FIRST WITNESS STATEMENT OF DAWN TRACEY LOW

Preliminaries

1. My name is Dawn Tracey Low. I am currently employed as [I/S]

2. I am making this statement in response to a Rule 9 Request for Evidence from the Lampard Inquiry dated 4 March 2026. I have been asked to provide information regarding my observations whilst working undercover on the investigative documentary, *"Hospital Undercover: Are Our Wards Safe?"* (the '**Programme**'). The Programme concerned mental health inpatient wards run by the Essex Partnership University NHS Foundation Trust ('**EPUT**'). It was produced by Harbar 8 Limited ('**Harbar 8**') (now dissolved) for Channel 4 Television ('**Channel 4**') as part of its Dispatches series and was first broadcast by Channel 4 on 10 October 2022.

Background and role

3. I am a retired [I/S] until my retirement in [I/S] My role within the Dispatches investigation was to work undercover as a Health Care Assistant ('**HCA**') on EPUT mental health inpatient wards in order to gather evidence of how they were being run. I was employed by the NHS as a "Bank" HCA, meaning I was employed on a zero-hour contract, picking and choosing which shifts I wanted to work and at which location within EPUT. I worked undercover for a two-month period, from 5 April 2022 to 8 June 2022, completing shifts in Willow Ward in Rochford Hospital, the Mental Health Urgent Care Department in Basildon Hospital, Cherrydown Ward in Basildon Mental Health Unit and Galleywood Ward in the Linden Centre.

4. The process of applying for the role as a HCA was a lengthy and frustrating one. It was extremely difficult to make contact with the recruitment department, the phone was rarely answered, but when it was, I was told on more than one occasion that staff were working from home. I was instructed to communicate via email, it would take days for

me to receive a response to email enquiries, I had to send numerous follow up emails to prompt a response. On 10 September 2021, I completed an application form which required me to fill out my personal details, work history and provide details of my previous employment. I completed a New Starter Pack which required proof of address and identity. As far as I can recall, there was no eligibility criteria apart from having to have had the Covid-19 Vaccination and completing a DBS check. There was no interview process. In December 2021, I was told via email that I had been successful in my application and was offered the role of Bank HCA, which I accepted.

Training and induction

5. Before I was allowed to work on the wards, I had to complete a series of online and in-person mandatory training courses. The online training courses had to be completed within seven days of receiving a training tracker (I had to chase the training tracker by sending numerous emails and making numerous phone calls on almost a daily basis to prompt the tracker to be sent to me). On the 24 January 2022, I received an email with the information regarding the training tracker. This tracker had a list of the online training courses that had to be completed and once these were completed, I had to book onto three in-person courses. Only once all these courses were completed could I be booked onto the Therapeutic and Safe Interventions ('**TASI**') training, which is a five day in-person course. I was told that I would not be allowed to work on any of the Mental Health Wards without having completed the training modules in the training tracker, the three in person courses and TASI course.

6. Access to the online training courses was via an NHS online training site and there was a total of 20 online training courses that had to be completed before I was allowed to book on the TASI Course. The online courses I completed were as follows:
   - Being open, Duty of Candour.
   - Clinical Risk for Non-Registered Staff
   - Corporate Induction
   - Induction Clinical
   - Dementia Awareness
   - Diabetes Level 1
   - Positive Cultures
   - Fit for work.
   - Infection prevention and Control

- Information Governance
- Mental Health Act for Non-Registered staff
- Engagement and Supportive Observation
- Make every contact count Physical Health Screening
- Pressure Care
- Preventing Suicide by Ligature
- Safeguarding Adults and Children Level 2 Inc MCA/Dols & Prevent
- Suicide Awareness
- Trust Values and Service Standards
- Covid-19 PPE and IPC Awareness
- Moving and Handling

The online courses were training packages, the majority of which ended with test questions where you had to achieve a pass mark in order to complete the course.

7. After the online courses, I completed three in-person courses at Rochford Hospital training unit, I have no recollection who delivered the courses. They were as follows:
   - Moving and Handling Face to Face training – this was four hours long and showed us how to use lifting equipment to get people in and out of bed/bath.
   - Grab Bag training – this was four hours long and focussed on the contents of the Grab Bag (which, from memory, was a bag that contained ligature cutters and other items that may be needed in an emergency). The training also focused on use of Oxygen and CPR and how to use a defibrillator.
   - Basic Life Support training – this was 2.5 hours long and included training on the use of a defibrillator.

   There was also a Fire Web Video that was completed via Teams. As far as I can remember, none of the training courses involved any practical scenario training.

8. Once I had completed these courses, I booked onto a TASI course. The TASI course was held in person, starting on 28 March 2022, and was delivered by several trainers employed by the NHS over five days (I am unsure of the trainers' full names). There were 14 students on this course, all NHS employees. The training covered many topics, for example communication skills and holding techniques when required to move patients and use of force powers. It was interactive and, in my opinion, a good course that covered many aspects of the role. There were conversations during the training between the students and the staff on how under resourced EPUT is, the main concern appeared to be the reliance on agency staff. The staff that delivered the

training had all worked on mental health wards, one of the staff being trained worked in Health and Safety and stated that staff that work in the Health and Safety department have to attend this course as they are required to visit the wards and look for ligature points every 6 months. The rest of the staff were NHS Bank staff, Student Nurses and Permanent staff, all of them apart from one of the people being trained had been working on various mental health wards prior to completing the training. There was a permanent HCA who had been working on Willow Ward since October 2021. I was surprised by this as I had been told that I had to complete all my online training and the TASI course prior to working on any of the mental health wards. During the scenarios and practical training, it was mentioned that some of the techniques used by the agency staff are not correct, specifically the fact that the use of force they adopt on the legs by grabbing the ankles is not correct and can be dangerous to the staff and the patients. The risk of absconsion was covered in the training along with the risk of ligatures.

9. Datix was spoken about and the suggestion was that it appears not to be completed when it should be. The use of the Datix appeared to be sporadic and inconsistent. From memory, Datix is a database that is required to be completed when an incident occurs, and force is used.

10. I believe that the training provided was adequate to perform the role. However, the training I did was not required to be done by the agency staff. The consensus from the trainers was that the agency staff are unreliable as they don't turn up for shifts and don't contact the ward to tell them they won't be attending. They are not TASI trained and do not complete the online training I completed and are paid more than the NHS staff.

My experiences and observations on the wards

11. I worked undercover on 13 shifts in total, each of which started at 07:00 and finished at 19:30. These were spread across the following wards: Willow Ward in Rochford Hospital (nine shifts), the Mental Health Urgent Care Department in Basildon Hospital (one shift), Cherrydown Ward in Basildon Mental Health Unit (two shifts) and Galleywood Ward in the Linden Centre (one shift).

12. Upon commencement of my first shift on each of the wards, there was no briefing on emergency procedures for that particular ward, nor was there any information on what to do if a patient was deteriorating or in cardiac arrest.

13. During my statement I will refer to the following terms:

- One-to-one Observations – This is where a patient has one member of staff constantly with them, engaging and supervising them at all times.
- Two-to-one Observations – This is where a patient has two members of staff constantly with the patient, engaging with them and supervising them at all times.
- Level 1 observations – This is where the patient is checked on every 30 to 60 mins depending on their level of risk.
- Level 2 observations – This is where the patient is checked on more frequently than Level 1 observations, from memory this was up to 5 times in an hour.

These terms were consistently used on all the wards I worked on, and carried the same meaning on each ward.

Willow Ward

14. My first shift as a Bank HCA was on 5 April 2022 in Willow Ward in Rochford Hospital. This is a female only ward. The shift started with a briefing, members of staff arrived in dribs and drabs, the briefing was taken by the nurse on duty, she relayed details of what had happened during the previous night. She had a list of HCAs that should be attending for the shift, the majority of which were agency staff as opposed to NHS. Any reference to a "permanent HCA" in this statement is to a HCA employed by the NHS on a permanent basis. There was no briefing on individual patients, the risks they posed or any information about their circumstances. Each HCA was assigned a task; it appeared that there was no consideration given to skills or experience and staff were given a role that was rotated every hour. A duties sheet was drawn up by one of the permanent HCAs for the whole shift, assigning specific roles and tasks and what time you would take your break. I highlighted that it was my first day with EPUT as a HCA and therefore my first day on the ward. I was given a tour of the unit by one of the permanent HCAs, I was shown where the ligature knives are kept, I was told quite specifically that should they be needed, I should bring all of them with me. After this, I was immediately put on a "one-to-one" with a patient at risk of self-harm.

15. As mentioned above, a one-to-one is where one HCA has constant observation of a patient; when the patient is in their room they are being observed at all times, when they move about the ward they are being constantly observed within close proximity. This is to ensure that should the HCA need to intervene to prevent the patient harming themselves then they are in a position to do so. As also mentioned above, a two-to-one is where two members of staff observe a patient at all times, again within close proximity. This is usually if the patient is deemed to be violent. Each patient on these close proximity observations has a handover sheet that is supposed to detail any incidents that happen and any observations of note, however in my experience, these were not completed correctly and had very little information contained within them. The HCA that observes the patient is supposed to complete the forms during the observations, but it was clear due to the lack of detail that these were not completed correctly.

16. For my first one-to-one on Willow Ward, I was not briefed by any staff member on the patient I was sitting with or asked if I knew what I was doing and what was expected of me. As I had no briefing on the patient and there were no notes for me to refer to, I was unaware of the risk they posed to themselves or staff members and was not given instructions on how to complete the observation sheets. I ensured that as much as possible I engaged with the patients. For the whole of my 12.5 hour shift I was on a one-to-one or two-to-one with patients, being moved around the ward from patient to patient without a break. I witnessed agency staff on one-to-one observations using their mobile phones, falling asleep and some of the staff could barely communicate in English. Agency staff failed to engage with the patients and would just sit looking at them.

17. Within a couple of hours of me starting my first shift there was a ligature attempt, the patient that attempted to ligature was on a one-to-one, the alarm was raised but I was unable to assist as I was on a separate one-to-one with a patient, so I was unable to leave them. I was unaware who was on the one-to-one with the patient that had ligatured at that time, I heard the alarm and was told by one of the agency staff which patient had attempted to ligature. Unfortunately, when responding to these alarm calls, the less staff there are on the ward, or busy dealing with other one-to-ones, the less staff are available to react to these incidents to assist.

18. Later during the same shift, the same patient that had attempted to ligature in the morning and who was being observed by a male agency HCA, went into her bathroom,

unobserved, and having collected a scarf from one of her shelfs, made a ligature with it and attempted to hang herself. The alarm was activated; I made my way to the patient's room as I was on my way for my break and therefore wasn't on one-to-one observations and was free. I passed the permanent HCA that had shown me round the facility earlier in the day, she had run to collect the ligature cutters, yet despite what she had told me, just hours before, about taking the whole bag with the range of ligature cutters in it, she had just grabbed one ligature cutter and it was the wrong one. I then ran back to the office where they were kept and brought the bag containing all the ligature cutters, by the time I got back to the patient the ligature had been removed. These precious minutes could have been the difference between life or death. This incident was shown as part of the Programme.

19. I had only been working on the ward for a few hours, but it was clear to me how the lack of properly trained staff had contributed to the incident that unfolded. This patient continued to attempt to ligature during my following shifts using other items from her room such as a bed sheet and a jacket she had apparently used on a previous attempt to ligature. Items were not removed from her room to prevent this happening. The male agency HCA should have requested a female member of staff come to the room when the patient indicated she wanted to the use the bathroom, but he didn't, and this is why it happened. There was no staff debrief following this incident, just the nurse that oversaw the ward for the day and the HCA that had brought the wrong ligature cutter arguing in front of the patient about what should have happened and why the wrong ligature cutters were brought to the room. At no time was I involved in any debrief after any incident of self-harm. The protocol as far as I am aware for dealing with an incident like this was that, once the alarm was raised, staff that were able to assist would make their way to the room concerned and assist. This was more of me using my common sense rather than being told specifically what should happen. As far as I could tell, there were no lessons learnt from this incident, and everyone went back to what they had been previously doing.

20. During my shifts on Willow Ward there were so many of the patients that required one-to-one or two-to-one care, the lack of staff meant that for many of my shifts I was on one-to-one constant supervision with the patients, despite the fact the trust guidance on one-to-one and two-to-one supervision states that you should not do back to back constant supervision. If observations are done correctly, staff should be actively engaging with patients to understand their mindset and build up some kind of rapport with them. I was on a two-to-one with a patient who I was attempting to talk to, it had

not been brought to my attention that she was in fact deaf, this was a key piece of information that should have been given to me. Not having sight of the patient's care plan or any knowledge of them apart from their name ahead of observations had a huge impact on the care and understanding they were given.

21. There was no information given to staff about patients' care plans on any of the wards I worked on. Each patient has an individual full care plan, but at no time was I shown any information on any of the patients I was caring for and during my time working with the Trust did not see one care plan. I asked several times if I could look at some of the patients' care plans, but I was told that there was no time for this as they were kept in the office and I would have to access a computer which I was not trained to do. This in my opinion caused significant issues and goes someway to explain why so many of the patients are failed by EPUT. It wasn't until my second shift on Willow Ward that I was made aware that there is a separate log that is held in the office that staff should use to record the food and drink patients consume. When someone is on a one-to-one there is a log that should be completed with whoever takes over, but there was no instruction on what should be put on the log. There is a system called MOBI that is meant to record everything that has happened during the shift, but the only computer that I was aware of was in the office that the more senior staff used. I am not confident that this system was used daily to record what had happened on the ward.

22. During my time on Willow Ward, I was given the task of carrying out observation checks on patients that need to be checked on up to five times an hour, I was not given any instruction on this and was just handed a sheet of paper with the names and room numbers, I had to seek clarification on what I was supposed to be doing. It was during this time that I would witness agency staff that were on a one-to-one either using their mobile phones, falling asleep and not engaging with the patient.

23. Overall, each ward I worked on was heavily reliant on agency staff, there were one or two NHS staff on each shift, and the rest of the staff was made up of agency staff. I observed a difference between the care given by the NHS staff and that of agency staff as the agency staff move round from ward to ward and usually the NHS staff are positioned on one ward. I was told by one of the permanent NHS HCA that her experience was that if one of the agency staff was spoken to by a manager about being on their mobile phone or sleeping, they would be told not to come back to the ward and would therefore often find work on another ward.

24. On Willow Ward, there were concerns about agency staff not fulfilling their roles, but unfortunately as I was nearly always on a one-to-one supervision, I could not see how concerns were dealt with. Concerns regarding agency staff as far as I am aware, were raised to the senior nurse in charge, there were agency staff caught using their mobile phones when they should have been watching the patients as well as agency staff sleeping when they should have been watching the patients. The senior staff on duty were aware of this, and I witnessed the perpetrators being told not to fall asleep. As far as I am aware they would be told not to come back to the ward, but this was something I heard via one of the HCAs, I don't know if anything further happened to them.

25. Willow Ward had the capacity for 19/20 patients at any one time. During the nine shifts that I worked there, the shifts were all short staffed. There was no resilience to support staff numbers and the staff that were on duty would just have to make do. I have no idea who the lack of staff would be escalated to and wasn't working on the wards long enough to know about staff turnover.

26. There were no arrangements for handovers to staff, there was also no time to familiarise yourself with patient records as they were computerised. If there were paper copies of them, they were not readily available to staff. I could not access the computer system as there was only one computer that I was aware of and this was in a locked room with the managers, likewise the agency staff definitely didn't have access to any of the computer systems as they didn't have NHS accounts. I had not completed any training on how to access the records of patients, so had I been able to access a computer I wouldn't have known how to. Crucial information about individual patients wasn't routinely shared, I was constantly attempting to find out information from the patients so that I could ensure they were dealt with in a sensitive and appropriate way, but I have to say that was not what I witnessed other staff doing. The agency staff were also unable to complete Datix as they didn't have access to the computer system.

27. In my opinion, across all the wards I worked on, the safety of the patients was not well managed. During my 13 shifts, there were several ligature attempts, I witnessed staff using force on patients on several occasions, there were little if any de-escalation techniques. I had a sense that the staff believed that they didn't have the time to use these and I found their communication style at times combative and unhelpful. On several occasions, I asked a staff member involved in use of force on Willow Ward if they had completed a Datix form and on each occasion, they stated that they hadn't. I

completed Datix each time I used force but was told by the permanent HCA who had access to the computer system not to bother and had to persist for me to be able to access the office and had to get help accessing the computer system. No relevant information was provided to staff caring for the patients, I was literally told to go and sit with a patient and make sure they didn't harm themselves. There was a turnover of patients and when a new patient arrived you were not told anything about them.

28. There were insufficient preventative measures put in place when safeguarding patients that wanted to harm themselves. There were items in the rooms that were used by patients to ligature, including clothing and bedding, they were not removed from the room once an attempt had been made. One girl had two guitars in her room; guitar strings pose a huge risk particularly for someone who was frequently on constant supervision. If a patient attempted to ligature, they would be put onto constant supervision if they weren't already and would be told not to do it again. I did not once witness a debrief from any of the incidents that occurred and didn't witness many interventions to mitigate the risk of it happening again.

29. It appeared to me that everyone was just so busy trying to juggle too many roles that communication with staff members was non-existent.

30. On 16 April 2022, my fourth shift on Willow Ward, one of the permanent HCAs told me that £320 belonging to a patient had gone missing from a staff office a few days previously. Another patient's £3000 hearing aid was also missing. The Police were not informed of this and as far as I am aware it was never found. The room it was taken from was a locked room that only staff had access to. One of the staff suggested that they should have a 'whip round' to cover the missing money, rather than investigate the incident.

31. I discussed with the HCA the issues of not being given any information on the patients we are there to care for, which raise concerns for both staff and patient safety. During this conversation I learned that one of the patients on the ward had a violent past, she had been in prison for violence related offences and had a history of attacking care workers. This was my fourth shift, and I have never been officially made aware of this.

32. I also learnt that one of the patients was anorexic. I had spent a number of hours observing this patient across the previous three shifts and was unaware of her eating disorder, this only came to light after she attempted to escape the ward after trauma

related to her anorexia was triggered. She managed to get through the first exit door but was unable to get through the air lock out of the building. Members of staff panicked which I feel made the situation worse for the patient, who was eventually picked up from the floor and pulled through the door back onto the ward. Staff are trained NOT to move patients from the floor. Instead, they should attempt to de-escalate, calm the patient down and allow them to get up by themselves. I wasn't aware of any reports being completed about these incidents, but I was told I didn't need to do any writing myself. I was fully aware that any use of force should be recorded but rarely did this happen. This incident was shown in the Programme.

33. Following this incident two patients (including the patient with an eating disorder who had attempted to escape) were sedated using an injection to calm them down. The nurse administering asked them if they wanted the sedation and it was administered. I was told by one of the HCAs that on the male ward, a HCA had administered a sedation which he was not qualified to do, and this had been covered up.

34. During the same shift on Willow Ward (16 April 2022), I witnessed two patients have a fight. I was told that they had fought the previous night. The reaction of some of the staff was chaotic, patients weren't properly separated, meaning there were more opportunities for them to fight. I struggled to see any therapy or treatment for the patients, I questioned what, if any, therapy patients on the ward were receiving and heard the same line from various staff – that there aren't enough staff. Patients confirmed that they were not having any therapy and would just be medicated. I helped introduce a new patient with crippling anxiety to other patients, had I not she would just have been left in her room. I encouraged another patient to leave her room and join other patients in the garden for some social interaction – this was the first time I had seen her leave her room.

35. Myself and the permanent HCA I had befriended whilst working on Willow Ward raised concerns about the health of one of the patients. The HCA told me she had been trying to get a nurse to see the patient for days but said that they aren't interested if it's not mental health related. The patient was eventually seen by a nurse towards the end of my shift; her blood sugar levels were so high she was taken to hospital. The HCA I befriended is a member of staff who really cares but the nurses are dismissive of HCAs.

36. On 12 April 2022, my third shift on Willow Ward, the Care Quality Commission ('**CQC**') completed an unannounced inspection. Willow Ward hadn't previously been inspected

by the CQC. I wasn't approached by anyone from the CQC, but I was aware of patients being spoken to. One patient told me that she had told the CQC that she'd made a ligature attempt the previous night and that the HCA who was observing her was asleep not long after her attempt. She stated that she had recorded them asleep on her mobile and showed it to the person in charge. The patient told me that she had woken the HCA up herself and then reported it to the nurse in charge that night and that HCA had been sent home.

37. I found the shifts extremely tough, particularly when on one-to-one observations all day. The observations are mentally draining due to the lack of interaction with patients (who are often asleep) or staff. There is little or no opportunity to use the toilet or have a drink. This may appear to be a small thing, but if staff are weary and jaded, they will not carry out their roles effectively. The managers are not checking that the staff are ok, there was no 'walk round' by the managers to ensure that those staff engaged on constant supervision are performing their job effectively and are ok. I would have one break of 45 minutes all day for a 12.5-hour shift. Staff have told me that Willow Ward was notorious for having staff on constant observations and not creating a safe environment for staff and patients. I suspect this is a reason for what appears to be a struggle to retain staff on the ward. My third shift at Willow Ward had nine staff on shift, four patients requiring one-to-one observations and one patient requiring a two-to-one observation. I was told there were only six staff on shift the previous day and the patient on two-to-one observation was moved to one-to-one due to a shortage of staff.

38. On 19 April 2022, my fifth shift on Willow Ward, the patient that had made a ligature attempt that I responded to on my first shift, was taken off one-to-one observations. I was surprised and concerned to discover this, the patient had made numerous suicide attempts, and I had spoken to her at length about this. The patient told me that she still feels suicidal. This concerned me, so I informed the senior nurse on duty, but was told that the patient wouldn't return to one-to-ones. It doesn't seem that a further risk assessment was made following my conversation with the patient and the nurse was happy to take a chance. Further to this, a member of staff took a stool and some curtain hooks into the same patient's room to hang some curtains and left both the stool and the hooks in the room. The Patient informed me of this and stated that she had considered using the stool and the hooks to hang herself from the door. I removed the items from the room and spoke to the nurse about this.

39. On 20 April 2022, my sixth shift on Willow Ward, the patient that had made a ligature attempt on my first shift remained off one-to-one observations. The nurse on duty stated during the handover that she had forgotten to complete the risk assessment for this change in frequency of observations. This patient saw a Doctor during the shift, he made the decision to halve her medication due to her not having any panic attacks, she was also told that she is no longer under section and was now a voluntary patient. Within a period of just over 24 hours, this patient had been removed from one-to-one observations, had her medication dosage halved and been taken off section, so she was free to leave if she wanted to. She was even told that she was allowed to go on unescorted leave the next day to go shopping at Primark. The patient told me during this shift that she had not had any therapy whilst being in hospital.

40. On 25 April 2022, my seventh shift at Willow Ward, I found out during the morning handover that the patient that had attempted to ligature on my first shift had made a ligature attempt on the 23 April 2022, only 3 days after being taken off section. She had apparently tied a blanket around her neck and then hung it from the door. The doors are alarmed and apparently the alarm went off, but staff couldn't get into the room as the patient was blocking the door. She was back on one-to-one in the morning, but later on into the shift she didn't have an HCA observing her. When I asked the patient where the HCA was, she told me she was no longer under one-to-one observation and had been moved to Level 2 (five checks per hour). I was surprised by this, due to her multiple attempts to ligature, but was even more surprised when she later left the ward to go shopping and buy herself a kebab. This made no sense to me, considering the patient had made a ligature attempt only two days previously. I cannot recall any member of staff explaining to me who had made the decision to reduce the patient's observation levels. I also cannot recall whether I spoke to any staff members about the change or if there were any discussions at the time about staffing levels influencing observation decisions. It was my impression, based on my own observations and experience, that there was insufficient staff on duty that day to fulfil the higher-level observations. In my opinion, had the observations remained at one-to-one then there would not have been enough staff to run the ward.

41. Further to this, during the same shift on 25 April 2022, I had been responsible for Level 2 checks in the morning, and four patients required these checks. When I returned to that duty later in the day, none of the patients were on Level 2 supervision any longer, I attempted to find out who had made the decision to reduce the checks, but could not get to the bottom of it, but again, I believe it was due to the ward being short staffed. It

was not clear who, if anybody, carried out the risk assessments behind these decisions.

42. A permanent HCA confided in me that she had applied for another job away from EPUT, citing the continual one-to-one observations and lack of breaks as a reason to leave. She told me that she had originally been posted to Cedar Ward, another ward at Rochford Hospital, as a HCA but was moved to Willow Ward after "whistleblowing" on another HCA who she had witnessed being abusive to a patient. The HCA told me that no action was taken against that individual, and she was made to feel uncomfortable.

43. The HCA also told me that she had been in receipt of an email from one of the NHS nurses, which appears to have only been sent to permanent staff as I did not have the email and it wouldn't have gone to agency staff. In it, the nurse stated that practices are slipping, and better communication is required in that staff must speak English when on the ward. One of the patients later told me that a number of agency staff got a telling off from one of the nurses for talking in their own language and being on their phones. The permanent HCA said the agency staff aren't good enough to do the job and haven't had sufficient training to carry out the role effectively. The NHS HCA stated that she has not been required to complete the online training I had done, and she hadn't been on a TASI course even though she is a permanent NHS HCA. She agreed with me when I said that I didn't feel I had been properly briefed on how to carry out observations as they were touched on during TASI training but not covered in depth. Agency staff are not even required to attend a TASI course or complete any online training.

44. A permanent HCA, who was permanently working on Willow Ward, was responsible for the rota on Willow Ward and she appeared to be running the ward.

45. One of the patients told me that she had previously been sexually assaulted at the Linden Centre by a male HCA grabbing her breasts. She said she reported the assault, but no action was taken. She also said she had £500 worth of Christmas presents for her children were stolen from a locked room and nothing was done about it. She said the Linden Centre is 100 times worse than Willow Ward. I am unaware if any of these incidents were reported to Police or what action, if any, was taken.

46. I had a conversation with an agency HCA who was employed by London Health Locums ('**LHL**'). He told me that he is earning £12 (or £14) per hour but is aware that there is another agency – Health Recruitment Network – who pay £19 per hour. I asked why he doesn't move over to them, but he said he can't as he has to stay with LHL in order to get a visa. Originally from India, he came to the UK on a student visa but is no longer a student. He's been told that if he stays with LHL he can get an extra four years on his visa. He told me he'd heard about LHL whilst working as a cleaner at Harlow Hospital. He completed a Prevention and Management of Violence and Aggression ('**PMVA**') course through the agency and paid for some online training himself.

47. I was aware of one of the patient's families not being happy with the way their daughter was cared for. I am unsure what the process was but am aware that they had complained to the Trust about it, I have no idea about the process or what was happening with the complaint.

48. There was a lack of keys for the ward, each set of keys had a pin alarm on them. I discovered during the handover on 6 April 2022, my second shift at Willow Ward, that a set of keys for the whole building had gone missing whilst a HCA was with a patient who had recently swallowed batteries and subsequently suffered a perforated bowel. The keys to my knowledge were not located. There was always a shortage of keys on the ward and there were times during my shifts that I was not in possession of a set of keys or a pin alarm. The alarms are what the staff use to alert other members of staff that they need assistance and link directly to an alarm that sounds in the ward to alert everyone.

49. On 27 April 2022, my eighth shift on Willow Ward, towards the end of the day, I was asked by one of the permanent HCAs if I wanted to know how to use MOBIUS – the system used to log the patients' record of care during each shift. I had never been given access to MOBIUS before but was aware early in my time on the ward that it was completed at the end of each shift. I was asked to create a log for two patients. The HCA logged on to the system and showed me how to copy and paste from the night duty entry (the last entry). I noted that within the text one of the patients was incorrectly said to be on Level 2 observations when in fact she was on Level 1. I altered this. I was aware that previously in inquests into patient deaths within EPUT it was reported that staff rely too much on copy and paste, which should stop. This is an example of recommendations not being followed which can lead to errors in the records of patient care.

50. On 19 April 2022, my fifth shift on Willow Ward, I was involved with two restraints on the same patient. The alarm was sounded after the Patient, who was on a one-to-one observation, made a ligature attempt. The patient had been head banging, and she had tied tights round her neck. Her ligature attempt was triggered by the anniversary of the death of a friend who committed suicide on Longview Ward in Colchester. Myself and four other staff restrained the patient, I was left with just one other HCA as the other three left to get a ligature suit. It wasn't appropriate for just two of us to be left with the patient as she continued head banging and I had to press my alarm for more staff to assist. It transpired that the ligature suit had to be retrieved from another ward. The patient has anorexia. When staff eventually returned to the patients room, one of the staff complained about being fat and being on a diet but only losing 2.5 pounds in weight, which further triggered the patient, who became increasingly upset and questioned why staff were talking about weight issues whilst restraining her – something she continued to be upset about throughout the day. Instead of showing empathy, staff threatened to send the patient to a ward for violent patients. This was a scene also shown in the Programme.

51. During a two-to-one observation on the same shift I was observing a patient with a male agency HCA, during which time the patient walked over to her bookcase and attempted to wrap a bra around her neck which she picked up as she walked. I managed to intervene and get my hand between the bra and the patient's neck before she could wrap it round. The agency HCA with me didn't react, there was another agency HCA in the corridor, neither of them sounded the alarm until being instructed twice by me to do so. The patient allowed me to remove the bra from her neck without using any force on the patient and she spoke to me calmly, so there was no need for her to be restrained. Following the incident, I spoke to the agency HCA who had been in the room with me and asked him why he had been slow to react and had not triggered the alarm until the second time I had asked him, and he just shrugged his shoulders. I spoke to a permanent HCA on the ward, about whether I should do any writing about what happened, and she told me it wasn't necessary as I hadn't used a ligature cutter. I did however, complete a Datix. I was unaware whether any follow up investigation was completed once my Datix reports were submitted. No one spoke to me about them.

52. Later in the shift I was back on a two-to-one observation the patient that had attempted to ligature with her bra, the agency HCA I was working with fell asleep – only a few

hours after the patient she was observing had made a ligature attempt. I challenged the HCA and told her she couldn't sleep but the HCA said it was ok because the patient was asleep. The HCA said she was tired and had a headache having been up since 5am to travel to work from Stratford, East London. I started my shift that day at 7am but wasn't allocated a break until 4pm.

53. I also spent some time with another patient during my fifth shift (19 April 2022). She had made a ligature attempt the previous night by tying two pairs of socks around her neck. She told me she was making a complaint about a member of staff who had been observing her just prior to the attempt as she had told him she was going to ligature but he ignored her. When he got replaced by another staff member she thought "f*** you" and tied the socks round her neck because he had ignored her.

54. During my fourth shift on Willow Ward (16 April 2022), when I was returning from a break, I was met with a scene of pandemonium. One of the patients was trying to escape and had been restrained and another patient was being restrained after trying to cut herself with the ring pull from a can of drink that was given to her. I was involved in the restraint of the patient attempting to escape, whilst other staff were restraining the other patient in the corridor at the same time. Instead of calming the patient in the corridor down, staff were arguing amongst themselves about who had given her the can of drink as this should not have happened.

55. Once the situations with both patients had calmed down, patients were allowed into the garden to vape – many of them had been frustrated by their vaping time being delayed. Prior to entering the garden – whilst waiting for other staff to open it up – the patient with the ring pull produced her vape and took a drag on it. Instead of removing it from her there and then, to avoid a further episode from the patient, I made it clear to her she wasn't allowed to keep it once vape time was over and made a point of telling her she needed to return it to me when the vaping time was over. The vapes were not allowed to be kept by the patients and had to go in a bag, they would then be dished out during vape time in the garden.

56. On 25 April 2022, my seventh shift on Willow Ward, a lot of information was given to staff during the morning handover. We were told that that during the previous night's shift, an agency HCA observing one of the patients fell asleep. The patient walked past him and alerted a nurse who woke him up and sent him home. I later learnt that the

patient had filmed the HCA asleep and the patient showed me a photograph of him asleep. She told me it was fortunate that she was in a good frame of mind at the time as otherwise she would have ligatured. For the first time since I had been working on Willow Ward, it was made clear to staff during the handover that falling asleep and using mobile phones is not acceptable on the ward.

57. There were only six HCAs on duty that day (the lowest number since I had been working on the ward), meaning that a patient who required two-to-one observations was reduced to one-to-one. I overheard one of the patients tell another patient that the Doctor had told her that he will send her home if she attacks another member of staff.

58. I expressed concern to one of the permanent HCAs for the number of suicidal patients in possession of items which they could potentially harm themselves with. One of the patients, for example, had been visited by her father and a female friend. The female put false nails on the patient and left a bag of false nails and the equipment needed to put them on with the patient, the nurse allowed the patient to keep the items even though they could be used to cause harm. Another patient who had been on unescorted leave wasn't searched on her return to the ward; she was able to bring a screwdriver onto the ward. A patient was found in possession of several birthday cake candle holders, which she had taken from the canteen when they were used on a patient's birthday cake. She had also tried to cut herself with a screw she found in the garden.

Mental Health Urgent Care Department

59. I completed one shift at the Mental Health Urgent Care Department in Basildon Hospital on 17 May 2022. This is a ward with 17 mixed beds on it. It's where patients go to be assessed for whether they should be sectioned after coming through the emergency services, self-referral or the police. The unit is supposed to have 72 hours to decide what should happen to the patient. One of the female patients on the ward had been there since February. She was a "voluntary patient" – so not under section – which apparently means it is harder to find a bed. She was on constant observations, which means she was at serious risk of self-harm or suicide.

60. The overall impression I had of the assessment centre was there was a lack of management – ward managers and senior nurses stayed in the ward office, leaving

HCAs to run the ward. Several of the staff on the unit were rude and unhelpful to me and the general attitude was very unhelpful and uncaring in general.

61. At the beginning of my shift, I was given a sheet of paper marking all the potential ligature points on the ward. I was told to study it later at home. Many of these points were in the showers, which were left unlocked all day. I felt it was a huge risk as it would be very easy for someone to enter the showers and ligature without being noticed. I also witnessed members of staff failing to complete proper observations, they were not checking patients at the necessary intervals and adding information to the logs that stated that the checks had been completed which simply wasn't true. I knew this because I was personally present during periods when the relevant checks should have been carried out but were not, as I was completing my own assigned tasks, and saw that they had nevertheless been recorded as having been carried out in the log. For example, when I came to complete checks that others had apparently completed previously, it was clear to me that these had not in fact taken place. This was because I had either been in the same corridor at the time the checks were said to have occurred, or I was observing other patients who were in the company of those who should have been checked. I do not have any direct knowledge of whether inaccurate recording was isolated or part of a wider pattern. Generally, there was little if any interaction with the patients, the atmosphere on the ward was not a positive one.

62. Whilst working on this ward I was yet again not given any information about any of the patients, not even their names. This was my first time on this ward, and I had not met any of the staff previously, at no time did anyone ask me if I understood what the role of one-to-one observations entailed and I was tasked with carrying out one to one observations during my time on the ward.

Cherrydown Ward

63. On 20 May 2022, I worked a shift on Cherrydown Ward in Basildon, this is another female only ward. Overall, the ward seemed to run more smoothly than both Willow Ward and the Assessment Unit. There were 20 members of staff on duty looking after 16 patients on this shift. Staff numbers were never this high on Willow Ward. As mentioned above, part of the problem I identified on Willow Ward was that staff weren't given breaks and were often on constant observations throughout their shifts. During my shift at Cherrydown Ward, I wasn't on observations for more than one hour at a time and had more opportunities to make myself a hot drink and use the toilet. I could

also interact with the patients and take time to speak to them and find out a bit about them. Whilst I was on a two-to-one observation with a male agency HCA, I watched him using his mobile phone for approximately 10-15 minutes while he was supposed to be watching the patient. When he realised he hadn't been watching the patient, he jumped up and stood over the patient to look at her (she had been trying to go to sleep), this startled and angered her as she was trying to sleep. There would have been no need for him to do this had he been properly observing her.

64. Whilst on another two-to-one observation with a patient, I saw her take a plastic spoon from her wardrobe back to her bed. She broke the spoon, and I removed it from her before she could harm herself with it and reported it to the ward manager. Patients are given disposable plastic cutlery to eat with on Cherrydown Ward which is obviously a huge risk to patients. On Willow Ward, the patients use re-useable plastic cutlery which is issued by staff and collected back at the end of the meal. It was interesting how the EPUT policy on cutlery is not the same across every ward. Patients were left alone in the dining area on Cherrydown Ward; there was an urn with hot water in there and access to plastic cutlery. I queried with staff members whether it was standard procedure to leave patients in the dining room unsupervised as I was concerned that they may be able to smuggle cutlery back to their rooms or harm themselves from the hot water in the urn within the room. I was told by a HCA that all patients are "supposed to be supervised but it depends on who the patient is." This suggests a lack of consistency around this rule and presented a massive risk to patients.

65. Communication between staff was an issue. Binders containing observation logs were kept in an office, not outside the patient's room (as they are on Willow Ward). This again means there is no information about the patient for staff, not even their name. Early in the day on that shift, I had observed a patient and was unaware that the patient suffers from seizures. I only learnt this when taking over observations on the patient again later in the day. I queried why the patient appeared groggy and I was told by the HCA I was relieving that this was because she'd had 4-5 seizures in the last hour. I had to ask what needed to be done should the patient suffer further seizures. There were no activities for the patients during the day, and they were just left to entertain themselves or sit in their rooms.

66. During my shift on Cherrydown Ward, I also accompanied a patient to A&E due to her colostomy bag being blocked. I spent several hours with this patient, a lady in her 30s who has MS. I spoke to her at length about her experience in the mental health system

and found out that the only reason she is still in hospital is because no suitable accommodation has been found for her. She stated that she needs ground floor accommodation that needs adapting, and this hasn't been sourced. She stated that she has children and had been medically retired from a high-grade civil service role. She stated that life on the ward was difficult, she stated that it is hard for her to see multiple ligature attempts throughout her stay. She spends most of her days going into Basildon town centre and walking round, just to get out of the environment.

Galleywood Ward

67. I worked one shift on Galleywood Ward on 1 June 2022. There were 6 HCAs on duty, a mixture of NHS HCA and agency staff and approximately 16 patients. Only one patient was on one-to-one observations.

68. I had no briefing on the patients as I was originally supposed to be working on the male only ward, but due to a shortage of female HCAs on Galleywood Ward, I was moved there for the shift and missed the briefing. As soon I went into Galleywood Ward, I was tasked with observing patients in the canteen. There was a patient on a one-to-one in the canteen with a HCA responsible for observing her. The patient suddenly jumped over the counter and out of the canteen door. Myself and some other staff pursued her out of the canteen and the HCA who had been observing her slipped and fell to the floor trying to stop the patient from getting away. The patient was able to get out of the door that leads to the kitchen on the ward, this requires a key code when the door is closed but had been left open to facilitate a delivery. The patient ran across the hospital car park, I chased after the patient and pursued her into the car park at the front of the ward, I asked another permanent NHS HCA if I should chase her, but I was told not to as staff aren't allowed to restrain patients alone or once they go past the car park barrier. I was able to follow the patient and provide communication of where she was heading, however, I was told that I was not allowed to follow her. Whilst I understand the risks involved in potentially attempting to restrain a patient, had I been allowed to follow her I would have been able to update the ward/Police on her location. I was unaware whether the Police were called, they did not attend during my shift.

69. I had pulled the pin on my alarm when this happened, which alerted staff from Galleywood Ward and other wards. I returned into the ward and after approximately 15 minutes, I personally witnessed the patient being walked back to the ward by several members of staff via the route she had taken. The members of staff weren't

working on my ward and I am unsure where in the hospital they had come from. I was asked to sit with the patient for a short period whilst the HCA who had been responsible for observing her composed herself. I spoke at length with the patient, and I asked her why she had run off and where she had been heading to. She stated that she was going to go to the multi-storey car park Chelmsford but was annoyed with herself because there is also a multi-storey car park in the hospital grounds. The patient told me that she is constantly looking for opportunities to escape. I didn't want to ask the patient if she intended to kill herself so as not to trigger anything, but I was left in no doubt that was her intention.

70. There was no debrief after this incident. Following the absconsion, there was no one-to-one with the patient to establish why she had done what she had done. No one had told me to speak to the patient about the incident, I did this of my own volition and relayed the information to the nurse on duty. I did not return to the ward after my shift, so am unsure what happened after this.

71. I spoke to two agency HCAs working on Galleywood Ward who had also worked on Willow Ward previously and they both said they didn't feel looked after on Willow Ward and didn't want to go back there – in part due to being on back-to-back one-to-one observations.

Reflections and recommendations

72. During my time with EPUT I would say it was one of the most difficult jobs I have ever done. There is no consistency across the wards, a severe lack of leadership and support for the staff members and an environment that is absolute chaos. I would say that for things to improve significantly there needs to be an overhaul of the way the wards are run.

73. The use of agency staff is clearly a huge concern. There is no consistency, they do not receive the same standard of training as the Bank/NHS staff. There is insufficient information shared about patients to ensure that they are treated so that their individual needs are met. I found the agency staff in particular disinterested. I found it difficult to watch patients being ignored when engagement should have been taking place. The managers on the wards, in my opinion, did not get to know their staff. I was never spoken to by any of them. The managers are reliant on the staff to ensure that the patients are safe, treated with respect and well looked after. The managers need to

know their staff; they need to ensure that they are performing their roles to the standard the Trust expects and should be actively ensuring that this is happening on a day-by-day basis. Willow Ward was severely understaffed. The patients understand the staff are disinterested in them and know how to take advantage of opportunities to harm themselves. If one of my friends or family members was admitted to an EPUT ward, I would be extremely concerned for them.

Statement of truth

I believe the content of this statement to be true.

SIGNED: [I/S]

DAWN TRACEY LOW

DATE: 28/05/2026