't realise something -- what was happening, that it was happening. But that's me answering your question if you know what I mean.
I don't have any knowledge or memory of that happening on the wards. That doesn't mean to say that that didn't happen.

Q. Thank you. I'm now going to turn to the management of the Linden Centre and the wards. As the Acting Clinical Manager or Service Manager, can you explain what your day-to-day involvement with the ward was?

A. Well, part of it was on those terms, I think. Well, I was responsible for ensuring that a number of -- the patients were safe, and that their needs were accounted for, and the same applies that I also looked at members of staff and that -- ensuring that they were safe, and that their needs were accounted for. Other things that I would be involved in, would be disciplinary procedures against members of staff, for example.

Q. Were you on the wards every day?

A. As the Acting Clinical Manager, I wouldn't say every day, but I went on to the wards when I wanted and when I was needed, and I didn't go at any pre-set times. I would just go on the ward and, you know, have a wander around and have a chat with the staff and that kind of thing. Just to make sure that, you know, if something urgent came up, yeah, the door was open. And as the Acting Manager, my -- I was based on the ground floor, so I was only just round the corner, down the corridor a little bit away from the wards. So -- and that door was always open, and, you know, to somebody who might want to talk to me about, you know, a course they needed to

go on or wanted to go on.

So they could either come to me or I would go to them. So that was the kind of arrangement that we had.

Q. And did you have any processes in place to supervise and monitor the conduct of staff?

A. Sorry, could you say that again?

Q. Did you have any processes in place to supervise staff and monitor their conduct?

A. I would say yes, but I know the next question is "What" and to be honest, when it comes down to the procedures, I'm afraid that memory is long since gone.

Q. But do you know in practice -- could you tell us, in practical terms, what you would have done to manage those you were supervising?

A. Well, we had formal supervision periods, but -- and the -- so I would supervise the Ward Managers, and the Ward Managers would supervise their staff. And senior members of their staff would supervise the junior members of staff. And when I say "junior", I don't mean inexperienced, I mean actually, you know, going from Charge Nurse down to Staff Nurse down to nursing assistant.

Q. Thank you. You've said in your statement that the management of Galleywood Ward and Finchingfield Ward had their own individual style.

A. Yes.

Q. And I'd like to explore that with you in a bit more detail. Can you describe what Mr Ayris's management approach was?

A. Very laid back. My memory of it is that he -- Mr Ayris was -- I think he came from the secure unit but I might be wrong on that. But he's very laid back with his staff. But always wanted to be in it, if you know what I mean. So he would rather be part of what was happening rather than in a position one step back, making sure that everything was going to plan.

Q. Could you give practical examples of how this laid-back approach manifested?

A. No, not really. But there were sometimes issues with staff which Mr Ayris wouldn't be aware of, because ... perhaps if I can give an example?

Q. Yes.

A. On the office of the ward was -- sorry, on the ward was an office which was the doctors' office so the junior doctors could go in there and, you know, have a cup of tea or hide or whatever they wanted to do. But it came to my notice that phone calls, substantial-costing phone calls would be made from that number. And what a lot of staff didn't realise is that the actual locks on the doors could be explored and we knew exactly who went in

to what room and what time that door was opened coming out. So we could actually find -- know who was making the calls, which we did.

But that came as a complete surprise to Mr Ayris that that was happening on his ward.

Q. And how did it come to your notice?

A. It came from the treasury department because they'd noticed these bills coming in which were, you know, had, you know, telephone costs which had never been in that region before.

Q. Thank you. I will just take a moment, Mr McGough.

You've just said that staff were going to hide in the room. What do you mean by that?

A. The doctors could go and hide in the -- in that room. It were the doctors', the junior doctors' room which they could use as an office. Sorry, I don't mean doctors went in there to hide.

Q. But did you mean that they were in there when they should have been on the ward?

A. They could have been in there when they were on a break.

Q. I see. We've heard from Mr Ayris that he thought his approach to self-harm was different to others, and that if someone self-harmed he wouldn't necessarily remove all of their belongings immediately, increase their medication, or increase their observations. Do you

remember being aware of Mr Ayris's approach at the time you worked at the Linden Centre?

A. I think it's important to realise that Stuart Ayris was a control and restraint teacher, trainer. So my expectation was always that he -- he'd actually probably trained a lot of the staff, if not all of us at some point, and was getting the message across, but Mr Ayris would always be -- yeah, I think he would be quite open to not doing things. But I don't think anybody would have removed all a person's belongings because something had happened, nor would medication be increased every time and I think that applies to most wards.

Q. So you think the approach that Mr Ayris describes is one that would have been taken by other staff in other wards?

A. I would hope so. And I believe that that probably -- I believe at that time that that was happening.

Q. Do you consider that that approach was in accordance with Trust policies at the time?

A. Yes.

Q. And in what way was that consistent with Trust policies?

A. What I was going to say, if I can just go back one step, and answer "yes" to the question, but, you know, the Trust had policies and procedures for just about everything, and there was a volume on control and

restraint, you know, I have no memory of the content of it, you know, these pieces of, you know, pieces of paper.

Q. But would it have been consistent with Trust policy to leave belongings with somebody who had self-harmed?

A. Well, it depends on what belongings you would leave. Obviously you would want to -- if you thought that everything needed to be removed, then in actual fact what you needed was the patient on constant observation, if, for example, they'd just made an attempt on their own life.

Q. And so the action that would be taken would be dependent on the particular circumstances?

A. That's right.

Q. Can I turn now to Ms Saibon's management style. Can you describe how that differed from Mr Ayris's style, if it did differ?

A. I suppose quite the opposite to what Mr Ayris's style was. Ms Saibon reminded me very much of the Board Matron, you know, that she was -- she knew what was going on, where it was going on, and also ensuring that the staff knew what was going on. And I don't say that in a -- I mean, I remember it was mentioned about fear and, you know, Ms Saibon, she ruled the ward, for want of a better description. But took her responsibilities

very seriously. So I can give an example, a student coming on to the ward inappropriately dressed, Rahma would be there and that student would be sent away to get appropriately dressed whether that was just a change of shoes or to change the way -- what she was wearing. But also, Ms Saibon would tell the staff what was required.

So two completely opposite ways of doing things. But I think it's possible that, you know, both got the results on the ward that served the patients.

Q. I note you say that, but did those different approaches create inconsistencies in patient care?

A. No, not to my knowledge.

Q. And are you able to comment on whether different management styles across NEPT created inconsistencies in patient care?

A. No, I couldn't comment on that.

Q. I would now like to move on to serious incidents and the reporting of those incidents.

A. Yes.

Q. We heard from -- the Inquiry has heard from Mr Ayris that he was provided with half a day training before completing his first incident report. Do you recall what training you were provided with before you completed your first report?

A. Do you mean at Essex, North Essex Trust?

Q. Yes.

A. No, I don't recall what training I was given, but it, it would have been well laid out in the policies and procedures file. If you look at the actual seven-day reports, if you go through the report you can see the structure of what was required. You can see that the structures of the reports are very much in the same way that you -- there was a set way of doing that report, and that would be purely down to the procedures and policies that were set out for -- the way to do that.

Q. Would it be up to the staff member who was tasked with undertaking the investigation to familiarise themselves with the policies document so that they can -- they knew how to prepare the reports?

A. Yes. Yeah, a copy of the policies and procedures was on every office and every ward shelf -- office shelf. It was on my shelf, it was on the offices upstairs shelf. You know, I suppose you would call it the bible within that Trust.

Q. Was there any action taken to ensure that a staff who is tasked with undertaking an investigation was familiar with the contents of the policy document?

A. I presume so.

Q. Sorry, I didn't hear that?

A. I presume so. I can't remember, I can't remember any, you know -- I remember going on training which looked at different types of doing the inquiries, for the life of me, I've been trying to remember what it was called. And I thought it was an excellent way of doing things. It allowed you to set up timelines and, you know, things like that, but I can't remember the name of the course. But the training, but I think all the managers would have gone on that same course.

Q. Thank you. The Inquiry has seen examples of seven-day reports and also Serious Untoward Incident reports from the time you were at the Linden Centre. Could you assist the Chair with this: were they different reports or are they different names for the same report?

A. Could you say that again?

Q. There was the seven-day report --

A. Right.

Q. -- and also the Serious Untoward Incident report?

A. Oh sorry, right, yeah.

Q. Are those two different types of reports, or different names?

A. Two different types of report. The seven-day report was a report that outlined what had happened, and that went to the Senior Management. At that point Senior Management would have asked for, you know, a more

in-depth report and that would have been undertaken by another person, not the same person.

Q. And would the more in-depth report, in your words, be the Serious Untoward Incident report?

A. Yes.

Q. You acknowledge in your statement that you wrote the Serious Untoward Incident reports in respect of the deaths of Diana Hammond, who died on Finchingfield -- having absconded from Finchingfield Ward on 2 December 2005, and also Georgina Sefton, who died on 9 June after having left Galleywood Ward on authorised leave and not returned.

Can you confirm that you were sent copies of those reports with the request to provide your statement to the Inquiry?

A. Yes.

Q. And can you confirm that you were sent those reports again so that you could read them before today?

A. Yes.

Q. Do you specifically remember preparing either of these reports?

A. No.

Q. Can you remember interviewing any staff before finalising either report?

A. I'm sorry, I can't.

Q. If I may press you on that.
A. Yes.
Q. Your report in relation to Georgina Sefton says you spoke to Rahma Saibon and two other members of staff. Do you have any recollection at all about what they told you?
A. No.
Q. Could I then ask you questions about how, generally, reports are written? I note, for example, that the report in Georgina Sefton's case was 12 days after she died, and the report in Diana Hammond's case was 11 days after she died. Would there have been a further report after the Serious Untoward Incident report which would have set out -- which would have gone into more detail into what happened?
A. There is a possibility that that would have happened, but I have no knowledge of it. No memory of it.
Q. Do you have experience of cases in which, following the Serious Untoward Incident reports there were further reports which went into more detail into incidents?
A. No, because they were normally done by another person, probably at Service Manager level or Associate Director level, or something like that. They didn't come as far down the ladder as to me, or to -- and we didn't get copies of those reports.

Q. Thank you.

A. To my knowledge.

Q. Thank you.

Now is a convenient time to take a break, and we'll return to serious incidents after the break.

A. Right.

(3.45 pm)

(A short break)

(3.55 pm)

MS ONABANJO: I'll return to questions on investigations. Did you ever experience pressure from senior members of NEPT to change reports because of the way NEPT might be portrayed?

A. No.

Q. Did you feel able to criticise colleagues when your wrote incident reports?

A. Yes.

Q. You have said that incident reports need to be honest and describe the true facts, including positive and negative points. You say this at paragraph 26 of your witness statement on page 7.

The Inquiry is investigating a number of illustrative cases where the quality and openness of incident reporting is in question. In respect of your experience working for NEPT, do you recall a culture of

minimising or covering up failings in incident reports?
A. (inaudible).
Q. Could you repeat your answer, please?
A. (inaudible). I mean, could you say that -- could you --
Q. So I asked whether, in your time working for NEPT, do you recall a culture of minimising or covering up failings in incident reports?
A. No.
Q. I'll now ask you some questions about how learnings and recommendations from incidents are dealt with. Do you recall whether learnings are shared with wider staff, so for example, if an incident relates to Finchingfield Ward, would it be discussed with staff on Galleywood Ward?
A. Yes.
Q. In what forum would that be discussed? How would it be shared?
A. A number of -- I would imagine a number of forums were available but every Friday on the Linden Centre, we had a managers' meeting on the morning and all managers were invited there and it was an ideal opportunity to, you know, communicate different, different things to all of the managers.
Q. And would it then be up to individual managers to ensure that information was fed down to their -- the staff they

supervised?

A. Yes.

Q. And do you know the extent to which managers ensured that they fed that information down to the staff being managed?

A. They would use the handover periods to give that information, bearing in mind that that announcement or that information would probably be repeated three or four times until you'd actually covered the whole of the staff, with them working different shifts and having different days off.

Q. So there was no mechanism for information in relation to learnings to be disseminated to staff at the same time, to all staff at the same time?

A. Well, I cannot recollect any specific things that were in place.

Q. Thank you, and I appreciate that it's been over 20 years.

A. Yeah.

Q. Mr Ayris has told the Inquiry that he received very little update on learning from higher level in relation to the reports he wrote. And by that, he means updates as to actions taken in relation to recommendations. Was this your experience? Did you receive feedback in relation to what was done in response to the reports

that you prepared?

A. I believe I did. Yeah, I have to say yes to that. But I can't actually recollect any formal way that that was done.

Q. So there's no formal mechanism. And so if you had found out, it would have been because you perchance happened to speak to somebody who knew what had been done in response to --

A. No, I mean my Associate Nurse Director, who was my boss, and his office was next door to mine. He was chair of the meetings on a Friday, so I can see that he would, you know, he'd get some information and would come into my office to tell me, for example. Or, you know, at that point I could go into the wards and tell them what was happening, or he could have gone into the wards. The communication could be at that level, as well.

Q. I'm now going to ask you some questions about the case of Ben Morris. Ben sadly died on 28 October 2008 whilst he was a patient on the Galleywood Ward at the Linden Centre and you've told --

A. 28 October?

Q. 28 December --

A. December. I yes, I thought it was.

Q. I apologise.

A. Yeah.

Q. And we've established that you left NEPT before that date --

A. Yeah.

Q. -- you think approximately 16 December. Ben was admitted to Galleywood Ward in early December, so you left after he was admitted --

A. Yeah.

Q. -- but before he died. Can you remember whether you were told about his death?

A. No, I wasn't told about his death.

Q. Would you --

A. Because I wasn't there.

Q. Would you have expected to have been told about his death?

A. No, I'd retired. I'd moved to the North West of England.

Q. Had you not retired and had you been on annual leave, would there have been an expectation that, as Service Manager, you would have been required to return?

A. If I'd been on annual leave?

Q. Yes, had you been on annual leave and would have been returning to your post as Service Manager, would you have been expected to be re-called to the ward?

A. No, I think in those situations somebody else would have been charged with doing the seven-day report.

Q. I know that the seven-day report was completed by Mr Ayris.

A. Uh-huh.

Q. Who determines who completes seven-day reports?

A. Well, when I was there, I took it as the norm that I would be to do the seven-day reports. Other than that, I would suggest that with me not being there, that would have come from somebody that was in my chair, as it were, or in my leaving, whenever that was, or directed from the Associate Director.

Q. Were you asked to contribute to Mr Ayris's report?

A. No.

Q. Do you consider that you would have had relevant information to contribute to that report?

A. No.

Q. I will now ask you some questions about patient care and treatment. What involvement did patients have in their care plans?

A. Well, the care plan is a joint plan made by the designated nurse and the patient themselves, and the family.

Q. And was that always the case, that it was a jointly prepared document?

A. I would hope so. I don't know whether it was or it wasn't, you know, I have no recollection of that. But

I would have hoped that would have been, you know, it's one of the norms in care planning.

Q. In relation to transfers to Psychiatric Intensive Care Units, do you recall why a patient would have been transferred from an acute unit to an intensive care unit?

A. Well, basically, if the behaviour -- and when I say that, including the elements of -- it normally -- it normally happened with people with schizophrenia, that kind of thing, when it couldn't be managed on the ward. So they would be transferred to the -- well, you couldn't just transfer them. They had to go through the formal process of being assessed by the Assessment Team of the Christopher Unit. Of course, if there were beds not available on the Christopher Unit, then we could always ask for the patient to go to the private sector.

Q. And did assessments, was it always the case that there needed to be an assessment before the transfer to the intensive care unit?

A. Yes.

Q. You've given examples of the types of patients that might be transferred to an intensive care unit. Would a patient ever be transferred because they were drinking alcohol or taking illicit drugs or perhaps because they were having violent outbursts?

A. Certainly not if they were taking drugs or alcohol. That could be managed on the ward. Sorry, what was the third part you were asking there?

Q. Patients with -- who had violent outbursts.

A. No, they could be managed, but it depended on -- if they're taking, for example, if they were taking place, the effect that that would have on other patients which could be very negative, you know, it could be very upsetting, could have kind of a knock-on effect that, you know, a patient may join in with that kind of behaviour. And behaviour is the wrong word because, you know, that kind of behaviour isn't caused just by behaviour. It's caused by what's happening, you know, in their psychosis.

Q. Do you recall whether, at the time you worked at the Linden Centre, treatment contracts were in use on acute wards?

A. No.

Q. Thank you. Turning now to the issues of sexual safety and mixed wards. You're clear in your statement that you considered that there were issues with mixed-sex accommodation, especially for females. Can you explain the risks and the challenges?

A. I think the fear, or -- of female patients who were on mixed-sex wards, it was always thought that, you know,

both sexes on the same ward would have a calming effect, but if you consider some of the behaviours, because of the person who is interested has happened. I could quite well see that females would be taken aback a bit, if -- you don't know what people's what -- you know, what people's experience of life is. So I was quite happy to see a locked door, but it was surprising the number of people that wouldn't lock the door, even when they were going out. They would leave the door open.

So in some respects, I take it they didn't want to be cut off from the rest of the ward, you know, or they didn't want to have to ask a nurse to open the door so they could get into their room. But, you know, it, you know, I think --

Q. When --

A. Sorry.

Q. -- when you refer to some behaviours, what types of behaviours are you referring to?

A. Acting out, behaviours of violence, behaviours that are given by the psychosis, you know, where that person is, you know, hearing voices, and the voices are telling them to undress, for example. So there they are in the middle of a day room taking, you know, taking all their clothes off kind of thing. So it's not really just limited to violence; it was also -- like on -- I mean,

if a female had experienced some form of abuse previously, if she was somebody acting out or being violent, must have got, you know, memories that they didn't want at that time, they had enough problems on their plate, as it would be.

Q. Can you remember whether there were any specific precautions put in place to ensure the safety of patients on mixed-sex wards?

A. Well, the first one that comes to mind was locked doors, but it didn't seem to work. But no, I can't recall the things that were put into place. Sorry.

Q. You say the one that comes to mind was locked doors?

A. Yeah.

Q. And is it your evidence that that wasn't effective?

A. Well, I'm only going on my thoughts that, you know, you could walk down the -- down the ward and you'd pass rooms, and you would expect to see them open or closed but what they'd do is have a towel over the door, and if you removed the towel, sure enough, if you walked up the ward just later, the towel would be removed. So there was obviously some kind of thing about the room, where other people would, you know, they would close the door and you, you know, unless you were actually making contact with them physically, you wouldn't have known where they were.

So -- I can't -- sorry, I found that difficult to understand to be honest with you, putting, you know, RMN's report through, you know, or on reflection, and when I reflect on it myself, if it was me, I can't come to a conclusion that yes, I would prefer it or no, I wouldn't. So I think it depends on each person's past-with, you know -- previous -- no, past-with (unclear).

Q. If I understand you correctly, is what you're saying that each person would have a different opinion as to whether --

A. I think so, yes.

Q. -- they wanted to be on a mixed-sex ward or a mixed-sex ward posed a risk or not?

A. Yes, I would think so, I'd agree.

Q. Can you remember how sexual safety incidents were supposed to be reported whilst you were at the Linden Centre?

A. I can't remember any reports on that basis.

Q. And do you remember if patients were told anything about how their sexual safety would be looked after whilst they were on the wards?

A. Well, through observation from the staff. I think, did somebody had had problems ... if one of -- one of the ladies that I did the seven-day report had problems with

sexual assault, and, you know, the decision to report and follow it up has to be the person's -- the person, the female's decision. And it would take discussions between the nurses, the doctors, their nearest and dearest, or their parents, as to what path they wanted to go down. But my memory of it, it always had to be the decision of the person, not the decision of anybody else.

Q. But if you, as Clinical Manager or Acting Service Manager, became aware of sexual safety issues, would you have raised that as a safeguarding consent, irrespective of whether the particular patient or the particular staff member wanted to pursue a complaint further?

A. Yes.

Q. I will now ask you questions about observations and therapeutic and intervention. Do you recall whether staff, permanent staff and bank staff, were given training on how to complete observations?

A. Yes, they were.

Q. And what did that training entail?

A. Well, the actual levels of observations, you know, was basically no observations, knowing where the person is at all times, and constant observations, and, you know, if you, for example, that training would involve talking about constant observations, that you'd -- you didn't

leave the patient because you needed to go to the loo, you know, you were on constant observation, and that person had to be constantly observed and if you had to go somewhere, then you needed to get somebody to continue that, you know, observation. Knowing where the person was, well, that would be a timely check to get the visual sight of the person on the premises. So it was those kind of issues that were in the training.

Q. And was that training delivered formally or would it have been delivered informally, for example, you talking to staff members you supervised?

A. I think it would have to be done formally, but I mean certainly RMNs, that was, you know, that was one of the things that was kind of knocked into you as a student: that this, you know, this is very important that this is the way that we do it, kind of thing. But there was always refresher courses and education for some people that were new into, say, the nursing assistant role.

Q. And what about the position of healthcare assistants, for example? Would they have received training, as well, from the Trust?

A. I believe so.

Q. The --

A. I mean -- sorry. Go on. I was going to say that some of the, you know, some of ... I'm sorry, I can't

remember the -- I was trying to work out in me head whether they actually undertook constant observations or whether it was, you know, the lower two levels, but I'm not sure. Sorry, I can't remember that now.

Q. Thank you, I appreciate it.

The Inquiry has received evidence from Ms Saibon that it was periodically reported to her that staff had fallen asleep whilst carrying out observation, and she says this would mostly have been agency staff. Do you recall there being a problem with staff falling asleep on observations?

A. I've no recollection of anything like that being reported to me. It doesn't surprise me, but I've no evidence that that has happened, you know, I've no recollection that -- or it would have been investigated.

Q. And when you say it wouldn't surprise you, why is that?

A. Well, back to our earlier discussions about bank staff taking the right, you know, the rest periods that they actually need to function effectively.

Q. And so your evidence is you were never personally aware of this issue of --

A. No.

Q. -- staff falling asleep?

Did you ever take steps to check whether staff were carrying out observations correctly?

A. Did I?

Q. Yes, did you or Ward Managers --

A. Well, Ward Managers, yes, being on the ward it would be -- you know, because the Ward Manager or the nurse in charge of the ward, they would be designating who was doing which observations, and they would have, you know, a list of changeovers and staff would know about that at the start of the shift.

Q. Thank you. I will now turn to asking you some questions about the ward environment and ligature risks. The Inquiry has received evidence from, again, from Ms Saibon where she says that she was unsure whether there were systems in place to address overlooked ligature points. But you say in your statement at paragraph 18 that the Trust's Health and Safety Department initiated safety checks and that those checks included checks for ligature points.

A. Yes.

Q. As Clinical Manager, was it part of your role to assess ligature risks?

A. If I was on the ward and noticed something or if I was in a different part of the hospital and noticed it, then I would deal with it. But, you know, the -- I can't remember the name of the untoward incident book, a big yellow thing, there were five sheets and they all went

to different parts. But even something like that could be reported to Works department, but I always got a copy of that, then I would take it very quickly to Works. But the Ward Manager, you know, or the nurse in charge, or the Staff Nurse, you know all they had to do was contact works, you know, and that would be seen to, as far as I am aware.

Q. Were those checks or inspections carried out frequently or would they just be spotted as and when issues arise?

A. No, I think they were done on a rotational basis. You know, I'm not sure whether that would be monthly or three-monthly or -- but it was certainly something that was in the diaries of people to actually undertake.

Q. So it was a periodic inspection?

A. Yeah, but how frequent, I am not sure.

Q. I understand. Do you recall how often patients attempted to self-ligature when you worked at the Linden Centre?

A. I think the ligature problems was very well managed on the Linden Centre, that it was dealt with. But the thing is, you know, if you wanted to hang yourself, you could do that on your door handle if you knew what you were doing. So you know, it leads to (unclear), you know, why is that bit of pipe sticking out of that wall there? Somebody could hang themselves on that. But,

you know, it's like on a nighttime. You know, observations would take place on all patients, you know, regularly, to make sure what was happening -- sorry, to make sure that that wasn't happening.

Q. Ms Saibon has in fact given evidence to the Inquiry to the effect that a number of ligature points were identified after a near-miss incident had occurred, and she identified, for example, metal picture hooks and door restrictors that were fixed on to the top part of doors. Now, is that what you were referring to, in terms of the doors?

A. Well, I think the immediate -- you mean with regard to ligature points? No, what I was saying is that somebody, if they wanted to hang themselves, could hang themselves by putting something around a door handle and they wouldn't be hanging but they'd be choking. But you know ...

Q. And what steps, and given the risk that you've identified, what steps were taken to mitigate?

A. I'm quite surprised that Ms Saibon made that statement that nothing was done with regard to -- but I don't -- I don't remember any -- whatever that book's called, I can't remember the name of it, you know, being entered on to that so that I received a copy or she came knocking on my door kind of thing to say, "Look, this is

happening, Stuart, we need to do something about it."

Q. Ms Saibon's evidence was that the ligature points were identified after a near-miss incident occurred and my question is: could you explain how those ligature risks would have been missed, given what you said about the periodic audit of ligature risks?

A. I can't explain it.

Q. Turning to the issue of sharps, and in particular, access to razors, to the best of your recollection, was there a policy in place that covered whether and when patients could be given sharps?

A. Well, it depended, I suppose it depended on the mental state of the patient as to whether they could be given sharps. I take it you're referring to the lady that was given the razor to do her legs?

Q. Yes, in relation to that example --

A. Yeah, yeah, I have no recollection of that incident.

Q. But as a more general point --

A. Well, you know, safety has to be -- safety of the person is very important, and if that person was at risk of doing something with the razor, well, then, where should have been -- well, there should have been, if that was going to happen, there should have been a nurse with them all the time, and the razor should have been returned to the nurse at the end of the procedure.

Q. And would there have been a specific risk assessment prior to giving -- issuing a patient with a sharp?

A. I do not think so. It would, you know, the nurse -- the patient would come up to the nurse and say, "I want to shave me legs, can I have a razor?" And that would depend on the number of staff that were available, but to me, that's the procedure that I would expect to have taken place.

Q. But given the significant risk associated with such items, ought there to have been specific risk assessment, and in particular, do you think that the treating psychiatrist ought to have been involved in such decisions?

A. No, I think in those situations, it isn't something that you would risk assess. You would risk assess whether it could be done and how it would be done, safely. But I can't see that things like that would form part of a risk assessment, you know, the ...

Q. And that risk assessment would be taken at the time, it would be not a formal risk assessment --

A. No.

Q. -- but a risk assessment taken at the time of the request?

A. Yeah, that's what I would conclude, yes.

Q. You've already mentioned the razor blade, but are you

aware of instances in which a patient that was at risk of self-harm was given a razor blade?

A. No. I mean it could be -- it could be an issue following what had happened, then I would have expected to be told about it, but also that the incident book would have been completed, and I would receive a copy of the actual incident.

Q. And would you --

A. -- (overspeaking) -- sorry.

Q. Sorry, you finish.

A. I was going to say, I think the book was called an SR1, but I'm not sure. Sorry about that.

Q. And what is an SR1?

A. Well, the book that we reported all incidents in, from -- well, basically anything which you, you know, weren't happy with or something had happened. It was a quite large yellow bound book which had four or five copies into it and one was kept on the ward, one came to the Clinical Manager, one went to the Health and Safety Department, and that would have been acted on by me, but I hadn't -- I have no recollection of receiving anything like that.

Q. And as you say, so the purpose of recording the incident would be so that's somebody at your level, an Acting Clinical Manager, a Service Manager, would review the

incident?

A. That's right.

Q. And if a patient was given a razor blade and self-harmed, would you have expected that action would be taken in relation to the staff member who gave them the blade? So, for example, would they be subject to additional supervision?

A. Additional supervision or health and safety education, or something like that, yes.

Q. Would there have been circumstances where disciplinary action would have been warranted?

A. Well, I think some disciplinary action would be warranted in that kind of situation, where the patient is given a razor and she self-harms. To me, that, you know, needs some looking at. Is the person, you know, doing their job properly? And how can we put it right if they had?

Q. And what form of disciplinary action would have taken place?

A. Well, an inquiry into what had happened, not only with the nurse, but with nurses around, the Ward Manager, the full range, really. I did a lot of disciplinary hearings in my career, and, you know, some ended up where the person was dismissed, and some, you know, ended up where they were demoted by grade so they didn't

have the same responsibilities. And, you know, education -- you know, training was taking place.

Q. Thank you. I will now ask you about patient access to alcohol and illicit drugs. Do you recall whether patients brought alcohol or drugs on to the ward?

A. I'm sure they did.

Q. And how --

A. -- (overspeaking) --

Q. How often were you aware of this?

A. Well, it would be dealt with at the ward level, normally, unless it was creating problems for other people on the ward. I mean, taking drugs is not a mental health problem, but taking drugs and ending up with a mental health problem, you know, is a different matter. So I think that is an area that needs -- somebody is addicted to alcohol, they'll bring it on to the wards, they'll hide it. But, you know, at the end of day, do you discharge them? No, you don't discharge them, because, you know, they wanted a drink. It's a very difficult scenario to deal with, in actual fact.

Q. And what steps were taken to mitigate the risks of patients accessing alcohol and illicit drugs on wards?

A. Well, it depends whether they brought them on the ward or not. I mean, the biggest problem with drugs was actually going on leave, even if it was only for a few

hours and, you know, finding somebody to sell them drugs or give them drugs or return to an environment where drugs were available.

Q. Do you recall whether patients were searched every time they came back from leave?

A. I want to say "yes" to that. But I think the proviso to that would be I'm not sure it would have happened if the person didn't have a history of alcohol or drugs abuse to start with.

Q. I will now turn to the question of engagement with family members. At paragraph 24 of your statement, you say that wards had an open-door policy, and then you referred to relatives being important in the caring situation and their concerns must always be examined and taken very seriously. In this context, what do you mean by an open-door policy?

A. That the -- that the office door was open. And that the patient or parent or the friend could approach members of staff, and express their concerns or whatever.

Q. Do you recall whether, in reality, this was something that was practised by all staff members? So to what extent -- so what I'm asking is, to what extent did friends and family -- did staff in fact engage with family members and ensure that there was good communication?

A. Well, I can't really answer that because I have no recollection of it, but I think in one of the seven-day reports, you know, it reports that she was engaging, you know, the family were being supported by the team and, you know, this kind of thing. So I'm sorry, I have no recollection of that.

Q. If I may -- if I may now ask you about informing family members about serious incidents. The Inquiry has received evidence that at the time you were working at the Linden Centre, it was the responsibility of the clinical manager to notify family members following the death of a patient. Is it correct that it fell to you to notify family members?

A. No, it's not correct.

Q. So whose responsibility would have been -- would it have been to notify family members?

A. Well, the nurse who came on the ward, for example, if it was a person that was absconding, they would contact the family and ask if they were there, and things like that.

Q. And would this have been the same in relation to serious incidents that did not result in death? Say, for example, self-harm incidents. Would it also have been the responsibility of nursing staff to inform families?

A. Well, no, I don't think I can remember who -- and I deviate slightly, but at one place I worked, the police

were always advised of the death, and they were the ones that went to the premises of the family and, you know, formally did that. But I must admit, I can't remember any details.

Q. And can you give an explanation as to why the family of a patient might not have been contacted in the case of a death?

A. No, I can't.

Q. Would it have been an oversight?

A. Well, it must be, yeah. You know, if you had a death on the ward, the police were -- automatically had to come, you know, to the actual ward and they would, you know, they would deal -- I think the police would still deal with the relatives but again, I'm a bit hazy on that, sorry.

Q. Turning to the question of -- to the issue of the management of patient complaints, was there a process for patients to complain if they were dissatisfied with treatment, or for their family members to complain about matters, including engagement?

A. Yeah. Perhaps once or twice a week the consultant of the patients would have a ward round, which would be multi-disciplinary so the patient could actually say something there but they would probably find it intimidating. They could, you know, they could have

asked to see me, and made a complaint and that would have been dealt with, you know, by asking questions and going through it. There was various ways that, you know, you could approach but that's -- sorry, I can't remember any -- I can't remember any complaints.

I think -- any complaints on the ward were dealt with by the designated nurse or by the Ward Manager.

Q. And was there a formal process for raising complaints or issues?

A. I can't, I'm sorry. I don't know. I can't remember.

Q. I'll now return to the issue of the culture -- the ward culture at the Linden Centre.

A. Yeah.

Q. The Inquiry has heard evidence that suggests that there was more use of physical restraint on Galleywood Ward than there was on Finchingfield Ward. Do you remember that?

A. No.

Q. And how would you describe the differences in the ward culture? You already -- you said earlier that Mr Ayris and Ms Saibon had very different management styles.

A. Yeah.

Q. How did that translate into the ward culture?

A. I'm not aware that it did. And I mentioned that, you know, there was a, you know, on Galleywood there was an

element of fear, but I never, when I visited the ward, nobody ever approached me. Nobody ever came to see me with regard to that and I was quite surprised to learn that Mr Ayris thought that the culture there on Galleywood was different.

I don't know if it's -- I never came across it, but I don't know if it was a difference in disciplines between Mr Ayris and Ms Saibon. Whether it was -- but that never -- I have no recollection of not being (unclear).

Q. Mr Ayris also raises, also in his evidence, said that in -- he raised issues with you, so in the months preceding the death of Ben Morris, that he raised issues with you, including in relation to a lack of risk assessment following admission, failure to update care plans during admissions, failure to discuss patients' suicidal ideations with them, even when that was the primary reason for admission.

Do you recall Mr Ayris raising these issues with you in the months prior to your retirement?

A. (inaudible).

Q. Could you repeat the answer, Mr McGough?

A. No.

Q. What would you have done if he had raised these issues with you at the time?

A. What would I have done? I would have been checking things out that Mr Ayris highlighted, on both the wards.

Q. And what mechanisms would you have had to effect change, to make changes to the areas he highlighted as being deficient?

A. Well, if that was the case, I think my responsibility would be to take it to the Associate Director and look at the actual stockings on the ward. I mean, if there was somebody that was not doing their duty, then of course they would be dealt with through, you know, the disciplinary procedure.

Q. You've just referred to disciplinary proceedings and in the context of my questions to you in relation to sharps, you referred to your involvement in a lot of disciplinary hearings. Was that whilst you were at the Linden Centre?

A. No, that was from the time that I was in Muirton Ward, Seafield Hospital in Scotland, and, you know, the different areas (unclear).

Q. So that was prior to your employment at --

A. Yeah.

Q. -- NEPT?

A. Yeah. I also -- there were quite a few at the Linden Centre, as well. You know, people -- when somebody was defrauding the organisation. And I'm happy to say that

they were struck off the nursing list.

Q. Were you involved in any disciplinary hearings that had to do with patient care, or where the actions of the staff subject to the hearings had impacted patient care?

A. I can't remember, to be honest with you. I did have disciplinary hearings with different staff levels but I can't remember being involved in any, you know, the specifics.

Q. Thank you. At paragraph 45 of your statement you state that, following the appointment of a Chief Executive with an accountancy background, the Trust appeared to become increasingly focused on achieving budgetary outcomes.

In your experience, what was the impact of this focus on budgetary outcomes?

A. The person who became the Chief Executive Officer was the Trust Finance Director. I had never worked in a Trust where the person in charge was out of the caring professions. I remember we had monthly meetings with the Chief Executive Officer, although that was his role, he had a Director of Finance, but the prime purpose of this meeting was to talk about budgets and an accountant was one of the team, finance team, was placed on the ward. And that's where she worked from. I got the impression that the whole of the Trust was very budget

orientated.

Q. And did this impact patient care?

A. Well, it would have with some people. I remember meeting with the gentleman and having a discussion where I explained to him that I was a nurse, and that if I needed some incontinence pads, and there was no budget left, I would go and order some incontinence pads, because I was a nurse first, and he didn't like that. But that's the way that, you know, I saw my role. Yeah, I had to be aware of budgets, but, you know, I think budgets were, you know, if you look at the cost of a Trust, the basic budget is the salaries that are paid, and the associated things with salaries. So any savings that had to be made, if that was £40,000, that was a nurse, if it was £50,000 it might be a higher-level nurses. Because it was easier to actually get rid of a nursing person, get your -- you know, get it sorted rather than actually look at different ways to get the savings that were needed.

And, you know, it's pretty difficult when you're dealing with the NHS, that they were always looking for savings and things like that, based on efficiencies. And savings that are based on stuff that was brought down from the -- NHS England, kind of thing. But there seemed to be this emphasis on budgets.

Did it impact on patient care? I think that depended on who the person was that was dealing with it. I certainly didn't see that in practice, because, you know, it, you know, patient care is built on trust. And, you know, it -- people have to be cared for, the staff have to be cared for. But it doesn't mean to say that budgets have to be the main focus of what you're doing. It should be healthcare.

Q. Thank you. If I may ask you about your recommendation, one of your recommendations is that there should be an England-wide review of mental health services.

A. Yeah.

Q. And what concerns about mental health services led you to make that recommendation?

A. Mental health has always been the very, very poor relation in the Health Service. It's had money taken from it. I can remember a scenario up in Scotland where I was -- I sat on the board, a board member, and the CEO announced that they had been gifted £57,000 but what we didn't realise was that the next financial year our budget was reduced by £57,000. So, you know, my feeling is that the whole, you know, the whole service needs actually looking at. There's that much going on, you know, I don't nurse but I do follow things, when you get things like the guy who was doing one-to-one

observations, at the end of the shift leaves the building and goes home, and the person he was watching self-harmed, I'm not sure if she died, but, you know, the whole system is broken. And this is from somebody that was doing it 17 years ago. I can't be convinced or nobody has tried to convince me that it's any different nowadays, especially with what I read.

Q. So if I understand your evidence correctly, you're saying that mental health services was inadequate at the time that you were working within it, and you believe that it remains inadequate?

A. I believe that it's been put under that much pressure that it has a very difficult time functioning, and that there will always be, unfortunately, things that go wrong because we haven't got the manpower and the funds to actually operate effectively.

I suppose I wrote that, but I wasn't just thinking about Essex; I was thinking about the whole of the country. It occurs to me that it's really, you know, it's really broken at the moment.

MS ONABANJO: Thank you, Mr McGough. That concludes my questions.

THE WITNESS: Thank you.

(5.03 pm)

(The hearing concluded)

I N D E X