Witness Name: Chloe Cawston

Statement No: 1

Exhibits: TBD

Dated: TBD

THE LAMPARD INQUIRY

Witness Statement of Chloe Cawston

I, Chloe Cawston, will say as follows.

Preliminaries

1. My full name is Chloe Ann Cawston.

2. I am currently employed by Essex Partnership University NHS Foundation Trust ("EPUT") as Service Manager covering the Linden Centre and the Crystal Centre, Chelmsford.

Background and Experience

3. In 2008, I started working for North Essex Partnership University NHS Foundation Trust ("NEPT") as a bank staff member (primarily on the Christopher Unit and Galleywood Ward (Linden Centre)). In 2011, I completed my Mental Health Nursing diploma at Anglia Ruskin University in Chelmsford and took up a role as Staff Nurse on the Christopher Unit. I reported to a Charge Nurse (Band 6), who in turn reported to the Ward Manager (Band 7).

4. In 2016, I briefly worked in the Community Mental Health Team in Maldon and then in the Home Treatment Team, based at the Linden Centre. I was a Band 6, so would have reported to a Band 7, who in turn would have reported to the Matron.

5. Also in 2016, I started working as a Ward Manager on Grangewaters Ward at Basildon Mental Health Unit, which was run by South Essex Partnership University NHS Foundation Trust ("SEPT").

6. In 2018, I became Matron at Basildon Mental Health Unit and also covered Cedar Ward at Rochford Hospital. I reported to the Service Manager, [I/S] who in turn reported to the Unit Director, [I/S]

7. In 2020, I took up the Service Manager role, covering Basildon Mental Health Unit and the Linden Centre.

8. In 2021, I went on maternity leave.

9. In May 2022, I returned to my role as Service Manager, covering the Linden Centre and the Crystal Centre. This is the role I currently hold. I report to Tendai Ruwona an Associate Director who is based at Basildon and oversees the Linden Centre, Rochford and Basildon sites. The Associate Director reports to Elizabeth "Lizzy" Wells, Director of Mental Health Urgent & Inpatient Services.

Inpatient Care

Assessments

10. Patients were referred for Mental Health Act (MHA) assessments through the Approved Mental Health Professional (AMHP) hub, with referrals received from a range of sources including General Practitioners (GPs), family members, Community Mental Health Teams, and the Home Treatment Team. Each assessment was coordinated and allocated to an AMHP (typically a social worker) alongside two Section 12-approved doctors. Following the assessment, a range of outcomes could be determined, including detention under the Mental Health Act and subsequent hospital admission, informal admission, or discharge back to the care of community services, depending on the individual's needs and level of risk.

11. The timeframe for assessment depended on the level of risk identified during referral screening. Urgent or high-risk cases were prioritised and assessed as quickly as possible, often

on the same day. Lower-risk cases may have experienced a longer waiting period depending on service demand and resource availability. Decisions regarding prioritisation were made by the AMHP hub based on the level of risk presented in the referral. Factors such as immediate risk to self or others, deterioration in mental state, safeguarding concerns, and lack of engagement with services were considered.

12. When working on the wards, admission decisions were communicated based on bed availability. The bed management team, or the site officer outside of normal hours, would advise which patients were to be admitted. A verbal handover was provided by the AMHP to the receiving team. Current practice involves sending clinical documentation to the ward team in advance of the patient's arrival, allowing it to be shared with the multidisciplinary team (MDT), including the Responsible Clinician (RC).

13. MHA assessments are conducted face-to-face, and referrals are prioritised according to the level of risk presented. Previously within NEPFT, documentation would be hand-delivered to the ward upon the patient's arrival. Additionally, the bed management service has evolved over time and now operates until 8pm, seven days a week, providing extended support outside standard hours. Bed availability could impact admission decisions, sometimes requiring consideration of alternative placements or delays in admission. At times, there could be system pressures related to bed capacity and service demand.

14. In most cases, the MHA assessment itself was sufficient to determine the outcome. However, in complex or unclear situations, further clinical review or reassessment could be required.

15. Further assessments could take place in the community at the patient's home, if there was high risk assessed within the community this could happen at a hospital. These were conducted by AMHPs, psychiatrists, or the relevant MDT would also including community teams including home treatment team. Differences in clinical opinion were resolved through discussion between professionals involved (AMHPs, doctors, MDT members), with consideration of legal criteria, risk, and least restrictive options.

16. During the assessment, relevant professionals were consulted who were involved in that persons care and family were informed where appropriate, and with consideration of confidentiality and consent, family members and carers were involved in the assessment process. If not directly involved, family members and carers could be informed following admission, depending on consent and best interests. They were typically engaged by the ward team and included in care planning discussions where appropriate. A patient's views were central to the assessment process wherever possible. They will be included in discussions about

their care, understand their wishes, and consider their preferences. Where patients were unable or unwilling to engage, or where there were concerns regarding capacity or risk, decisions were made in their best interests, taking into account all available information. Confidentiality and consent were always considered when involving others, but where appropriate, family and carers were included to support.

17. Following a decision not to admit, several alternative care pathways were available to ensure the individual continued to receive appropriate support. For example referral to Home Treatment Team (HTT), Community Mental Health Teams (CMHT) or GP. These pathways were selected based on clinical need and level of risk.

18. Training was available, including Mental Health Act training, risk assessment training, and safeguarding training. AMHPs and medical staff also received role-specific training in applying the MHA. Relevant training was available to support decision-making regarding interim levels of care. This included training in risk assessment, crisis management, safeguarding, and application of the Mental Health Act. Staff were also supported through local policies and clinical guidance. However, in practice, determining interim care often relied on clinical judgement, experience, and multidisciplinary discussion, particularly in complex or high-risk situations. Informal support from colleagues and senior staff was also an important in ensuring safe and appropriate decisions.

19. The timeframe varied depending on bed availability and service pressures. In some cases, admission could be arranged the same day; however, delays could occur where beds were limited or required out-of-area placement. While awaiting admission, support could have included monitoring by Home Treatment Teams including medical review and medication where appropriate or observation in A&E.

20. In my experience substance misuse (including alcohol, prescribed, and illicit drugs) had a significant impact when assessing a person. Being under an influence could cause barriers to effective assessment for example making it difficult to distinguish between substance-induced symptoms and underlying mental illness or capacity or engagement, particularly if individuals were intoxicated or in withdrawal. There were delays in assessments, as assessments were sometimes postponed until the individual was clinically stable or medically cleared. Incomplete assessments or delayed information could impact risk assessment and decision-making for the patient for example if they require admission.

21. In my experience there were a number of barriers that could affect the quality and adequacy of assessments for example high service demand and time pressures, limiting the ability to conduct fully comprehensive assessments, availability of professionals, including AMHPs and Section 12 doctors, bed availability pressures, which could influence decision-making and timing or engagement difficulties, where individuals were unwilling or unable to participate fully. In my experience, when such barriers have arisen, they have been escalated to senior management and addressed appropriately. For example, issues relating to bed pressures have been discussed during bed calls, while AMHPs have raised concerns through their line management using a solution-focused approach to identify practical resolutions. Overall, I have found that these matters have been managed and addressed effectively.

Admission

22. In my experience, decisions to admit patients informally were made through a combination of clinical assessment, legal criteria, risk evaluation, and multidisciplinary discussion. For informal admission the individual had to be willing to consent to admission and treatment and deemed to have capacity to make informed decisions.

23. In my experience, decision-making processes evolved over time due to service development, increased demand, and changes in working practices within the Trust. Working towards the NHS National Plans such as The NHS 10 Year Health Plan and increased emphasis on community support. Over time, there was a stronger focus on avoiding admission where safe to do so, with greater utilisation of Home Treatment Teams. Improved coordination through bed management. The role of bed management became more structured, with extended operating hours working until 8pm, 7 days a week, which improved the allocation process and communication between teams. The trust now has a flow team which helps support operational teams with flow and capacity which I believe has been in place since 2023. This includes a service manager and clinical patient flow lead for purposeful admission and they have supported with clinical demands including supporting with system escalations for example. Practice shifted from documentation being provided on arrival to sending clinical information in advance, allowing receiving teams and Responsible Clinicians to review cases earlier and prepare care plans with MDT involvement.

24. Several factors influenced admission decisions including bed availability, level of clinical risk assessed at the time of assessment, availability of staff including AMHPs, doctors, and ward staffing levels could influence timing and placement. Patient preferences such as gender-

specific wards, PICU beds, or specialist services could affect where admission would take place. Out-of-hours could affect access to beds as bed management work until 8pm. If admission is required outside of bed management working hours this will fall to the site officers to lead on sourcing a bed. I had not experienced any pressures or incentives not to admit patients. Patient views were central. Patients were encouraged to express their preferences and concerns regarding admission. Where capacity was present, their consent was a key factor in informal admission. The views of others were also considered including family members providing collateral information.

Ward Environment

25. In my experience, ward environments were designed and purpose built for the time they were developed and the environment has changed throughout my career with the trust. From mixes sex acute wards with patients sharing rooms, dormitory accommodations to full refurb of environments ensuring we are meeting the national standards and managing risk, safety and therapeutic value. There have been notable improvements over time including recommendations from the Care Quality Commission (CQC), and increased awareness of patient-centred care. There was limited sensory spaces or therapeutic environments when I first started my nursing career however the trust has an increased focus on trauma-informed care and least restrictive practice. We have environmental risk assessments in place including the wards now having ligature audits in place and available on the ward. Better zoning of wards for example quiet areas, activity areas and increased provision of sensory rooms, de-escalation spaces, and gender-specific areas. As evidence based practice has developed over time we have improved recognition of neurodiversity, dementia-friendly design, and accessibility including rooms available to accommodate wheelchair access and profiling beds.

26. The ward environment will allow for the staff to have lines of sight including the use of mirrors for example to blind spots and visibility, we also have included in our ligature audits heat maps and layout of the wards for staff to understand the environment when thinking about risk areas if any ligature points or rooms which will need supervision such as the laundry room due to ligature risk poses with pipes etc. As technology has advanced we have a number of alarms on the ward including nurse call or Door Top Alarms to support staff. Wards were generally clean and maintained to acceptable standards, with routine cleaning schedules. However some of our older ward environments have showed wear and tear.

27. Therapeutic value has changed over the years and offer of therapeutic interventions has established with the development of the MDT. The trust has ensured that there are available structured activities, availability of therapy rooms and sensory spaces. Ensuring there is outdoor space where available. But also acknowledging the environmental restrictions such as locked doors.

28. Ward environments contributed to recovery by providing structure and routine, supporting engagement in therapeutic activities which were provided by psychologists, OT, physio and nursing team.

29. The trust now has single occupancy rooms to ensure we are maintaining patient's dignity and privacy. Ensuring we are providing privacy during personal care and providing our patient with respect during completing observations ensuring they are not feeling intrusive for those being observed.

Treatment

30. In my experience, decision-making processes in inpatient mental health services have evolved over time. Earlier in my career decision-making tended to be more clinician-led, with senior medical staff holding primary authority. Multidisciplinary input was present but not always fully integrated into final decisions I am unable to recall when this happened. There was a noticeable shift towards a more multidisciplinary and patient-centred approach. Greater emphasis was placed on collaborative care planning, incorporating the views of nursing staff, allied health professionals, and, where possible, patients and their families. More recently there has been increasing focus on shared decision-making within the inpatient and community teams, trauma-informed care and greater consideration of physical health alongside mental health

31. Decisions were typically made within a multidisciplinary team (MDT) including Consultant psychiatrists, junior doctors, nursing staff (including ward managers), psychologists and occupational therapists this is not an extensive list. Over time, MDT involvement has become more structured and central to decision-making.

32. Difference of opinion regarding treatment were typically resolved through the MDT discussions or escalation to the consultant psychiatrist.

33. Comorbidities were generally recognised but not always fully optimally managed, particularly earlier in my experience. Physical health conditions are now care planned and documented throughout the patient's admission. Physical health conditions could be deprioritised in acute psychiatric settings in the past. In more recent years the trust ensures that there is routine physical health monitoring from start of the persons admission, Integrated care approaches and working towards evidence based practice by also the use of physical health screening tools

34. Risk was assessed using a combination of the trust risk assessment forms, risk management plans and clinical judgement. There would be ongoing reviews of the risk assessments in place the time frames would differ to inpatient and community settings.

35. Throughout my experience key risks considered included self-harm and suicide, harm to others, vulnerability/neglect and safeguarding risks when working in the community we would also consider potential hazards such as dogs/animals in the house and access to weapons as few examples.

36. On inpatient wards, risk management strategies included consideration of observation levels, de-escalation and behavioural strategies including care plans and Positive Behavioural Support Plans (PBSP), review of care and treatment plan including medication reviews and engagement with the MDT such as working alongside psychology

37. As a trust we are risk assess on an individual bases ensuring that we are reviewing the least restrictive practice, patient dignity and autonomy, positive risk-taking and trauma-informed care. Aimed to balance safety with recovery-oriented care, recognising that overly restrictive environments can be detrimental to long-term outcomes.

38. A range of treatments were available including antidepressants and antipsychotics, as well as some access to psychological therapies. However, access to newer medications and consistent psychological input could at times be limited as this could be dependent on resource availability. In my experience this could impact patient care on the ward; when psychology team had a number of vacancies the interventions offered and provided were reduced and then the offer for psychology support before and accessing medication. I also recall there were times when there was a process that needed to be completed before ordering medication arriving which impacted on delaying discharging.

39. In my experience there were several barriers to effectively treating patients with substance misuse issues. One key challenge was the unpredictability of newer illicit substances, which made it difficult to determine appropriate treatment and anticipate patient responses. Substance use could also complicate diagnosis, masking or exacerbating underlying mental health conditions. Additionally, withdrawal symptoms and ongoing substance use often interfered with treatment engagement and recovery. Management typically involved close monitoring, use of detoxification protocols where appropriate.

40. Patients with Emotionally Unstable Personality Disorder and Borderline Personality Disorder (EUPD/BPD) often presented with additional complexities compared to other mental health conditions included managing high levels of emotional distress, self-harm, impulsivity, and difficulties in therapeutic relationships. Management typically focused on risk management, supportive engagement, and use of multidisciplinary team input. Psychological input has varied over the years and at times has been limited due to availability of ward psychologists but in more recent years the psychology service has increased including increase of staff and availability on the wards.

41. There were patients who were of an older adult age who would often present with reduced mobility, greater risk of falls, and multiple comorbidities, which required additional monitoring and physical health support. My experience with patients with organic diagnosis such as Alzheimer's disease or dementia being admitted to a functional adult ward could impact on the person's presentation increasing their confusion and disorientation that could be difficult to manage within a mental health ward environment.

42. Managing physical health needs alongside mental health conditions presented additional complexities ensuring the right equipment was needed on site and also ensuring patients had access to prescribed medication for physical health care could sometime cause delays. We would work alongside any specialist involved in that persons care and follow advice provided however due to the environment at times this could cause some limitations for example the need to order equipment that might not be available on site.

43. A mental health ward is a complex and demanding environment, where patients present with diverse needs and varying manifestations of illness, even among those with the same diagnosis. In recent years, there has been a noticeable increase in the acuity and complexity of presentations, particularly following the COVID-19 pandemic. This includes a higher prevalence of individuals experiencing severe mental health crises, such as acute psychosis.

44. While established care approaches continue to be applied, recovery trajectories appear to be more prolonged than previously observed. Furthermore, the management of patients with co-existing substance misuse has become increasingly challenging, particularly due to the emergence of new and less well-understood illicit substances, which can complicate assessment, treatment planning, and overall clinical outcomes.

Medication

45. Medication is usually prescribed by a consultant psychiatrist, specialty doctor, or registrar after clinical assessment and prescriptions are documented on inpatient drug charts paper and now electronic. Administered by registered nurses, typically at set medication times/rounds.

46. If the patient had capacity and refused their decision was generally respected, even if clinically unwise. Staff will provide information and reassurance and explore concerns. If detained under the Mental Health Act (MHA) medication could be administered without consent in the first 3 months (with appropriate documentation). After 3 months, a Second Opinion Appointed Doctor (SOAD) must approve ongoing treatment if the patient still refuses. If lacking capacity, a further capacity assessment is carried out.

47. In my experience I have not witnessed a practice or culture of over-medication.

48. Patient choice was an important part of care, particularly where the patient had capacity. Patients are informed about medication options, risks, and benefits and given opportunities to express preferences. Family members and carers are and were consulted when the patient is consenting. Input from community teams are included especially on admission and discharge. This helps ensure continuity of treatment when discharged and awareness of prior care plans or medication regimes.

49. In my experience I have not been made aware of any restrictions placed upon prescribers by the hospital as to what medicines they could prescribe.

50. In my experience there was a mental health pharmacist available on the ward who was responsible for carrying out medicine reconciliation.

51. In my experience nurses administering medication on the wards were given protected time to do so.

52. In my experience I am not aware of any barriers to appropriate and adequate prescription and administration of medication to mental health inpatients.

Transfer

53. Decisions regarding the transfer of patients between wards, units, or hospitals were traditionally coordinated through bed management teams. When services operated across two separate Trusts, this process involved liaison between bed management teams, with subsequent communication to the receiving and transferring wards, particularly where movement to an acute ward was required. For transfers to more specialised settings, such as Psychiatric Intensive Care Units (PICU), a formal referral process was followed, including the completion of a detailed referral form and clinical review. More recently, I am unable to recall the exact date, the Trust has adopted a more collaborative and multidisciplinary approach to patient transfers. This includes direct Responsible Clinician (RC) to RC discussions, alongside a structured, risk-informed decision-making process. Transfers are now carefully considered in terms of clinical need, risk management, and safeguarding requirements, with a clear focus on ensuring patient safety, delivering least restrictive care, and providing the most appropriate therapeutic environment. In my experience in the past, decisions have been made to transfer a patient without involving professionals within that persons care.

54. Continuity of care was a key priority during patient transfers and was maintained through a number of structured processes. This included ensuring a comprehensive handover to the receiving ward, with all relevant clinical documentation shared in advance, particularly where different electronic record systems were in use. Care was taken to ensure that patient medication accompanied the individual to prevent any disruption to treatment.

55. Families and significant others were routinely informed of transfers, a process which has significantly improved following the introduction of Family Care Ambassadors (FCA) they are a support, advocate and liaison role to help families and carers when they have a loved one admitted to an inpatient ward, this was part of the Time to Care initiative which aimed to free up more clinical time to spend on direct patient care and strengthening our multi-disciplinary teams to ensure we have the right mix of skilled and experienced staff to deliver safe, high quality care. For my area we have had FCA in post since 2025. In addition, community teams were notified of all transfers to support ongoing care coordination and maintain seamless communication across services.

56. Changes to a patient's environment or transfers in my experience have been planned. Unplanned changes or transfers in my experience have occurred due to a change in clinical risk and presentation of the patient at the time the decision is made. There are some transfers which are deemed more clinically urgent and unplanned such as urgent need to transfer to PICU due to increasing risk towards others as an example. As trust we do have planned transfers so this could be when a patient needs to step down from PICU to Acute wards. Also, we will have planned transitions from CAMHS to adult which are planned following the person turning 18 years old. On the acute adult wards we have band 6 nurses who had specialist training for CAMHS transition in January 2024. This was provided by an external company called Association for Psychological Therapies however, I am not aware of what the training consisted of due to not attending the training myself. This was offered following lessons learnt from a patient safety incident that took place on Chelmer Ward involving patient Morgan-Rose Hart. We will attend ward reviews, professional meetings and attend the CAMHS wards to start building our therapeutic relationship, this will often include the person and their family where appropriate visiting the adult ward.

57. The process of transferring patients has improved over time and there are now more robust systems in place across the adult inpatient wards such as ensure the patients are informed where they are being transferred to and the clinical information being shared with the treating

58. While working at Basildon Mental Health Unit during the opening of Thorpe Ward in 2018/2019 to support NEPT's out-of-area patients, I identified and raised concerns regarding the admission process. There were instances where patients arrived on the ward without prior notification or sufficient clinical information relating to their transfer or admission. These included patients being transferred from Peter Bruff Ward, admitted via A&E, or directly from the community. When addressing the issue with Peter Bruff Ward for example, there was a meeting put in place which took place monthly between the leads on the ward to review any concerns of admissions. This was in place after the death of Bethany Lilley.

59. I recognised this as a potential safety risk, as ward staff were not adequately prepared to safely manage new admissions without prior knowledge of the patient's presentation, risks, or care needs. I escalated these concerns to my line manager at the time and contributed to identifying and implementing improvements.

60. As a result, several changes were introduced. A generic ward email inbox was established, accessible to the entire nursing team, to enable clinical documentation to be shared centrally

rather than sent to individual email accounts. This allowed for continuous monitoring of incoming information, ensuring accessibility 24/7.

61. In addition, I began attending NEPT bed management calls to ensure that Thorpe Ward was represented in discussions regarding potential admissions and transfers, enabling the timely collection and sharing of relevant information with the team. We also developed a structured clinical handover document to support nursing staff, ensuring that key clinical information was consistently communicated and any gaps in information could be clearly identified and addressed prior to patient arrival.

62. These actions contributed to strengthening communication, improving admission processes, and enhancing patient safety within the ward environment.

63. Following review of the Root Cause Analysis (RCA) surrounding the death of Bethany Lilley and its ten key findings, I can confirm that twelve of the thirteen recommendations have been implemented and are now embedded within current practice across the Trust, particularly in relation to discussions and decision-making around internal transfer they are as follows:

a) All emails sent with regards to the transfer of patients are to have a subject line as to the patient's name, DOB/NHS number from where they are being transferred from and to;

b) Where information is shared via email it is the responsibility of the transferring clinician to ensure that the information has been received;

c) A risk-assessment and transfer form should be completed prior to every transfer;

d) An inventory of patient's property should be undertaken as part of the admission to the ward and prior to transfer;

f) Patients should not be transferred until the receiving ward has confirmed that they are expecting the patient and they should receive copies of all relevant notes;

g) There should be a verbal handover between staff from the outgoing and receiving wards for all transfers, the content of which should be recorded in the clinical notes;

h) When complex patients are transferred there should be Consultant to Consultant discussion regarding their history and identified risks;

i) All patients on level 3 observations should be accompanied by a member of staff from the ward;

j) If a patient is transferred to a new ward without being accompanied by sufficient background and case notes, the staff on the receiving ward must immediately contact staff from the patient's previous ward to obtain the necessary information as a matter of urgency;

k) All Consultants should have access to and training for the use of the patient record system not used in their locality (i.e. Paris or Mobius). l) All staff should be familiar with HIE and

how to use it. m) Staff should be provided with further training on the Trust's 'Discharge and Transfer Guidelines', which sets out the procedure to be followed when transferring a patient from one ward to another.

However, I am unable to definitively confirm whether Action 10e has been actioned or embedded. This related to whether regular checks or reviews were consistently undertaken by the Ward Manager or Security Lead in relation to the remaining recommendation. This is because I don't have access to the records to be able to provide the assurance needed.

Leave, Absconsion and AWOL

64. In my experience, decisions relating to leave escorted and unescorted leave would be held within the patients ward review/care review where the decision would be made by the RC if leave can be granted. There will be further discussions held with the MDT meetings regarding all patients leave status. If a patient is detained they will require Section 17 leave which the RC would need to complete the form and this might include some conditions on the leave including who may accompany the person on leave. All patients are risk assessed prior to leave taking place by the nursing team this is the same progress for detained and informal patients on the ward. If leave is accompanied this might need to be preplanned so example if a family is arriving at a certain time or they are expected to attend an appointment for a certain time and transport is needed then the risk assessment can be completed earlier.

65. All leave decisions are to the communicated to the team following ward review plans being shared these are normally via sent via email. During the ward review there the decision will be made following the patient's clinical presentation, risk profile, reasons for leave and safety planning, this could include ensuring the ward has available staff to ensure the leave can go ahead.

66. Overnight leave or longer periods of leave would be agreed with community team to ensure there was appropriate support including if appropriate referral to the home treatment team for going support, regular contact from the ward, preplanned appointments with the community team for example care-co. Family would be provided with the ward details should they need to contact the team for any support or advice.

67. There have been times throughout my career within inpatients where patients have been declined leave due to lack of staff availability. In my experience this was the only barrier I have knowledge of for a patient not accessing leave. However in current practice now with the increase of staffing and MDT working the patients aren't just reliant on the nursing team

supporting them for leave, this can now be completed by staff that are deemed competent to complete this role, and this includes Allied Health Professionals (AHP), peer support workers and activity coordinators.

68. For all patients who went on leave they would be signed out by the nursing team this would be completed on paper when I was working in SEPT the risk assessment would be held within the Section 17 leave folder, once all completed this would be scanned into the paper records. This would also be documented on the fire list so we would know if patients had returned or not in the event of a fire. When working in NEPFT, the patients who were on leave this would be documented on the bed state/24hour report book. They also had a paper risk assessment for leave patients. Since the trust has merged there is now an electronic leave risk assessment in place on the patient records.

69. In my experience the process of patients being risk assessed and signed out for leave has not always been appropriate as in my experience I have witnessed when this process hasn't worked. For example a patient being let out when they hadn't had section 17 leave approved or being let out when their leave had been suspended.

70. The management of patient who has absconded and then is AWOL would be led by the nursing team initially with the support of the MDT and following the trust policy and support with ongoing escalations.

71. In my experience, I have been directly involved in incidents where patients have gone absent without leave (AWOL). These have included situations where patients have absconded from escorting staff during periods of authorised leave, gained unauthorised exit by tailgating through secure doors, scaled perimeter fencing, or failed to return from agreed periods of home leave. These examples reflect the range of scenarios encountered within inpatient settings.

72. In cases where patients absconded during authorised leave or home leave, appropriate risk assessments had been completed and reviewed by the multidisciplinary team (MDT), and patients were deemed safe for leave at that time. Incidents such as fence climbing or tailgating were not always identified as foreseeable risks prior to occurrence. Following each incident, safety measures and risk management plans were reviewed comprehensively as part of the Trust's incident reporting and investigation processes, to identify learning and reduce the likelihood of recurrence.

73. All AWOL incidents involved appropriate liaison with the police. Incidents were reported promptly by the nursing team, and police support was sought to assist in locating and safely returning patients when required.

74. In all cases of absconding, patients' next of kin or family members were informed in line with the patient's consent and preferred method of communication, whether by telephone or other agreed contact methods. Additionally, relevant professionals involved in the patient's care were notified. During out-of-hours periods, communication was typically managed via email, while during working hours direct contact was made. Senior management teams were also informed through established escalation processes.

75. Following AWOL incidents, patients were offered dedicated one-to-one time with staff to debrief and reflect on the event. This provided an opportunity to explore the reasons underlying the incident, support the patient therapeutically, and inform any necessary updates to risk assessments and care plans.

Safeguarding

76. I have consistently felt confident in raising safeguarding concerns relating to patient care throughout my career. Where concerns have arisen, I have escalated them appropriately through established channels, including line management, Responsible Clinicians (RCs), safeguarding leads, the Executive team, the Risk team, and the Freedom to Speak Up process. In my experience I have raised concerns regarding sensitive information from our patients or family members, following concerns being raised regarding professional behaviour of staff. For example, it was disclosed that a patient and staff member had an inappropriate relationship this was managed via the trust conduct and disciplinary process support by HR and the matter was fully investigated as per trust policy and the outcome was the staff member was dismissed. These concerns have been followed by the appropriate process including, if needed escalation to senior management team, support from safeguarding leads, Deputy Director of Quality & Safety (DDQS) and support from patient safety team.

77. In my experience, these mechanisms have been effective, responsive, and supportive. Concerns have been acknowledged, and feedback has been provided in a timely manner. I have also felt able to raise concerns regarding the actions or practice of clinicians or other staff members where necessary, and have done so when required.

78. In leadership roles, I have additionally engaged with Human Resources where appropriate and have a clear understanding of the Nursing and Midwifery Council (NMC) referral process, supported by direct experience in this area.

79. In my experience, I have not encountered any cultural or systemic barriers within the Trust that have prevented me from raising or reporting concerns. I have found the organisational culture to be supportive of openness, transparency, and speaking up in the interest of patient safety.

Clinical Records

80. In my experience, record keeping has evolved significantly over time. When I commenced employment with NEPFT in 2008, paper-based records were in use across both inpatient and community settings. Clinical documentation was maintained within physical patient files, including during my work within community teams. I am unable to recall the exact date of transition; however, the Trust later introduced an electronic patient record system (Carebase). When I moved to SEPT in 2016, an electronic system (Mobius) was already fully established and in routine use.

81. Patient information has been shared through a range of communication methods to support continuity and safe care delivery. These have included structured handover periods, multidisciplinary team (MDT) meetings, telephone discussions, and face-to-face meetings. Community teams routinely attended ward reviews to ensure joined-up care. Over time, communication methods have increasingly incorporated email as a standard approach, although I am unable to recall the specific timeframe of this transition.

82. Access to electronic records required individual staff login credentials to maintain accountability and information governance standards. In circumstances where staff did not have their own access, wards could provide a temporary or guest login to enable documentation during shifts. This practice was consistent across both NEPFT and SEPT to ensure that patient records were updated in a timely and accurate manner.

83. In relation to paper-based records, I am unable to confirm the exact process by which patient notes were received on the ward, as this function was typically managed by administrative staff. I am also uncertain whether community and inpatient teams had shared access to these records or whether delays were experienced.

84. In my experience, electronic record systems have generally been user-friendly and supported effective clinical documentation. Appropriate training was provided to staff, and the presence

of designated "clinical systems champions" on wards ensured that additional support was readily available when required.

85. My personal preference is for the Mobius system, which I have found to be the most intuitive and user-friendly of the electronic record systems I have used. Where concerns regarding electronic record systems have been raised for example temporary staff not having a log in to the system, support was provided by providing guest logins being provided for staff so that they could access to the clinical records and minimise disruption to patient care. Iin my experience I found that these were typically addressed in a timely manner. However, I recognise that system enhancements, such as the development and implementation of new documentation templates, can take longer due to the complexity of changes required.

86. In my experience, access to IT equipment such as desktop computers and laptops has generally been sufficient to support clinical work. However, there have been occasions where availability has been temporarily limited, for example due to equipment loss or delays in replacement, which has impacted immediate access.

87. I am aware that, at times, clinical records have not always been updated in a timely, accurate, or appropriate manner. This has included instances where key documents, such as risk assessments and care plans, have not been regularly reviewed or updated. I have also observed occasions where documentation has been duplicated through copying and pasting, which can compromise the quality and accuracy of clinical records. I am not aware of any introductions of alerts where records have been copied and pasted, or if records have not been updated. The trust has taken measures to address these issues for example it has been included within the Matrons & Nursing Home Managers Assurance Audit on Tendable where the clinical notes are reviewed for evidence of copying and pasting from earlier notes.

Care Plans

88. Care planning within EPUT services is a collaborative and person-centred process, developed jointly between the individual and the clinician. This may involve the named nurse within an inpatient setting or a Community Psychiatric Nurse (CPN) in community services. The aim is to ensure that the individual's voice, preferences, wishes, and goals are clearly reflected throughout the care plan.

89. With the individual's consent, family members, carers, or significant others may also be involved in the development of the care plan and provided with a copy, enabling them to

support ongoing care and contribute to crisis management planning. Care plans also include dedicated sections addressing community care arrangements and discharge planning to support continuity across services.

90. Physical healthcare needs are routinely incorporated into care plans, recognising the importance of a holistic approach to care. Within inpatient settings, care plans are typically reviewed on a weekly basis to ensure they remain relevant and responsive to the individual's current needs. In older adult services, care plans are further adapted to reflect specific requirements, with additional sections such as falls prevention.

91. Throughout my career, I have received ongoing training in care planning, which has evolved over time to reflect best practice standards. I have consistently viewed care planning as an integral component of a person's treatment and care, rather than an administrative task.

92. However, I recognise that there have been challenges in consistently delivering high-quality care planning. These have included factors such as increased patient acuity, competing clinical demands (for example, responding to incidents), and resource pressures, including IT system issues and staffing levels, all of which can impact the timeliness and quality of documentation.

Therapeutic Engagement and Supportive Observation

93. Clinical decisions relating to risk management and observation levels are determined based on the individual's presentation at the point of admission and ongoing assessment. During working hours, these decisions are made collaboratively, involving the nursing team, Ward Manager, medical team (including the Responsible Clinician), and the wider multidisciplinary team, depending on the complexity of the presentation.

94. Outside of core hours, decisions are made in conjunction with the nursing team, the on-call doctor, and the Clinical Site Officer, with additional advice sought from the out-of-hours management team if required. In my experience, once agreed, risk management plans and observation levels are consistently implemented and adhered to.

95. Observation levels are clearly explained to the patient, and these decisions are regularly reviewed within ward rounds and care reviews to ensure ongoing appropriateness. With consent, this information is also shared with family members or carers to promote transparency and support.

96. A least restrictive approach is always prioritised, taking into account patient preferences wherever possible, for example preferences regarding staff gender. The Trust has maintained an Observation and Engagement Policy, which has evolved over time to reflect best practice. I have consistently received training in this area and have also delivered training to staff within my teams to promote safe and effective practice.

97. In my experience, there have been occasions where staffing pressures have impacted the delivery of required observation levels, particularly in situations involving unplanned or enhanced observations. For example, patients requiring escort to A&E—particularly where legal status necessitates continuous supervision—can place additional demands on staffing resources.

98. While support is typically available from other wards to provide additional staffing where needed, there are instances where the unpredictability of the inpatient setting presents challenges that cannot always be anticipated or fully mitigated. Despite this, efforts are consistently made to maintain patient safety and meet observation requirements through effective coordination and resource management.

Discharge

99. Discharge planning has evolved over time in line with national NHS guidance and developments within mental health services, including the NHS Long Term Plan. It is initiated at the point of admission, with early identification of potential barriers to discharge to enable timely resolution. For example, this may include addressing environmental factors such as the need for property cleaning or repairs to support a safe return home.

100. Discharge planning is regularly reviewed within ward rounds and care review meetings, involving relevant professionals across the multidisciplinary team, including community services. With patient consent, family members, carers, or significant others are invited to contribute, providing valuable insight and supporting holistic care planning. Information is gathered through multiple sources, including engagement with the patient, liaison with family and carers, review of clinical records, and communication with other professionals involved in the individual's care.

101. Throughout admission, patients undergo a range of assessments, both as part of standard admission processes and in preparation for discharge. This may include specialist assessments, such as housing or capacity assessments, often completed in collaboration with external agencies such as local authorities. Risk is continuously assessed and documented, with final assessment and discharge decisions made by the Responsible Clinician (RC) in collaboration with the MDT. A key consideration at the point of discharge is whether the individual can return home safely or requires additional support.

102. I recognise that some barriers to discharge are outside of direct clinical control, such as the availability of suitable accommodation, placements in supported housing, or access to specialist services. Despite these challenges, care plans include a dedicated discharge planning section, developed collaboratively with the patient to promote transparency and shared decision-making.

103. Where possible, inpatient teams take a proactive approach to discharge, including the timely ordering of medication through pharmacy services for planned discharges. However, delays can occasionally occur in cases of unplanned discharge. Decisions regarding medication risk management are made within discharge planning meetings and are clearly documented within clinical records and discharge summaries, which are shared with GPs and community teams to ensure continuity of care.

104. While I am aware of the ongoing pressures within mental health services, including national bed capacity challenges, I have not experienced pressure from management to discharge patients unsafely. In my experience, practices such as the use of overnight or trial leave remain valuable in supporting patients' transition back into the community.

105. Overall, I have observed that discharge planning processes have strengthened over time, becoming more structured, collaborative, and patient-centred, with a clear focus on safety, continuity, and positive outcomes.

Continuity of Care and Treatment in the Community

106. Continuity of care and treatment in the community has changed over time with the NHS national guidance working towards care in the community and looking at alternatives to admission with the development of community teams and access to community services strengthened.

107. A Care Coordinator plays a central role in planning, organising, and reviewing a patient's care to ensure it is safe, effective, and tailored to individual needs.

108. In my experience I am unable to recall how many vacant posts there were within the community team and case load management and numbers were discussed within the weekly MDT meeting.

109. From my experience when I worked within the community services I would attend the patients care/ward review at the point of discharge to discuss what support I would be offering and also to arrange follow up appointments at times/dates that were convenient for them to attend. The patient would be followed up within 48hours depending on the day of the day discharge. The day of the discharge would determine who would conduct the 48 hours follow ups. If the discharge was on a weekend this would be picked up by the home treatment team and if during the week this would by the community team. The discharge summary would be available to the teams and documentation on the clinical system.

110. Information would be shared with community teams including the home treatment via conversations, emails, telephone call, teams chats, attending persons ward review, any professional meetings and referrals via the clinical records. In my experience I haven't had any issues with information I have always found speaking with another clinician more beneficial when discuss the referral this is my own personal method to ensure information is accurately shared.

111. Information would be shared with family members if the patient had consented this could take place during the visit if they were present, via appointment or telephone. The only issue I found was when the patient did not wish to share information, which meant within my experience I was only able to listen and comment on non-clinical matters which I can understand how difficult this was for worried loved ones and family members. In my experience I did always offer support to family members were appropriate including offer carers assessments.

Engagement

112. Throughout my career within the trust I have always explained to patients I have worked with how confidentiality works in practice and if there is a significant risk to themselves or others than this may need to be broken to ensure safety, I have found being open and honest in my approach provided a good understanding to those if I should of needed to do that.

113. Where a patient did not consent to share information I would always ensure this was documented and updated via the clinical records and always reproach the subject with the patient as I am aware that consent can change. I would also speak with the family members and being open and honest explain my limitations at point but always listened, documenting the concerns and answering on non-clinical comments providing space for that persons concerns to be heard and offering assurance that they will be looked into. Understandably this was very difficult and worrying for those family members.

114. In my experience I have always respected the patient's wishes and have been open with them about how I can manage risk and support provided when or if risk increases.

115. In my experience the only situation I have been involved with where patient wishes were over ruled has been when risk are presented as high, they have been offered informal admission they have declined and then referred for Mental Health Act. As part of the Mental Health Act assessment the NOK is contacted, and information is shared to form part of the decision making to understand if this patient requires hospital admission via detention.

116. In my experience we have been able to accommodate patients with communication difficulties, we have a number of easy read leaflets for example and also we have transition service available which can provide in person support and via the telephone. We can also provide information leaflets in different languages which in my experience have been provided to family and carers.

117. In my experience family members have been invited to care reviews as inpatient and working across the community teams.

118. Following a patient being involved in an incident they are supported by the nursing team following the incident and also members of the MDT. They will be offered one to one time to discuss the incident. Family members will be informed if the patient provides consent for the nursing team to contact them.

119. Family members would often be contacted via telephone if this was there preferred method of contact to be informed of any incidents. These could also be discussed when meeting with the MDT within the patients care/ward review. Depending on the incident the family could also be provided with Family Liaison Officer to offer continued support and provided with regular updates.

120. There have been improvements in family engagement following serious incidents including the role of family liaison officer within the patient safety team.

121. We now have the Family Care Ambassador role across the Trust. The funding for that role was approved last year. Part of the role involves providing physical and virtual drop-ins for family members. I hope that family members now feel heard. I feel positive that the role will change the experience of family members and carers.

122. The family care ambassador role is dedicated to inpatient wards providing a single point of contact to provide ongoing support and updates regarding their loved ones care. For example if a family member is unable to attend the ward review they can attend on their behalf and feedback by their preferred method of communication this could be phone call, text message or email.

123. The family liaison officer plays a key role in supporting communication and relationships between patients, their families, and healthcare teams especially during sensitive or complex situations such an incident. This role is very different to the family care ambassador which is supporting family during a person's admission.

124. This role was developed following the Time To Care project and following feedback from family who have struggle to get regular updates from the ward, or get through to the wards at times this role has provided a single point of access for information sharing and providing sign posting and ongoing support.

Safety

125. Since working in the trust 2008 there have changes within the environments for example ligature reduced furniture, including skinks and toilets. This means the furniture is now fixed to the floor. When patients have been assessed as risk towards themselves one of the preventive measures put in place is nursing that person on enhanced observations to reduce the risk of the person harming themselves or others. Over time the trust has developed a contraband list which has a number of items on their patients aren't able to bring on to the ward. The ward layout and environment now has ligature audits which include 'hot spots' which are areas that are high risk for example the laundry room, which is classified as a "red room" as it needs staff to accompany the patients due to ligature risks that are unable to be reduced like the pipes from the washing machine. I am unable to recall the exact date of when these developments have taken place.

126. When an alarm is activated this will call for a rapid response from other wards and also staff from the same ward, this will involve a ligature pocket which holds the ligature cutters, being brought to the alarm and also the grab bag (a bag which contains necessary basic life support equipment).

127. In my experience there have has been varied response including very responsive response for the alarm including equipment being brought that has been needed and there has been times where the response hasn't been well attended or no equipment brought to the alarm. These have been down to clinical issues such as ward already managing an incident on their own ward which meant that there was no capacity within the team to respond.

128. The restrictive practices that I have experience and are used to is seclusion and long-term segregation. The seclusion being used on PICU in cases where a person has been at significant risk towards others for example and also the same use for Long Term Segregation (LTS). When a patient is in LTS or seclusion there is documentation that the staff need to complete including completing a datix and informing safeguarding.

129. There have been times when patients feel safe when they were on mental health wards and times when they have felt unsafe on the wards. In my experience patients have felt unsafe when they have witness staff assaults from patients and patient on patient assaults.

130. I have had concerns raised directly to me from families and carers regarding patient safety for example when they have been informed of patient assault incident on the ward. I have received these concerns informally via verbal conversations and also via formal routes such as PALS/Complaints.

131. In my experience there have been times when I have felt unsafe at work and working on the wards this has been mainly when I have been personally assaulted by a patient or when we have needed support from the police and they haven't arrived. I am unable to recall the exact number of times we haven't had assistance from the police. As a trust we do have support security but they are not able to provide the same level of support as the police could.

132. I did have access to a personal alarm which I haven't had an issue using.

133. Incidents involving physical harm to staff in my experience were dealt with appropriately and adequately by the trust however we haven't always had the support from the police during and after such incidents.

134. Decision making relating to staff safety affect inpatient care would be involving the MDT to look at safe options to ensure that care can be provided this would also be escalated to the senior management team.

135. The trust has worked alongside Essex Police and safeguarding boards to protect patients and / or staff members at risk. We are able to make referrals via the safeguarding team.

136. During my experience I have witnessed incidents of self harm, attempts of suicide, assaults on staff and assaults on patients. The incidents I have been involved in, or witnessed, have been dealt with in a timely manner and appropriately.

137. I have observed and been part of efforts to make the wards safer for patients. There has been a lot of work done around ligature risk. For example, we have reduced anchor points in bedrooms and there have been changes to the way ligature audits are conducted. They are a collaborative process with the Estates and Risk teams as well as previous patients. We also involve junior staff so that they build awareness of risk. We have a ligature hotspot map in the ligature wallet on the ward. The map marks the location of potential ligature risks and staff are shown the hotspots as part of their induction.

138. I am aware that changes have been implemented as a result of serious incidents. For example, Abbigail Smith was a patient on the Galleywood. During one incident she was able to barricade a door and self-strangulate. Following that incident, work was done to introduce anti-barricade doors. There was an incident in the garden at the Lakes when a lady died having ligatured using a door handle. There was a lot of work done in the gardens and in relation to door handles following that incident.

139. In my view the ward environment generally has become safer. Previously gardens weren't closed off so patients could more easily abscond. We now have anti-ligature doors, toilet-seats and sinks. When I worked at Basildon we had dormitories with five beds in a room. Now we have individual modern rooms. The space is more appropriate for the number of patients we have.

Ligature Audits

140. Ward Manager completing the ligature audit I would be part of the team that would go around the environment during the audit. I ensured all areas were checked thoroughly and regularly. Staff were aware of risks and mitigation strategies, took immediate action on identified risks

during the audit and escalated estates issues promptly. I maintained accurate documentation ensuring the ligature wallet was maintained. I would deliver team briefings and supervision to reinforce safety awareness and share the new audit. As Matron, I provided oversight and quality assurance across multiple wards. I would review audit outcomes and completed matron inspections and spot checks to ensure the wards were adhering to the audit. I would escalate to estates to address any concerns. As Service Manager, I ensured learning from audits and incidents informed service-wide improvements, reviewed risk registers and action plans. I do check on the ward ligature wallets to ensure we are meeting the trust standard. I will also share lessons learnt or trends via various meetings.

141. With regard to changes to the environment following ligature audits, in my experience, the priority would be identified via the estates and risk team then updated to the ligature audit. I am unsure why there was delay in the works being completed relating to the hand dryers and shower heads (as per paragraph 44 of the Rule 9 Request for Witness Statement) as I am unable to access the system that was in use at the time to check. Also I am unable to see when the task was updated and how this information was pulled via the excel spreadsheet as it is shown in the Rule 9 request. More generally, depending on the task from the audit there could be delays if items are needed to be made, for example when we needed to change vents on Galleywood and Finchingfield ward within the toilets these needed to be made by an external company so this took some time before they were fixed and the task completed. If there was trust wide project, for example when all the wards had new bedroom doors fitted, this would have meant there would be scheduled work at times across the trust. I am unable to comment on how common it was for there to be delays across the trust I am aware in my experience, there were delays with actions and meeting deadlines due to parts being delivered and works being completed late. From the excel spreadsheet (paragraph 44 of the Rule 9 Request) provided I am unsure if this information is pulled from Datix and if the updates were provided at the time the Datix action was updated or this was the actual date of completion.

142. There was mitigation put in place whilst waiting for ligature risk to be actioned/completed. This could be for example making this room a red room so patients would need to be escorted to and in that room.

143. In my experience I have been involved in cases when a patient has reported such events of sexual safety concerns I have not witness this myself. When a patient has reported such a concern I have reported this via datix, safeguarding and police if appropriate including the involvement of HR. Investigations would be launched and completed.

144. When working on mixed wards and single sex wards the risk profile can differ and when working with patients that have been through trauma its important they are offered a choice and their preference is always considered. This is understood by the trust.

145. From my experience there was consideration given to physical and / or sexual safety risk management on mixed-sex and / or single sex wards. They would have been recorded in the risk assessments. Staff were adequately and appropriately briefed and trained on such risks.

146. There are still mixed-sex wards in the trust.

147. I am unable to recall when starting with the trust from 2008 if I was aware of children being admitted but from 2016 I can confirm that I am aware of children being under the age of 18 and being admitted to our Health Based Place of Safety (HBPoS) following being detained under 136 Mental Health Act.

Technology

Oxehealth

148. My role was to support the piloting of the technology on the ward and attending meetings to feedback information and concerns regarding the roll out of this on Hadleigh Unit. Also to provide support to the ward when piloting such a new technology on the ward and then roll-out of Oxehealth at EPUT across all the wards I was responsible for at the time. I am unable to recall if I did or didn't feedback any concerns. During the roll out of Oxehealth we were provide with online training with the company and also had on site support from the team during this period. My experience was that it was helpful having onsite support when rolling out something that's new and in experience they were helpful. The training online had mixed feedback from staff as some staff felt it wasn't helpful and others found it helpful.

149. My comments about the Oxehealth pilot are included in the Early Insights and Implementation Lessons Learned. There are none that were not reflected in that report.

150. My reasons for my view that *"Oxehealth will help us to reduce 1-to-1 observations"*. In particular we had patients who were being nursed on level 3s to monitor their sleep pattern including the completion of sleep charts. Oxehealth could monitor sleep without it being as invasive as a person doing this. I did consider that it would help reduce our 1-1 in relation to physical health care monitoring and reducing the risk towards staff at times especially on a

PICU. Since the Early Insights Report was published I have found Oxehealth has helped with monitoring physical health but not reduce 1-1 who are at risk to themselves.

151. Oxehealth has helped improved the monitoring of non-contact observations for example being able to monitor someone sleeping pattern if they have a condition such a sleep apnoea this would generate a report for the team to review.

152. In the statement I made regarding not disturbing patients in their sleep this referred to the taking of vital signs which could disturb sleep, so if the patient did have the areas visible for the vital sign to be taken that could be non-contact observation and not disturbing the patient who was sleeping this would be beneficial for the patients recovery.

153. I have experienced patients not wishing to consent to Oxehealth and this has been turned off and also when providing information during admission to the patient and their family they have asked for this to be turned off this has been acted on.

154. I have personally had concerns raised from patients who have been paranoid who have believed they are being watched and listened to also have supported them with turning it off and also the same for patients who have experienced trauma.

155. I have experienced and witnessed staff not using Oxehealth as per the standard operating procedure and I am aware of staff suffering from 'alarm fatigue'.

156. In relation to the initiatives that Zephan Trent discussed within his second witness statement following the focus group which took place in January 2025,I can confirm the SOP has been revised within the trust and implementation of the SOP. The new consent process is in place within the trust. I can confirm further training has been implemented and is available to staff via OLM. I was not part of the Focus Group and therefore cannot comment any further on this.

Other Technology

157. I am unable to recall the dates that mobile phones were introduced within the trust but we do use them on the ward and if patients don't have access to mobile phones we will provide these when they go on leave and part of discharge. I am not able to recall the introduction of CCTV and body worn cameras. In my experience I have found the use of technology to support with patient safety, safeguarding and investigations. I have used body worn cameras to support with

good practice and sharing this with staff. Also found CCTV has been helpful with supporting patients who have raised concerns and providing assurance as part of fact finding.

158. In older adult wards we have had the support with technology assisting in reporting falls for example slip, trip and falls matts which are a sensory matt with alerts that go to staff via a pager and would make a loud noise as well these would also be used in chairs until 2021. We also have the use of Oxehealth which will send an alert when a patient is at the edge of their bed. Also we have beds that are able to be lowered to the ground to reduce risk of harm.

159. There have been concerns raised by patients using our services with CCTV breaching privacy and dignity the CCTV. Patients have been informed it's not within their bed rooms or bathrooms only within communal areas such as corridors and lounges.

160. Staff have been trained regarding CCTV and the use of body worn cameras.

Staffing, Training and Support

Staffing

161. In my experience from working on the wards in 2008 the number of staff working has increased the baseline numbers. When I first joined the trust we would work on a total of 3 staff at night on one of the wards and now we work on 6 including 3 qualified staff.

162. Staff were allocated tasks/roles within the handover by the nurse in charge, the rosters were completed by the ward managers and when I first started allocations would be reflected in the roster.

163. In my experience there was a difference in care delivery when working with substantive staff, temporary and agency if they hadn't worked on the ward before, when working with staff who had regular shifts or knew the workings of the ward this could have a positive impact on the care that was provided.

164. Any concerns raised where dealt with via the management team of that particular ward, I can comment on my experience when concerns were raised and how I dealt with these. These concerns would speaking with the bank office raising concerns and these being fully investigated. If did have concerns raised regarding communication or performance these would have been dealt with the same way.

165. In my experience agency shifts would be approved if these shifts were not filled by substantive or bank staff. If there had been a previous agreement in place for a temporary contract for agency these shifts would have been agreed beforehand and rostered accordingly.

166. There were qualified staff and unqualified staff that were signed shifts these were to cover the shortfalls in vacant posts on the ward. On every shift there needed to be a minimum of 2 qualified on the ward per shift, if these were uncovered they would be backfilled with non-qualified staff and the decision made to move someone to another ward if this was possible. The trust would discuss safer staffing on a daily basis during the bed calls/sitreps where we would discuss safer staffing, bed capacity and demands for beds.

167. Nursing staff were allocated to cover both days and nights however in my experience it was more difficult to cover day shifts during the week.

168. I am unable to comment on the doctors work patterns

169. Throughout my career within the trust there has at times been high turnover of staff this was very noticeable following the dispatches programme being aired and also there has been vacant posts when our own staff have been promoted as well. There has been a national shortage of nursing and this has impacted in mental health. The trust drove an overseas recruitment which has successfully helped with staffing.

170. In my experience I have worked with locum consultants and also wards that have had vacant consultant cover.

171. In my experience when there have been vacant posts we have been supported by the recruitment team to advertise these posts and any concerns would be escalated via management and staffing levels have been datix. When staffing levels have been low this has had an impact on the standard of care we have been able to provide to our patients. I was supported to work with bank and agency staff to review block booking to review the role of those staff ensured that they had the same training available to them as our substantive staff and also the same roles.

172. In the period following my maternity leave, I raised concerns I had about staffing on the wards. I raised concerns with my Director and with Paul Scott, when he visited the wards. This was following the Channel 4 *Dispatches* programme and I was concerned about staff. The team was struggling; people were phoning up wanting their family members transferred and staff were not sleeping because of anxiety. I was overseeing two wards and was

concerned about the number of resignations we received, and how we would provide the care that the patients deserved. You can't provide the same level of care with half a team. I hadn't dealt with anything like this before and I felt I needed to reach out for support. We temporarily closed the wards for admissions, recruited additional staff and did a lot of work around patient experience and changes they wanted to see happen within the service.

173. In the aftermath of the *Dispatches* programme, we had staff leaving and there was difficulty recruiting. Bank staff, who are able to choose where they work, did not want to work on wards that were in the public eye. We had to rely on agency staff at that time.

174. There have been various times when staffing the wards has been difficult. We had high numbers of vacancies when there was a national shortage of nurses from 2022 onwards. Ward Managers had to step in during that time. We worked hard with our international recruitment programme to fill those vacancies.

Training

175. When starting new roles within the trusts I have experienced adequate training for my role and I was provided with protected time to complete such training as Oracle Learning Management (OLM) the system that the NHS uses for online training. Training has always been offered at a number of venues including the option of attending virtually, this has been accessible for me in my experience. Training was appropriate for my roles I have been in. I have not personally experienced any issues with attending training including refresher courses. I haven't needed to fund my own training. I have been offered additional training that has benefited me in my role.

176. In terms of training, this can vary between Trust and agency staff. Agencies have a training matrix that differs to the Trust's. For example, the Trust's training for physical interventions focuses on verbal de-escalation, while agency training may focus on managing aggression and physical restraint. In my experience I am aware of the two forms of training provided Prevention Management of Violence and Aggression (PMVA) and Therapeutic and Safe Interventions De- escalation (TASID). The trust was more focused towards the verbal de-escalation and provided 3 out of the 5 days with this training however with PMVA this had less focus at the time with verbal de-escalation. From when started with the trust in 2008 the shift towards moving away from physical interventions has developed over the years focusing on the verbal de-escalation I personally was aware of these changes from 2018 however this is my own memory this could differ. I feel that with the national guidance and

principles of trauma informed care this has helped direct the trust. I am aware that the bank office would review all agency staff training to ensure it was in line with the trust standards. The bank office would have a list of framework agency that would we need to use, if we were unable to cover shifts this would mean we could seek permission to go off framework which could potentially mean the standards of training could differ.

177. At the Linden Centre, agency staff were enrolled in the Trust's training sessions. For example, they would join the safeguarding or therapeutic interventions training so that they had the same skills and operational knowledge as other nursing staff on the ward. We would also look to recruit from a pool of individuals that we know have had training that is closest to that provided by the Trust.

Support

178. There are more support mechanisms in place for staff now than there used to be. We have support from the Psychology team included support spaces such a reflective practice and referrals for staff and also self referrals for "here for you" which offers psychology support to staff on a one to one basis and additional support through 1-to-1's. We support each other and we encourage staff to have more frequent breaks away from the ward.

179. Sometimes the wards can feel unsafe. For example, when you have patients who are aggressive and you don't have support from the police. In recent years we have seen an increase in assaults and racial abuse by patients towards staff. It can be difficult to lead a team when you know they have to experience these things.

180. Support for staff on the wards has improved over time from other agencies such as the Police. Their understanding of mental health has improved and we now have dedicated officers that provide support on the wards. We have worked alongside the police and have developed working relationships including having a local officer allocated to the individual sites to support on investigations and provide feedback.

181. The introduction of the police initiative "Right Care, Right Person". Right Care, Right Person (RCRP) is a national approach used in the UK—particularly between the NHS, mental health services, and police—to ensure that people receive support from the most appropriate service at the right time, rather than defaulting to police involvement when it isn't necessary.

182. We also have support from the Trust's Violence and Abuse Prevention & Reduction (VAPR) Team is a key NHS safeguarding and safety framework aimed at minimising violence, aggression, and abuse towards staff, patients, and visitors, while promoting a safe, therapeutic environment. When staff experience any form of racial abuse there is specific support for staff which is a tailored de brief to review the incident as part of the datix.

183. I have always felt supported by the Trust following a serious incident. I received a lot of support from my manager when Bethany Lilley died.

184. There has always been support for staff following the loss of a patient or when there is a serious incident. However, since returning from maternity leave, I've noticed more support beyond those instances senior management from the executive team are present on sites. I now see the management team passing by the ward, wanting to check in or following incident because they are there on site. Their visibility and presence has increased since the COVID pandemic.

185. I am a vocal person, especially when it comes to patient care. I've always raised concerns and felt empowered to do so. When I worked on the Christopher Unit as a Band-5 nurse 2011, I raised my concerns to my Band-6. If my manager wasn't around, I'd go to their equivalent. I've even called Senior Managers out-of-hours when I've been worried. People were receptive, although matters may not always have been addressed as quickly as I would have liked as this was due to how the system worked for example the recruitment process taking some time before new staff are able to start. However, communication about progress was always shared. I feel that my concerns were actioned.

186. One of the concerns I raised at the Christopher Unit was around observations and my feeling that there were too many patients on the ward on Level 3 observations. I felt that the reviews of the observations at this time from 2011 was only taking place in the weekly reviews/ward rounds so there was a delay in reducing if this risk had reduced for the patient. I had raised the concerns with the management team at the time, the policy for observations was different to the way we practice currently. The concerns were dealt with and reviews of observations levels were completed more frequently and reduced delays in the observations levels being changed.

187. I have explained above at paragraph 50 the concerns I raised about the process of admitting patients to Thorpe Ward at the Basildon Mental Health Unit.

188. During my time within the trust when it's been NEPFT, SEPT & EPUT I don't personally think the trust has always been able to provide adequate or appropriate support in my experience and there could have been support offered in different ways in the past than there was for example wellbeing checks, referrals to psychological services and ongoing support with regular check ins.

Culture and Management

189. The culture was variable at times there were clear intentions to promote a positive, supportive, and patient-centred environment, the reality was influenced by staffing levels and skill mix, the pressures inherent in acute inpatient mental health settings and it could become strained.

190. In my experience learning and collaborative working was encouraged throughout working within the trust. I have witnessed appropriate behaviours from staff to staff. I have experience those staff in managerial and leadership positions display positive role-modelling behaviour when working in the trust.

191. In my experience instances of bullying, harassment and /or intimidation managed on wards via the leadership team and escalated further up the managerial chain. These were in line with the trust policies. In my leadership experience I have sought support and advice from HR when managing this concerns.

192. During my nursing career when I was newly qualified there were practice on the unit that I do recall being informed "this how we have always done it here" when I raised concerns about, restrictions were in place on the PICU reflecting on the allocated times for hot drinks for example these restrictive practices would have had an impact on patient care and treatment.

193. In my experience I am aware of the beliefs and assumptions amongst staff impact the care and treatment given including the fear of this impact on staff career. In my experience I did not witness any stereotyping or stigma round addiction. In my experience staff worked within the guideline within the trust at the time to ensure patients with protected characteristics were treated with dignity and respect.

194. In my experience I am not aware or witnessed structural racism and/or discrimination.

195. In my experience I have witnessed compassion fatigue across the services I have worked. When I have been in a leadership role and I have noticed the signs of this from staff, I will offer increased support, look at additional support such as Occupational Health referral. This is a supportive measure to offer advice and support to staff and if needed, suggesting reasonable adjustments for that individual and offer psychological interventions and well-being support.

196. In my experience there is a risk of desensitisation amongst staff I do feel this could potentially be higher risk within the inpatient setting following staff being repeatedly exposed to trauma, aggression and self-harm. Within my leadership role I have always worked closely with the psychology teams to ensure that offer/space is provided for all staff who may be exposed. Reflective sessions offer an opportunity to ensure this a safe space for our frontline staff to discuss such incidents. Ensuring staff access regular supervision and debriefs take place following incidents.

197. In my experience 'therapeutic nihilism' has been a factor in of the teams I have managed this has been present within the inpatient but I have also witness this within the community. It has been present when patients have a had a long length of stay on the wards when staff feel they haven't improved and possible still engaging in the same behaviours as they presented with at the start of the admission, within the community I have witness when working towards discharging patients who have been under the CMHT/Community teams for a long time.

198. Within my management and leadership role I have supported staff through difficult personal circumstances and also through difficult times at work. I have also received support from my line managers including when I was studying to become a nurse until today. I have experienced sharing of policies and procedures in relation to the provision of safe and therapeutic mental health care and treatment. These would be shared with the teams via meetings including team meetings to ensure staff have a good understanding and implemented by staff.

199. The culture on inpatient wards can at times be challenging and, depending on the composition of the team, and may become difficult or strained. Ward teams are typically made up of a mix of healthcare assistants, support workers, Band 5 nurses, and Band 6 nurses. With a workforce of around thirty individuals, it is inevitable that not all staff will naturally work cohesively.

200. Team dynamics can be particularly complex when teams are newly formed or include staff from a wide range of professional and cultural backgrounds. For example, some international staff members may have limited prior experience working in mental health settings, which can

add to the challenge of integrating differing levels of knowledge, expectations, and approaches to care.

201. In addition to differences in experience, varying personalities within a large team can contribute to tension. At times, some staff may be less willing to engage with patients who present with behaviours that are perceived as challenging. These dynamics can affect team cohesion and the consistency of care provided.

202. Where there is tension or poor communication within the team, this can become apparent to patients. Patients are often sensitive to the atmosphere on the ward and may respond negatively to perceived discord among staff. As such, it is important that staff remain mindful of how team interactions and communication are presented, and strive to maintain a professional, unified approach in their engagement with patients.

203. Even though all Service Managers have the same title, how they manage will differ. When I moved from NEPT to SEPT, I found the leadership was very different. There was more senior visibility at SEPT. At Basildon, my Matron and Service Manager were very visible on the ward.

204. When I returned to a NEPT facility after the merger of NEPT and SEPT, I felt that things had improved. When I went on maternity leave during the pandemic, I was worried that the visibility and leadership that had been there might have been lost but I was glad to find that it hadn't when I returned.

205. In my experience I have always felt able to approach my line managers with concerns and supervision has always been key priority within the trust in my experience. In my experience clinical supervision has been provided and offered.

206. In my experience management/leadership team did ensure complaints and safety incidents were documented, acted on and investigated as per the trust guidelines. I have not experienced any barriers with reporting complaints or safety concerns.

Quality of Investigations

207. Throughout my career I have been involved in a number of investigations including HR, 3&7 day reports, prone restraints reports, patient safety investigations, safeguarding and NMC investigations as a few of the examples. These have been undertaken in person and virtually. I have been supported via the associated guidance within the trust. Where appropriate the remit

of the investigation in terms of reference could be HR for example. Staff who conducted the investigation would have receive appropriate training. If there were external investigations or reports they would be commissioned by the trust. I have not experience any culture barriers within the trust when completing investigations. When undertaking investigations I did feel safe and supported where I felt it necessary to make critical findings in respect of the Trust or individual staff members.

Quality of Responses

208. When I did complete investigations the findings produce meaningful results, recommendations and did action for change. These would be shared for implementation with the leadership team. It would be for the leadership team to ensure there is further monitoring within their own areas of accountability. Responses would be open and in accordance with the overarching duty of candour. Lessons learnt would be taken into consideration and appropriate action including any disciplinary action if deemed appropriate from the investigation hearing.

209. In my experience those who raised concerns or issues internally have been protected as per trust policy and I am not aware of any repercussions.

Good and Poor Practice

210. I love my job and can point to excellent care having been provided in the wards and teams I have worked in. I have seen patients being supported with psychological interventions and discharged home having fully recovered from mental health crises. At the same time, throughout my career I have witnessed examples of poor-quality care. For example, I have witnessed staff falling asleep while carrying out Level 3 observations, staff being rude or dismissive to patients and staff not making time for patients.

211. As a manager I have had to manage staff who have failed to meet standards through the HR process. I have also been involved in implementing policies to address some of these issues. For example, the trust introduced a policy in 2019, that meant a staff member couldn't be undertaking observations for more than two hours. This has helped with staff not being allocated back to back observations and ensures that staff are fit to complete the observation and breaks allocated between.

212. The observations policy has changed a number of times throughout my career. It has now been jointly written with people with lived experience and that has been important for getting it right.

In the past, observation was very much about sitting and staring. It felt very task orientated. Now it is really about engagement with the patient.

The *Dispatches* programme

213. I knew the Channel 4 Dispatches programme was going to be aired before it was, but I didn't know who or what would be featured. I was really worried about the patients and I wanted to make sure that we had people in place to support them when it was aired. One of our patients had fled domestic violence and I was particularly worried about her being featured. At the time, my concern was for the patients and I hadn't thought about the staff. Reflecting on it, I should have been thinking about both.

214. I felt helpless watching it. I was upset that someone had come in and videoed the wards. I felt sorry for the patients and team members, and I felt like I'd failed people.

215. The aftermath of the programme airing was very difficult. I had questions from family members and I couldn't talk about it because it was confidential. It had a real impact on staffing for a number of reasons. Firstly, through resignations, I lost six good nurses who left the profession completely because they were worried about the impact on them and their families. Secondly, recruitment became more difficult because people didn't want to work at a facility that was in the public eye in this way. Thirdly, it created issues of trust amongst staff because people now feared that when a new team member joined they were there as an undercover reporter.

216. There were lasting impacts for patients and their families too. The media would often turn up at the Linden Centre, wanting to ask patients questions and that can be very distressing. I didn't want patients to stop benefitting from day-to-day activities, like going on leave with their families, but going in and out of the building may have meant facing the press. A number of families have declined to have their family member admitted to the ward because of negative publicity. They've opted for them to go out of area, which means being away from their support network and not having the same access to meaningful engagement and support.

217. There have been positive changes because of the Dispatches programme including additional support for those wards and staff affected, the trust supported with reduction of patients, bespoke training for staff including safeguarding training but I wish it hadn't been as public as it was for those patients affected the documentary.

Concluding remarks

218. I hope the families involved in the Inquiry get the answers that they want and the peace they need. I hope the Inquiry will instil trust in our services and that people in Essex will see that there is good in the Trust and that we do help people to get better. I hope that people will use mental health services when they need them. I feel honoured to be involved in the Inquiry because I think it will shape how mental health services are delivered nationally.

I believe the facts stated in this witness statement are true.

Signed: [I/S]

Date: 08/06/2026