Stuart McGough

[I/S]

First Witness statement of Stuart McGough requested 19 March 2026

1. I confirm that I am a past member of staff of the Mid Essex Partnership NHS Foundation Trust and was in post from approximately August 1999, before I retired on December 31, 2008

2. My qualifications were as follows

Registered Mental Nurse

Master of Laws (Mental Health Law)

Bachelor of Arts

C & G 7307 Teaching in Further Education Certificate

My professional Career is as follows (dates are approximate) -

3. September1988 - February1990. St. Lukes Hospital, Middlesbrough, Cleveland. After qualifying as a Registered Mental Health Nurse (RMN) I worked on a Male Acute Ward as a Staff Nurse

4. February1990 - August1991. Queens Park Hospital, Blackburn, Lancashire, in post as a RMN Staff Nurse in the Day Hospital, involved in therapeutic individual and Group work.

5. August1991 - May1993. Department of Psychiatry for the Deaf, Prestwich, Manchester. This was a central government-funded Unit, which accepted deaf patients from all United Kingdom Regions, including Northen Ireland. Pre and Post Lingual deaf Patients who were experiencing Mental Health issues were admitted for up to 12 months, to enable a complete assessment of the individual, Diagnosis, Care Needs, and treatment. I was in Post as Charge Nurse, involved in all aspects of the patients care as defined above.

6. May 1993 – August 1999. Muirton Ward, Seafield Hospital, Buckie, Morayshire. This was an inpatient Dementia Care Unit managed by the NHS based in Elgin, Morayshire. now called NHS Grampian. I worked as the manager of the Unit which cared for thirty mixed gender patients, my role was to further enhance the delivery of care to the patients, supervise staff and attend to the concerns of relatives. I was involved with the Consultant Psychiatrists and medical team. The Unit invited relatives and friends to visit without set visiting hours. I was also a member of the Executive Board as a Nurse Advisor supporting the Director of Nursing. This Board managed General, Mental Health and Community Services, and as part of this role I liaised with nurses in all three service areas.

7. August 1999 – 31 December 2008. Mid Essex Partnership NHS Foundation Trust. My career there commenced with my appointment as a Band 7 manager of New Ivy Chimneys Rehabilitation Unit in Witham. The unit had seven beds and a mixed team of various grades of Nursing Staff, Art Therapist and an Occupational Therapist. Medical care was provided by a part time Consultant Psychiatrist normally based at the Linden Centre.

8. My philosophy of care (simplified) was 1. Ensure that my patients were OK. 2. Ensure my staff were OK. 3. Assist The Trust to provide the services that were required to meet its aims and philosophy of care.

9. I think it was approximately eighteen months later I was asked by the Director of Nursing to temporarily manage Cherry Trees Day Hospital in Maldon as they were experiencing issues around team cohesion and leadership. I worked there for approximately 12 months and was to return to New Ivy Chimneys following the appointment of a permanent Unit Team Leader.

10. I never returned to New Ivy Chimneys as again the Director of Nursing contacted me to be the Acting Clinical Manager at the Linden Centre, as the current incumbent was leaving.

11. The Linden Centre comprised of two acute wards, Galleywood and Finchingfield, a mother and Baby ward, Tillingham Day Hospital, and Cressing Ward a small, short stay facility. This was

later to become a dedicated facility for use by the Crisis Intervention Team.

12. On the same site, but not part of the Linden Centre, was The Christopher Unit, a secure Psychiatric Intensive Care Unit (PICU), which also housed the Section 136 Mental Health Assessment Suit.

13. Later in my employment at the Linden Centre, I was successful in obtaining the Service Managers post for the Linden Centre and two community teams.

14. It is approximately twenty years since I commenced my role of Clinical Manager at the Linden Centre, and I have been retired for seventeen years. The passage of time has not been kind to my memory, and I find my recall of past events is very poor. For example, I am unable to recall details of the assessment procedures, the content of Trust policies, procedures and protocols.

15. I believe the admission wards were initially designed as single sex units but were converted to mixed sex following the Governments guidelines. Each patient had their own Room which was lockable. Each patient had their own keycard, which offered good privacy, although a few patients preferred them to be open, often wedging them open with towels. This was perhaps due to them not wishing to sit in a closed room or should they forget their keycard upon leaving, having to ask a nurse to open the door.

16. The issues regarding mixed accommodation carried their own challenges. Certain individuals especially females I believe felt threatened and unsafe sometimes.

17. I don't think that any hospital procedures, treatments or management inadvertently caused patients any harm or distress.

18. The Trust Health and Safety Department initiated safety checks throughout all areas of the Linden Centre, checking on ligature points and any other potential hazards. To the best of my recollection these checks would be carried out by walking the area and would include members of the Health and Safety Department, Works Department and a member from the area being assessed. For example, the Ward Manager, Domestic Supervisor.

19. The Wards' cleaning service was provided in-house and the buildings were very clean and inspected regularly by a domestic supervisor/manager to ensure that the high standards were maintained. Maintenance was done on a rotational sequence. The wards were kept in a high state of repair by the works department. If a member of staff noticed that any repair was required, the works department could be contacted by telephone if urgent or a docket sent if not deemed urgent. The Works department were good at responding to request for work to be completed. The Trust also had a Health and Safety Department who undertook safety and security assessments and arranged Staff training regularly.

20. The management at Galleywood Ward and Finchingfield wards each had their own individual style, which achieved positive results. The training which was undertaken by the staff in relation to control and restraint and patient management provided by the Health and Safety Department would be the same. Every nurse had to attend the courses. This was mandatory and staff had to attend to be updated every two or three years. The manager from Finchingfield Ward was also an instructor in the use of safe control and restraint. I cannot recall any differences to the use of control and restraint in the wards.

21. Regarding Ms Georgina Sefton self-harming following her being given a razor to shave her legs, I cannot recollect any details around this incident. I would have expected an incident report to have been made and then investigated. I would have also expected that upon her receiving a razor that she would have been under the supervision of a staff member and the razor would be returned immediately following its use.

22. I have never been aware that there was ever any rivalry between the wards and am surprised to hear now that any individual felt the other ward was less than caring.

23. Although I was a visible manager, available to all my staff, I was never made aware of any culture of fear or competition in any area. My priority would have been to investigate this and to take steps to change any such situation.

24. As far as I am aware, an 'open door ' philosophy was implemented by both Galleywood and Finchingfield wards. Relatives are important in the caring situation and their concerns must always be examined and taken very seriously. I believe my staff knew that communication is the essence of care, reassurance and progress. The staff were dynamic teams, not given to avoiding any challenges, but committed to resolution and healing.

25. In Mr Ayris's written statement, he said that with regard to his draft seven-day report on the death of Ben Morris on Galleywood Ward that he "*received some push back from my senior manager Stuart McGough stating Rhama Saibon (manager of Galleywood) was unhappy with my report in that it did not paint the ward in a good light*"

26. Mr Ayris is mistaken. I did not see his seven-day report. I was no longer physically in post. I have never 'pushed back ' on any reports. Indeed, this would invalidate the report as it is the fundamental document which gives senior Trust Managers the initial findings around an incident. It needs to be honest and describe the true facts including positive and negative points.

27. I am also unsettled by the inference that I could be influenced by another member of staff. This was never the case.

28. My formal date for retirement from the Trust was 31 December 2008, I had accrued Annual Leave (approximately fourteen days) to take, and my last day of working was approximately sixteenth December.

29. There always seemed to be a lot of agency nurse hours used within the Trust. This was very expensive. As a result, costs increased annually, which resulted in a huge spend one year. The Trust formed its own Nurse Bank with external staff and the Trust staff being able to sign up to the Bank. This was not only a sound financial move but created greater continuity for both patients and their families.

30. With agency staff we could fill a shift at a considerable cost. The downside of this 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 may not have the necessary current skill to care for patients in the area they were allocated to.

31. Bank staff were in the main Trust staff, or external staff who had worked in the trust environment. Pay grades were lower and the Trust did not have to pay a premium to employ staff. Of course, some nurses preferred to remain as Agency Staff and did not join the Trust nurse bank.

32. Using bank staff did provide a higher element of continuity for patient care. Managers could request named staff and whilst

completing the duty rosters could ask their own staff to fill in the vacant shift slots and advise the Bank administrators of the completed bank shifts. My concern was always that the individuals working on the bank did not get enough rest time indeed some staff would take a week's annual leave and then work that time on the trust bank or as an agency staff for another Trust/Private sector organisation. The use of agency staff could only be authorised by a senior member of the Trust. I am unsure now if the use of Agency/Bank staff was a result of staff vacancies not being filled or if there were not enough staff hours to cover shifts.

33. I believe that training sessions were instigated for those joining the Bank. I am unable to recall the details.

34. There were certain regulations in the Nurse Bank to avoid staff working excessive hours. I am sure that obtaining a balance between the regulation rules and professional requirements would be the priority of the ward managers. But the need to ensure the safety of the ward and care to the patients is always a challenge.

35. On the acute wards the need for additional staff could change very quickly. For example, an increase in numbers of patients through urgent admissions or an increase in patients whose observation levels had changed. This always put pressure upon the ward staff and the nurse bank. Staff in all areas were very good in covering these situations.

36. I recall Paul Keedwell (Director of Nursing) undertaking a project to determine how many staff should be employed in care units within the trust. This was a large undertaking as there were no recommended national ratios for the provision of care staff. The Trust did implement Mr Keedwell's recommendations, but I am unable to recall now if this resulted in an increase in staff or a reduction in numbers.

37. I found that the quality of support provided within the trust was very good. I had no qualms about speaking to my service manager or Associate Director regarding any issues within my role. Within the Linden Centre there were meeting at least weekly that the managers met where any issues could be discussed, there was a trust wide meeting of Clinical Managers/Modern Matrons monthly which was very supportive.

38. The Trust also had an Occupational Health Department who met with staff to assist them in their occupational role and offer support. Staff members could self-refer or could be referred by their manager should he/she have any concerns regarding their health. The process was very transparent with staff being able to have leave with a plan for return to work being formulated. Occupational Health staff could also refer the individual for counselling. The Human Resources Department could also be involved in this process. In this way the Trust attempted to provide adequate support. To the best of my recollection staff were supported when raising concerns or complaints.

39. Regarding the quality of investigations, unfortunately I have no memory of my preparation of reports for the Serious Untoward Incident (SUI) following a seven-day report on the deaths of Diana Hammond and Georgina Sefton.

40. I am sure that the Trust had Policy and Procedures in place to cover such untoward incidents, and I would reiterate that I have no recall of the content of these documents.

41. Untoward Incidents were always taken very seriously by the Trust and were normally investigated by the Clinical Manager of the area the incident occurred in. In some cases (for example, if the area Clinical Manager had other commitments) the investigation could be undertaken by another Manager, and I believe this decision would be made by the Area Associate Director of Nursing (ADN). In the case of the Linden Centre that would be **[I/S]**

42. All reports had to be completed in a timely manner and submitted to a department (I forget its name). **[I/S]** was one of its administration staff who would request the report, and I believe she collated the documentation and distribute it to a Senior Manager Forum which would include but not necessarily only, the Director of Nursing, Medical Director, Associate Nursing Directors, Health and Safety. This department I understood also advised the Mental Health Commission should the patient have been detained under the Mental Health Act.

43. The Senior Manager Forum would discuss the SUI, look at the recommendations detailed, add others if appropriate and define a pathway for recommendation to be implemented.

44. I always felt safe and supported when undertaking an investigation. **[I/S]** was always helpful and supportive, and I could always approach my line manager ADN **[I/S]** at any time. I always furnished **[I/S]** with a copy of my reports as a matter of courtesy.

45. When I was initially employed by the trust, the Chief Executive Officer (CEO) was a Social Worker by profession. Later when he stood down the Trust Director of Finance was appointed as the CEO of the Trust. His profession was Accountancy. Thereafter the Trust appeared to focus on budgetary Outcomes wishing to come under or on budget each year. I was often confounded by the appointment of an accountant to lead an organisation whose priority requirement was to provide treatment and care to vulnerable people.

46. My aim has always been to promote the best professional standards of care and to examine closely any concerns, so that changes might be implemented. After so many years absence, I cannot comment on what those needs might currently be. I was always a visible manager and listened whenever concerns were raised. This approach (and commitment to honesty) ensured greater levels of professionalism in every instance.

47. I have reviewed Enclosure 8 which contains a list of names of deceased patients. I have no additional evidence or comments to offer.

48. I would hope that the recommendations of the enquiry would offer some closure to the relatives and friends of the deceased and relieve some of the pain that they have experienced.

49. My second hope is that the recommendations would result in an England wide review of Mental Health Services.

50. I have always thought that excellent mental health nurses are the result of excellent education and training. I am sorry to say that the move of the Registered Mental Health Nurse (RMN) education and training from hospital-based schools of nursing to higher education has changed the outcome of professional nurses. University education is degree driven not profession driven. Hospital based nursing schools gave the student nurse a full immersion into mental health, its treatment and more importantly the care of vulnerable people experiencing mental health issues. The courses were taught exclusively by RMNs, Placements were not a problem to source and teaching was to smaller groups of students. I do believe that nurses were more aware of the needs of patients and understood perfectly what was required of them. I believe that nurses were more aware of how the profession would support them in their career.

51. My third hope is that your finding can pave the way for a very close inspection of how we educate and train nursing staff in the future.

52. I believe the content of this statement to be true.

[I/S]

Stuart McGough

22 May 2026