Second Witness Statement : Stuart Ayris

Former Employer: EPUT

Role in organisation: Registered Mental Health Nurse (retired as of 13th August 2024)

Date of statement: 4 June 2026

This Statement is in response to a Rule 9 Request dated 20th April 2026

Section A: Safe & Therapeutic Inpatient Care

Clinical Assessments

1. During my time as Ward Manager of Finchingfield Ward at The Linden Centre, the assessments that were conducted on the ward concerned information gathering, either on a one off basis (ie background history, family and social network, mental health and physical health history) as an adjunct to the assessment that would have been completed by the referring agent and the admitting doctor. There would be ongoing, more informal assessments, of mental state conducted by an allocated worker per shift and at the multi-disciplinary ward reviews that were held on a weekly basis. Ad Hoc mental state reviews were also conducted by the junior doctors as and when required in between the scheduled ward reviews.
2. When I was Team Manager of Maldon Community Mental Health Team, full assessments were carried out by qualified members of the team (Social Workers, Mental Health Nurses and Occupational Therapists). The purpose of these assessments was to gauge as to whether or not the person referred met the criteria for Secondary Mental Health Services and which pathway would best suit the needs highlighted following assessment. These assessments were almost exclusively in response to referrals from GPs.
3. Referrals would be made in writing by GPs and other professionals such from Primary Care Services. People could also contact the team by phone, between 9am and 5pm, if in a crisis and assessments would be arranged on a needs led basis, some calls resulting in a full assessment, others in advice and sign posting to appropriate statutory and non-statutory services.
4. The criteria for accepting a referral for assessment would be primarily based on factors such as risk and the impact of the person's mental state upon their ability to function. This was sometimes complicated on occasion by the person not knowing they had been referred, not having agreed to the referral or the referral itself containing erroneous or scant detail.

5. Assessments would be either classed as 'routine' or urgent, the latter being conducted within a few days, whereas the former at an agreed later date. There were occasions when it was difficult to arrange a timely assessment, particularly if the person referred was in full-time employment and only available weekends or evenings and had to take specific time off to be available for the assessment.
6. Assessments would take place, face to face, at the team base, the person's home, or another agreed upon venue such as a closer Trust premises. Family members or other support, including friends or involved professionals, would be invited to the assessment at the request of the person being assessed.
7. The assessments would include physical health issues and whether the person was receiving care from/been referred to other specialist services such as Dementia Services and Eating Disorder Services.
8. I do not recall there being specific training regarding the conducting of assessments, although those conducting them would have been well trained in assessing mental state during their respective diploma/degree courses that led to them gaining their qualification in mental health nursing, social work, occupational therapy etc.
9. Once an assessment was completed, the case would be discussed at the multi-disciplinary meeting and the outcome agreed upon, which would be conveyed to the person referred and the referee. Cases could also be discussed outside of the multi-disciplinary meetings with other team members, including the team psychiatrists and psychologist. Support within the team was good, knowledgeable and accessible.
10. Assessments were documented on the Carebase electronic system. There were occasional issues with the reliability of the system, occasions where it could be 'down' for a few minutes or a few hours, which would be a cause of frustration to practitioners when needing to input information into the system in a timely fashion. Carebase was later replaced by Paris, but this too was not without its stability issues.
11. Alcohol and substance misuse issues played a part in a significant number of referrals and, consequently, assessments. If it was deemed that they were the predominant factor in the presentation, the person would likely be referred to specific agencies such as Changes to manage their misuse issues before being treated under Secondary Mental Health Services. The reasons given being around the prescribing of

psychotropic medication and the ability to engage consistently in their care and treatment if under the influence of alcohol/drugs.

12. Assessments for admission – known as Gatekeeping Assessments - were carried out by the Crisis Resolution Home Treatment Team. I am unable to provide details on this process, never having worked for that particular team.
13. Assessments under the Mental Health Act (1983) were conducted by Section 12 approved doctors and Approved Social Workers/Professionals. I was not qualified during my career to conduct such assessments, although there were a number in my team that did.

Transfer

14. If a patient was transferred for care and treatment to another area, the relevant care co-ordinator would be expected to be invited to the ward reviews on the receiving inpatient unit and to be kept up to date on any incidents or granting of leave, discharging planning etc. This, in my experience, did not always happen. On one occasion, I patient for whom I was Care Co-ordinator was transfer from Cedar Unit in Colchester to a Secure Unit in London, without my knowledge nor that of his next of kin. I formally complained about this at the time, but don't recall receiving any feedback. The next of kin was incredibly distressed and that patient's mental state considerably set back. Communication between inpatient units and community teams was never, in my experience, without its issues, and this remained the case right up until the time I retired from the service in August 2024.
15. Towards the end of 2023, I was working as a Community Psychiatric Nurse in Braintree Community Mental Health Team when I was allocated a client who had been an inpatient at The Linden Centre for several months. I was informed that the relationship between the ward and the existing Care Co-ordinator had "broken down" due to a disagreement around discharge planning. I was tasked with attempting to assist in order to repair the damage to the relationship between the two units involved in the case with a view to bringing about a cohesive discharge plan. A Professionals Meeting was held at Braintree CMHT, with representatives from the ward appearing via Microsoft Teams on a big screen in the meeting room. This included the Consultant Psychiatrist, the ward keyworker, the ward manager, the

Clinical Manager of the Linden Centre and others. From Braintree CMHT, there was me, the other Care Co-ordinator, the Team Manager and a Clinical Nurse Specialist.

16. At one point during the ensuing meeting, my fellow Care Co-ordinator became very upset about the way she was being spoken to/about by the ward team and began to cry before abruptly leaving the room in tears. I went out after her to see if she was ok. It was clear that she was not in a fit state to return to the meeting, so I returned to the room alone. To my dismay, the meeting continued as if the incident had never occurred, representatives from both teams discussing the case at hand in order to seek a way forward. It got to the point when I felt compelled to intervene, stating that we could not ignore the fact that a fellow professional and colleague had felt the need to leave the room in tears and that surely this had to be addressed within the broader context of the relationship between the ward and the community team. It seemed to me that the others in the meeting were taken aback by my statement and, after some muted assertions that efforts would be made to catch up with my absent colleague after the meeting, the meeting continued to the end.
17. After the merger of Trusts that formed EPUT, if a patient was transferred to a unit within what was previously NEPFT, a Care Co-ordinator would be able to follow the daily progress of the patient for the Carebase/Paris system, which was often helpful if communication from the inpatient unit was inadequate. If, however, the patient was transferred to what was previously SEPT, there were difficulties in that they used (and continue to use, a different recording system for clinical notes (System One). It was a regular occurrence for Care Co-ordinators to find out after the fact of treatment changes, leave arrangements and, sometimes, discharge. Families were not only impacted by the considerable distance they may have to travel to visit their loved one or participate in reviews, but also by the lack of cohesive communication between the various team involved within which was, ostensibly, the same organisation.

Leave, Absconsion and AWOL patients

18. Decisions around leave would be made in the multi-disciplinary ward review. The member of nursing staff attending the review would solicit the patient's request before attending the review and then inform the rest of the review team. A

discussion would then be had before the patient was brought in. If family members were present, they would be brought into the review before the patient in order for them to give their opinion with regard to leave requests. The patient would then join the review and leave would be discussed alongside progress since last review, risks etc. Although, often, the patient would be informed during the review the outcome of their leave request, there were certainly occasions when they would be told a decision would be relayed to them after the review. This would invariably be on occasions when the leave request had been denied and the member of nursing staff left with the task of relating the disappointing news to the patient.

19. Ideally, at the review, the respective Care Co-ordinator would be present or, at least, a representative from that particular Community Mental Health Team. Unfortunately, this would not always happen, particularly if reviews were running late or leave was discussed, as frequently occurred, outside of multi-disciplinary reviews, with only nursing staff, the junior doctor/psychiatrist being present. This would invariably happen on a Friday, making it impossible for CMHT staff to monitor how leave over the weekend was going. The Care Co-ordinator would be expected to make contact with the patient whilst on leave and seek feedback from relevant family members. This could not happen at t he weekend due to CMHT's operating a 9-5, Monday to Friday service.
20. If a patient had been granted a short period of escorted leave from the hospital, this would be entirely dependent upon the availability of staff. There were times when it wasn't possible to facilitate such leave, which would leave to understandable frustration on behalf of the patient involved. Prior to going on leave – even short periods of escorted leave – a checklist had to be completed and the patient signed out. On return from unescorted leave – of whatever duration – the patient would be searched for contraband prior to return and signed back into the ward.
21. Unescorted leave was always a difficult situation for nursing staff to manage as there was never any guarantee that the patient would be going to where they said they would be going or that they would comply with the agreed time of return. Equally, such was the confined nature of inpatient admission, particularly with regard to accessing alcohol and illicit substances, the temptation once back out in the community would often be too much for the patient on leave to resist. If it was

suspected that they had indulged in alcohol or illicit substances, a breathalyser test and/or a urine drug sample would be requested and the multi-disciplinary team informed of the outcome.

22. After periods of home leave, feedback would be sought from family with whom the patient had resided, as well as the Care Co-ordinator, in order to get a complete picture of how the leave had gone.
23. In my experience, the systems in place regarding leave arrangements were appropriate but I was always concerned when short periods of unescorted leave were granted, the risks, in my opinion, often outweighing the benefits.
24. Having worked many years in inpatient wards and many years in the community as a Care Co-ordinator/Team Manager, leave arrangements were often the subject of poor communication between teams and were often fraught with problems as a consequence. This was particularly the case when patients were placed outside of the area covered by their Care Co-ordinator, whether that be in another part of the Trust, the county or the country.
25. When I worked on the inpatient wards, there were occasions when patients absconded from the ward. These were fairly infrequent but would be most likely to happen whilst a patient was on short periods of escorted or unescorted leave, either running away from the staff accompanying them or failing to return at the agreed upon time. If a patient was detained under the Mental Health Act (1983) or it was felt there was a risk the absconding patient may be a risk to themselves or others, the Police would be contacted. In my experience, the response from the Police was generally dismissive in nature and condescending in tone. As time went on, it became less and less likely that they would perform welfare checks at patient addresses, even if that patient was detained under the Mental Health Act (1983). When reporting a person 'missing', the response would be, I presume, the same as with any other missing person report. Family members and Care Co-ordinators (by phone if during working hours, or email if not,) would be alerted to the absconsion and be asked to contact the ward should they have any relevant information as to the patient's whereabouts.

26. When AWOL patients were returned to the ward, we would sit down with them and discuss the event in order to attempt to understand the reasons behind the absconsion so as to make any repeat less likely.
27. I believe there was an AWOL Policy, which would have been available to all staff in the ward office.

Safeguarding

28. Between March 2009 and October 2009, I successfully completed Best Interest Assessor Training and subsequently worked in the Safeguarding Team as a Best Interest Assessor until being appointed Team Manager of Maldon Community Mental Health Team in 2009.
29. A Best Interest Assessor operates under the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. My duties included assessing the mental capacity of patients to consent to their care and treatment, determine if the care arrangements amounted to a deprivation of liberties, consultation with family and relevant professionals and write reports with recommendations.
30. During my brief time working with the Safeguarding Team, I would occasionally step in to help deliver Safeguarding Training should one of the trainers be, for whatever reason, unavailable.
31. Concerns from patients and relatives could be raised to the nurse in charge of the shift (ordinarily a Charge Nurse), to the Ward Manager – either in writing or in person, to the Clinical Manager, to PALS, or to the Chief Executive.
32. Staff could raise concerns about a patient's care and treatment to their Ward Manager, to the Clinical Manager or by using the Whistle Blower policy. In my role as Ward Manager, I would raise any concerns to my line manager – the Clinical Manager. Although I felt listened to on these occasions, I don't recall any specific outcomes from my concerns as I don't believe it was common practice for the person raising the concerns to receive feedback on the outcome.
33. Although I was aware of how to raise concerns to professional bodies, such a circumstance, were it to occur, would following the results of an investigation into professional practice.

34. Whilst employed at EPUT, I wasn't aware of any cultural or systemic barriers that would have prevented me from raising concerns. I do strongly feel, however, that the opinions and recommendations I voiced in some of the Serious Incident Reports I compiled, had a negative impact on my career pathway.
35. Following the 7 Day Report I compiled subsequent to the death on Galleywood Ward of Ben Morris, a series of events unfolded that led me to feel I was being punished for what had been deemed by others too negative a report.
36. I came into work one day to find the stack of incident books in my office had been removed. I then received notice that, due to the fact there were some forms in the books that had not been previously sent to Risk Management, I was to be the subject of a formal disciplinary process. The outcome was that I received a Final Written Warning that would last three years, for "putting staff and patients at risk." I found this particularly upsetting given my commitment (and record) of maintaining the safety of patients and staff during my time as Ward Manager of Finchingfield Ward. I later discovered that many managers across the Trust had been known to have not sent incident reports back in a timely fashion.
37. I was then told that I "needed a break" from The Linden Centre and that I was to be moved to other duties yet to be determined. During this time, I applied for a Ward Manager's job in Epping. I thought I had a good chance of getting the job, given my extensive experience. The job, instead, was given to a Charge Nurse on the ward in question.
38. I was told I would be carrying out duties at the behest of Area Director, [I/S] and that my position on Finchingfield Ward would be taken by one of the Charge Nurses on Galleywood Ward. The first of these duties was to deliver Trust literature to patient addresses around the Chelmsford area, followed by some weeks doing audit work. It was around this time that the Director of Nursing, Paul Keedwell, said to me "We had high hopes for you." I took this as to meaning my career was effectively over with regard to progressing to higher grades. I then read in the local paper, in an article with regard to suicides at The Linen Centre, a quote from Paul Keedwell in which he stated, "both ward managers have been removed," which made it look as if I had been complicit in the suicides that had occurred on Galleywood Ward.

39. I was then informed I had been put forward to do Best Interest Assessor Training and thus would be working with the Safeguarding Team. Some months later, I was informed I would be taking over as Team Manager at Maldon Community Mental Health Team.
40. This was a hugely destabilising period for me, particularly given the fact I was under the sanction of a Final Written Warning. I felt, rightly or wrongly, that I was being set up to fail or being pushed to resign, though, I did neither.
41. I cannot say for certain that the events outlined above were a direct consequence of the report I compiled, but it was, and is, the only thing that makes sense to me.

Clinical Records

42. When I first began working in the Trust, clinical records were an amalgamation of hand-written and electronic entries by the various professionals involved in a patients care. Over time, this transitioned into a fully electronic recording system via laptop or PC.
43. Before becoming fully electronic, patient information would be shared, on the wards, at the verbal handovers that took place at the change of each shift, in the pre-ward review meetings that occurred before a patient was brought into the ward review. Outside of this, the paper records would be accessible to relevant professionals via the filing cabinet in the ward office, the electronic records via the Carebase, and later Paris, systems that ran across what was formerly NEPFT.
44. Access to records was ostensibly restricted to those who were involved in the patient's care and treatment, including frontline staff on the ward or in the community. Those tasked with writing reports or conducting audits would also be able to legitimately access the records. If a member of staff had a familial or other connection to the patient, there was a facility whereby they could be blocked from accessing that patient's records. Other than that, I believe that the records were accessibly by anybody with a username or password to the relevant system, although I understand the monitoring of who was accessing electronic records became more stringent over time.
45. When a patient was admitted to the inpatient unit, the paper records for that admission would be created and any existing file requested from the records

department. This would sometimes take a couple of days for unplanned admissions, depending on the time of day or day of the week. Having the previous notes would always improve the quality of the initial risk assessment, the opposite also being true.

46. Inpatient staff would only have access to community team records that had been input onto the electronic recording system – whether that be Carebase or Remedy. If a patient had been transferred from what was formerly known as SEPT, they would not have access to these records due to SEPT using a different system (System One).
47. Paper nursing notes (Care Plans etc) were filed separately to Medical Notes. In my time, I don't recall any medic requesting to see the nursing notes. In my experience, the medical notes were often difficult to read due to handwriting styles. The transition to fully electronic recording was an essential improvement in this area.
48. The Carebase and Paris electronic recording systems were both valuable tools but were often bemoaned by staff for the system 'freezing' leading to a loss of recently inputted data. They both appeared to me to rely very much on the clinician learning as they went, although, certainly for Paris, there was a raft of specific guidelines the clinician could access to help them if stuck on a certain screen or issue. Paris appeared to be relentlessly added to in terms of data required of the Clinician, to the point there were regular complaints about how much time was spent during the working day using a PC or Laptop.
49. Paris had a relatively efficient helpline, which I accessed when required.
50. Whilst working in the community, I was allocated a work laptop and can't recall a time when this was not the case. I cannot say if this was the same for all clinicians across other teams.
51. Whilst Ward Manager of Finchingfield, case note audits were conducted by the Charge Nurses on a monthly basis. I was also able to run a check on Carebase/Paris that would provide a printed list of omissions or areas that were out of date. I cannot recall if there was any outside audits conducted other than during CQC visits. The Charge Nurse would have a checklist that they would match up against each file and sit with the relevant keyworker and explain what was required. This would also be an aspect of the routine 1:1 supervision sessions that were conducted on a monthly basis with all staff.

Therapeutic engagement and Supportive Observation

52. When increasing or decreasing levels of observation, the predominant factor was risk to self or to others, either by decisions the patient may make or the impact of prescribed medication. Ideally, these discussions would always have involved the patient, but this was not always the case. There many times when the patient was informed of the decision to increase observation levels after the fact, which was, in my view inappropriate and not at al conducive to the strength of the therapeutic relationship. I always felt it important that a patient be aware why various aspects of their behaviour were considered to have a high-risk profile in order that they could engage with nursing staff in reducing the risks, and therefore the observation level, potentially leading them closer to discharge from the unit.
53. There was a Trust Inpatient Observation Policy and, I believe a mandatory Risk Assessment Training module accessible online. Risk assessment was also discussed during CPA Training.

Section B: Safety

54. There were occasions when I worked on Finchingfield Ward that patients expressed not feeling safe on the ward. When I first began working there, some of the rooms were shared spaces and this would at times lead to patients expressing concern about feeling unsafe sleeping in the same room as somebody else suffering from mental health difficulties. This was alleviated, in time, when the rooms became single occupancy only. The task of the staff was to listen and make alternative arrangements, if possible, and the to mitigate the fear expressed without breaching confidentiality.
55. When pin-point alarms were activated, this could cause fear and trepidation in some patients, particularly if it was their first admission. We always made a point, on the patient's arrival on the ward, of explaining the alarm system and asking that remain clear from any incident, should it occur. After an incident, I encouraged staff to reassure the patients on the ward that they were safe and this would lead to the eventual return of a calm and therapeutic environment.
56. The greater the degree of trust between patients and staff, the more likely it would be that patients would feel able to express their thoughts and feelings about being

on the ward. This could only be engendered by staff spending extensive 1:1 time with patients and engaging both honestly and clearly.

57. Family members or visitors could approach the nurse in charge of each shift, or myself if present, to discuss any concerns about their own safety or that of their relative on the ward. I actively encouraged this process and, if the issue was systemic in nature, would advise concerns be put in writing in order that they be formally addressed.
58. During my time working on mental health wards, I felt personally safe, largely due to the fact I made every effort to know the patients in my care, to attempt to understand what they were going through and to impart as much information as I could about the system within which they were being cared for. All the staff had access to pin-point alarms, but their use was infrequent due to the good relationship between most staff and most patients the majority of the time. I actively encouraged staff to spend time with patients and not in the nursing office. This soon became standard practice on the ward, leading to a largely calm and therapeutic environment.
59. The pin-point alarms needed to be charged regularly in order to function effectively and the system was checked routinely, as far as I recall.
60. There were very few physical assaults on staff whilst I was Manager on Finchingfield Ward but, when they occurred, I believe they were dealt with appropriately and adequately. A significant proportion of the Ethical Care, Control & Restraint Course, of which I was a long-standing instructor, covered issues such as debriefing and de-escalation which I feel I was able to put to good use in practice, should the need arise.
61. Health and safety inspections were conducted routinely by the Risk Management team, a part of which included ligature audits. As a Ward Manager, I would be responsible for alerting Risk Management should I notice a potential ligature issue. I would also take it upon myself to routinely walk around the ward checking the environment for hazards, including potential ligature points. I don't recall any incidents of patients suspending themselves from a ligature point whilst I worked on Finchingfield Ward, but there were occasions when patients engaged in self-strangulation behaviours using scarfs and other items of clothing, bedding.

62. The fact that patients continued to locate and use ligature points across a variety of wards across an extensive period of time, would lead me to believe that the systemic processes in place were, in themselves, neither adequate nor appropriate, without the adjunct of additional oversight by those working day to day in the ward environment.
63. When I worked at The Linden Centre, there was a policy for managing the issuing of sharps to patients. If a patient was deemed, following a risk assessment, to be at risk of self-harm were they to be in possession of a sharp (such as a razor), the items in question would be kept in the locked clinic and be labelled with the patient's name. The patient would inform a member of staff when they needed the razor and, whilst they were using it, the staff member would be in the room at the time in order to ensure appropriate use. There was also a stock collection of disposable razors should the patient not have one amongst their property on admission.
64. I don't recall there being a policy that covered patients keeping their own razors as a means of promoting autonomy, nor do I recall there being occasions where there were incidents following the policy regarding the safe issuing or razors etc was not followed, although this does not mean they categorically did not happen.
65. I believe, if the policy was followed, then the approach was safe and appropriate, although I did have issues with regard to how self-harm generally was managed, particularly the aftermath of any such incident. I was very much of the view that we, as a nursing team, should seek to understand why somebody felt compelled to self-harm as opposed to responding by immediately stripping a patient of any personal items in their room that may be utilised as a means of self-harm. This latter approach felt to me like a punishment that was more likely to lead to resentment and further, perhaps more extreme episodes of self-harm, intended to protect the organisation as much as to protect the patient.
66. There were times whilst Finchingfield Ward was a mixed sex ward that issues of sexual safety arose. This from, what I recall, was infrequent and arose due to overtly disinhibited behaviour as a symptom of relapse in patients suffering a manic episode. At these times, management would be a combination of medication and increase in observation, the former to reduce the intensity of the symptoms, the latter to attempt to safeguard the dignity of the patient. In my experience, other patients on

the ward were largely sensitive to the fact that such presentations were part of a mental health presentation and behaved with kindness and empathy.

67. I don't recall any specific events when a report of sexually abusive behaviour between patients/patients and staff was reported to me whilst Ward Manager of Finchingfield Ward. There was, however, an incident involving a member of nursing staff and a junior doctor where the nurse accused the doctor of inappropriate sexual behaviour having been directed at her by the doctor whilst both were in the ward clinic. This accusation was taken very seriously by me and others, resulting in the doctor accused being charged and the matter addressed at Crown Court. I attended each day of the court proceedings in order to support my staff, although I cannot specifically recall the outcome of the trial.
68. Should a member of staff feel a patient was vulnerable to sexual abuse either on the ward or in their home environment, a Safeguarding referral could be made and advice sought. As stated earlier, I cannot recall any specific examples in relation to these sort of incidents.
69. Looking back, I don't believe the risks associated with mixed-sex wards were particularly well understood. I don't remember being involved in any strategic discussions on mixed-sex wards nor on the transition to single-sex wards. Such discussions may have taken places amongst those in more senior positions, but they were not one of those topics discussed on a day-to-day basis on the ward. I don't recall their being any specific risk assessments with regard to sexual safety, but were this a part of the patient's presentation, it would likely have been addressed in the Vulnerability section of the Risk Assessment. I also don't recall any specific training on Sexual Safety and, given that, I am convinced there was more that could have been done to ensure the sexual safety and well-being of those, both male and female, who were under our care.
70. Finchingfield Ward was an Adult Acute Admission Ward and during my years there as Ward Manager, I don't recall any instances when a child was admitted to the ward.

Section C: Technology

71. During my time working for EPUT, the technology I used consisted of a mobile phone and a laptop whilst working in the community and a pin-point alarm when working

on the wards. I also had a pager when performing On-Call duties. I had no experience of body worn cameras and heard of Oxevision and Oxeobs only as a consequence of evidence given by others during the course of this inquiry.

Section D: Investigations

72. Whilst working as Team Manager for Maldon Community Mental Health Team, as a Band 7 Nurse, as I was when Ward Manager of Finchingfield Ward, I would be tasked with conducting Single Clinician Reviews. I would receive a request from the Investigations Team (headed by [I/S]) with the details of the case to be investigated and the remit of the investigation. I cannot say whether investigations were initiated promptly and in accordance with any associated guidance, nor was I aware of who set the remit for the Single Clinician Review, only that once received, I always gave them the highest priority and always completed them before the scheduled deadline.
73. When undertaking investigations, my sole focus was on gathering relevant information from whatever sources I deemed appropriate in order that the facts be clearly presented and appropriate learning outcomes formulated. I was aware that some of my reports were not received well by those responsible for the management of the areas that were the report's focus. This at no stage deterred me from pursuing the facts of any investigation with which I was tasked or making the recommendations that I felt were warranted.
74. I don't recall receiving any direct feedback as to whether or not any recommendations I made were deemed sufficiently worthy to be acted upon. Once the report was received by the Investigation Team, that would be it, as far as I recall.
75. With regard to the recommendations I made in my Single Clinician Review of Glenn Holmes's case, I was not aware at the time what response they received from senior members of the Trust at the time. Having been sent them by the Lampard Inquiry Team as part of the correspondence for this Witness Statement, I can confirm that all the recommendations I made in November 2012 appear to have subsequently, over time, been acted upon.

Section E: Recommendations

76. The setting up of a substantial Dual Diagnosis Team across all areas of EPUT, in order that Dual Diagnosis be given the priority it is due, given the prevalence of suicides involving those suffering from mental health difficulties who use alcohol and illicit substances as a mean of coping with their experience of living out their life from one day to the next.

I believe the content of this statement to be true.

Signed

[I/S]

Stuart Ayris

Date: 4 June 2026