UPDATE ON THE LAMPARD INQUIRY'S EMERGENCY RESPONSE AND RESUSCITATION INVESTIGATION

Introduction

1. Chair, over the course of the last year, you have heard many accounts from Bereaved Families which have included details of patients being discovered by staff on mental health inpatient units in circumstances of serious medical emergency. A number of those accounts have revealed apparent systemic issues in mental health inpatient care relating to emergency response and attempts to resuscitate.

2. Furthermore, in December last year Chair, you invited submissions from Core Participants in relation to the Inquiry's work more generally. Those submissions included concerns raised by Core Participants about the evidence the Inquiry has heard in relation to emergency response and attempts to resuscitate.

3. In March this year, having heard the accounts given by the Bereaved Families, and having considered the Core Participant submissions, you directed your team to look closely at issues relating to emergency response and resuscitation of deteriorating patients on mental health inpatient units, and you asked us to do so without delay.

4. Put shortly, you considered that some of the evidence this Inquiry has heard gives rise to serious questions, amongst other matters, about the recognition of emergency situations, clinical response, emergency decision-making, the availability and accessibility of vital equipment, and the adequacy of resuscitation practices and procedures, past and present, within mental health inpatient settings. You have determined that this is an emerging area requiring investigation

because it holds potential implications for the safety of **current** patients and may also be of national impact.

Evidence from Bereaved Families and Illustrative Cases

5. Questions relating to the adequacy of emergency response and resuscitation efforts arise in at least 21 of the Inquiry's illustrative cases. Many Illustrative Case Summaries were disclosed to Core Participants in advance of this hearing.

6. The evidence the Inquiry has heard from Bereaved Families has revealed a number of potential systemic issues that appear to extend across almost all aspects of resuscitation and the processes of emergency response on mental health inpatient units.

7. Those potential systemic issues can be summarised broadly, at this stage, as:
   - Failures to identify and to understand the true nature of the emergency, and to act accordingly;
   - Clear issues with sufficiency of knowledge, familiarity with appropriate procedures and equipment, and adequacy of training for staff;
   - Problems with the availability and accessibility on wards of vital equipment;
   - Delay, at every stage.

8. With those broad headings or issues in mind, examples of the types of perceived failings that Bereaved Families have told us about, or that have emerged from our illustrative cases. include:

- Failures by staff to understand the urgency and nature of self-harm attempts and injuries, delays in responding, and failures in senior clinical leadership;
- Staff training records showing non-compliance, gaps and absences in mandatory training. In one case, seven out of ten staff involved in an emergency response were found to have been non-compliant with mandatory training;
- An insufficient level or absence of knowledge amongst staff about their roles and remit during any emergency; the equipment that should be available; where to locate it; how to use it competently;
- A lack of clarity about whether pinpoint alarms used by staff signified medical or mental health emergencies, and a lack of clarity over who should respond to that alarm;
- Failures to remove ligatures before attempting resuscitation;
- Failures to bring appropriate ventilation equipment to the scene, even where such equipment *was* readily available;
- Failures, where that equipment was brought, to be able to locate it within the "grab bag", and to apply it correctly and without delay;
- Life-saving equipment being misused: incorrect placement of defibrillator paddles, use of the wrong masks and problems administering oxygen, including failing to appreciate that pull tabs on oxygen cylinders would need to be removed to start the flow of oxygen, or persevering with broken equipment;
- In other cases, life-saving equipment was missing or broken;
- Delays in staff raising the alarm, with vital minutes lost before emergencies were identified, before appropriate steps were taken and before emergency calls went out from the ward;
- Issues with the basic practicalities of making emergency calls;

- The basic fact that the situation was an emergency, not being explained by those on the ward to staff who were called out, with one on-call doctor having been told that he had time to get his coat;
- In one case, that call being delayed because the staff member making the call was unaware that an additional 9 would need to be dialled for an outside line;
- In another, the emergency number for the general hospital resuscitation team having changed without staff on the unit being informed, meaning that the team simply could not be reached and alternatives had to be tried, with vital seconds and minutes passing;
- 999 calls being made by staff on non-portable phones, which were sometimes not available, and who therefore could neither see the patient nor provide proper, up-to-date information to emergency services operators;
- Failures to give clear, accurate information about timings and crucial events to 999 call operators and to attending paramedics, delaying or hampering appropriate intervention further;
- In one case, a failure to inform paramedics who were attempting resuscitation that the patient had swallowed an item;
- Paramedics being misdirected in terms of the site of or access to the ward, being given conflicting addresses and directions to different entrances;
- Paramedics being unable to gain access to wards despite having been called out to an emergency;
- When access was gained, further delay while emergency responders were slowed by having to be escorted or allowed through a series of locked doors;
- In one case, family members who were present in the reception area of the unit having to intervene to assist attending paramedics to gain access to the ward;

- Attending emergency responders in numerous cases describing "chaotic" scenes on arrival, with ward staff in states of panic, confusion and disorganisation;
- Apparent failures in terms of investigations after the event, and the Trust's ability to assess failures and to learn lessons from them, including failures to complete "resuscitation event" forms;
- In terms of potential systemic issues, the real risk that opportunities to identify learning have been lost.

9. Furthermore, over the past two weeks, the Inquiry has heard evidence from staff who **currently** work on mental health inpatient units in Essex. This included the evidence of Brian O'Donnell who, on Wednesday last week, shared his concerns as to whether those who are first on scene of an emergency situation have always received adequate training.

10. Whilst the evidence we have heard, and the illustrative cases the Inquiry has looked at, appear to reveal systemic issues dating back to the early 2000s, your motivation in considering this topic *now* is your concern about **current** patient safety. You have therefore directed your team to focus on recent policies, procedure and practices and recent training provision, and to ascertain the current position.

Cardiac Arrest and Secondary Cardiac Arrest

11. Before I go any further, I would like to say a little about Cardiac Arrest and Secondary Cardiac Arrest. We will hear evidence about this shortly. Cardiac arrest is the ultimate medical emergency. It is defined by the absence of a person's normal breathing and/or signs of life. When a person is in cardiac arrest, their heart stops pumping blood

around their body and they lose consciousness. We will hear that without Cardiopulmonary Resuscitation ['CPR'] and, where indicated, defibrillation, a person will not survive a cardiac arrest.

12. CPR is the combination of administering chest compressions and delivering rescue breaths. In acute clinical settings, like general hospital wards, CPR is supplemented by additional key skills which are provided by a specific expert team (often called the cardiac arrest or resuscitation team). This team will be mobilised to attend a patient when a cardiac arrest call is made. This is unlikely to be the position in many mental health inpatient units, however.

13. A significant proportion of cardiac arrests that take place in healthcare settings, and in particular, in mental health inpatient settings, are what are known as **secondary** cardiac arrests. Secondary cardiac arrests are a patient's response to a preceding clinical event or trigger. Examples of trigger events include many of those common to mental health inpatient settings, such as low oxygen levels (hypoxia), airway obstruction, overdose, severe physical deterioration and ligature-related asphyxia.

14. In circumstances where there has been a trigger event such as those I have just described, a patient goes into cardiac arrest *at the end of* a process, which includes deterioration of the patient, the patient's loss of consciousness, and the patient stopping breathing. Secondary cardiac arrests usually result in *non-shockable* heart rhythms. This means that the use of a defibrillator, which works for shockable rhythms, is not usually indicated for secondary cardiac arrests. Survival rates of secondary cardiac arrest are therefore poor.

15. Secondary cardiac arrests therefore need to be managed *differently*, depending on the trigger event. For example, if a patient goes into cardiac arrest secondary to low oxygen levels (hypoxia), the key treatment is to manage the patient's airway and provide high-concentration and high-flow oxygen, by providing artificial ventilation along with CPR.

16. In mental health inpatient settings, those who are *first* on the scene of a medical emergency should provide treatment to the level they have been trained, at the same time as urgently summoning expert help. In circumstances where secondary cardiac arrest has not yet occurred, there may be an opportunity to identify deterioration, and intervene *before* that secondary cardiac arrest takes place. We will hear evidence about this from Resuscitation Council UK ['RCUK'] this morning.

17. On a mental health inpatient unit, **preventative** measures might involve removal of the ligature, recognition and prompt management of airway or breathing compromise, monitoring and escalation of deteriorating vital signs, management of overdose or intoxication, and early transfer or escalation to acute medical services. Any delay could be fatal.

18. Given the massive impact that certain skills and intervention may have on the outcome for the patient, one of the issues this Inquiry intends to investigate is the level and type of training that could, or should, be provided to those who might find themselves as *'first responders'* on mental health inpatient units, and which elements of training specific to mental inpatients should be included.

19. With regards the *expert* help to be summoned, in a mental health inpatient setting, this *might* be a cardiac arrest team depending on the location of the unit, but more commonly it will be the ambulance services, or in the interim, ward staff who are trained in more advanced resuscitation skills whilst waiting for a larger team.

20. The Inquiry also intends to look at what sorts of arrangements could, or should, be in place on mental health inpatient wards to ensure that expert help can be called quickly, and most importantly, to ensure that help can get on to the ward, and to the patient, without confusion and delay.

21. We will hear some evidence today that the window of opportunity to influence the outcome for these sorts of emergencies is small. It would appear therefore, to be of paramount importance that those who are first on the scene can identify the emergency and signs of deterioration, that they know what to do, that they have access to the equipment and drugs they need to treat the patient, that there are suitably-trained staff available to lead the emergency response and resuscitation attempt, that there are systems and resources in place to summons expert help, that there are processes by which that expert help can gain access without delay and so on. These are all matters that you have directed your team to look at Chair.

Life Support Training

22. To this end, may I also say a brief word about Life Support Training.

23. *Basic Life Support (BLS)* training teaches the *basic* set of first-aid procedures needed to keep someone alive during a life-threatening

emergency, before *advanced* medical help arrives. Anyone can undertake basic life support training and many do, in the workplace for example, or at sports clubs, or as volunteers in the community. BLS training often includes the use of an Automated External Defibrillator ['AED'] which provides prompts.

24. *Immediate Life Support (ILS)* training is more comprehensive. It is aimed at healthcare professionals who may have to act as 'first responders' in emergency situations, and it provides those healthcare professionals with additional skills required to manage patients in cardiac arrest before expert help arrives. ILS training may also be suitable for other types of first responders such as police officers and air stewards. ILS training can teach a variety of skills including managing a deteriorating patient, identifying causes and treating cardiac arrest. You do not have to be clinically trained to undertake ILS training.

25. *Advanced Life Support (ALS) training* is as its name suggests, *advanced*. ALS training is designed to ensure that healthcare professionals are equipped to recognise and manage cardiac arrest situations, and can lead or work effectively within a resuscitation team. A healthcare professional requires certain relevant clinical qualifications before they can undertake ALS training.

Resuscitation Council UK ['RCUK']

26. When I have finished this update Chair, we will hear evidence from Adam Benson-Clarke, the Director of Clinical and Service Development of Resuscitation Council UK. Mr Benson-Clarke is also a registered nurse. RCUK is a non-statutory, charitable incorporated organisation which describes itself as *"dedicated to saving lives by*

developing guidelines, influencing policy, delivering courses, and supporting innovative research concerning resuscitation practice".

27. RCUK are the organisation responsible for issuing resuscitation practice guidelines and standards for the healthcare sector throughout the UK. RCUK develop and publish the Quality Standards for Cardiopulmonary Resuscitation Practice and Training ['the Quality Standards'] for healthcare organisations to follow. These standards are based on the most recent RCUK Resuscitation Guidelines. We will look at some of the relevant parts of the Quality Standards with Mr Benson-Clarke this morning. The Quality Standards reflect a number of different types of settings where clinical care is provided and where resuscitation may be required. One of those settings is Mental Health Inpatient Care [known as 'MHIC' for the purpose of the Standards].

28. Chair, there has been a wealth of relevant policy, review and guidance issued or published on this topic over the course of the period the Inquiry is investigating, which I will not rehearse for the purpose of this Update. These have included, but are not limited to, NICE Guidelines, guidance issued by the Royal College of Psychiatrists, DHSC guidance (on the Use of Force), Health Service Circulars, and previous Guidelines published by RCUK.

29. The current Introduction and Overview to the RCUK Quality Standards was first published in November 2013 and was last updated in May 2020. The sections on Mental Health Inpatient Care, and Equipment and Drug Lists for Mental Health Inpatient Care, were first published in May 2014. That was the first time that formalised national standards had been published by RCUK in respect of mental health inpatient care. They too, were last updated in May 2020. The Royal College of Psychiatrists was one of the organisations that contributed to the

Quality Standards and were on the Working Group, but there does not appear to have been any input from a Mental Health Nurse, for example, and it is unclear the extent to which the Standards reflect the experience of those with 'on ward' experience.

30. The RCUK Quality Standards Introduction and Overview set out 9 core standards which we will look at shortly:

    i. The deteriorating patient is recognised early and there is an effective system to summon help in order to prevent cardiorespiratory arrest;
    ii. Cardiorespiratory arrest is recognised early, and cardiopulmonary resuscitation (CPR) is started immediately;
    iii. Emergency assistance is summoned immediately, as soon as cardiorespiratory arrest is recognised, if help has not been summoned already;
    iv. Defibrillation, if appropriate, is attempted within 3 minutes of identifying cardiorespiratory arrest;
    v. Appropriate post-cardiorespiratory-arrest care is received by those who are resuscitated successfully. This includes safe transfer;
    vi. Implementation of standards is measured continually, and processes are in place to deal with any problems identified;
    vii. Staff receive at least annual training and updates in CPR, based on their expected roles;
    viii. Staff have an understanding of decisions relating to CPR;
    ix. Appropriate equipment is available for resuscitation.

31. The Quality Standards for Mental Health Inpatient Care provide a framework and outline **RCUK's expectations** for CPR practice, governance, training, equipment and medication provision and emergency response arrangements within mental healthcare provider's organisations. The Equipment and Drug lists set out **RCUK's position** on the minimum resources required to support effective resuscitation.

32. As for the status of the Quality Standards, RCUK state that their Quality Standards are intended to support organisations in developing *local* systems, policies and training arrangements appropriate to their clinical environment, patient population and available resources. RCUK does not mandate implementation of their Standards, and RCUK does not operate any formal compliance, accreditation, or assurance process in relation to the adoption of their Standards within mental health inpatient providers.

33. Furthermore, as the Inquiry understands the position, no separate organisation undertakes accreditation processes nor inspects nor regulates specifically the implementation or operation of RCUK's Standards in any setting. Formal regulatory oversight of inpatient mental health care providers in England, including provision relating to emergency response, sits principally with the Care Quality Commission ['CQC'] of course. RCUK does not direct the CQC's inspection methodology and does not receive routine provider-level assurance information about implementation of RCUK Quality Standards.

34. When Mr Benson-Clarke gives his evidence this morning, we will look at the relevant parts of RCUK's Quality Standards that relate to mental health inpatient care, and at those which indicate that certain units

should have in place particular processes for resuscitation in special circumstances. Those circumstances include suffocation, application of ligature, self-harm, seclusion, and rapid tranquilisation. We will also hear that RCUK's Quality Standards are due for review later this year.

35. In respect of restrictive interventions, Chair, there has long been guidance in relation to restrictive interventions. The CQC has separately issued the 'Brief guide: Immediate Life Support training for services that may use restrictive interventions' which in turn refers to NICE Guideline NG10. NG10 recommends that in any setting where restrictive interventions (rapid tranquilisation, restraint or seclusion) are used, there should be immediate access to staff trained in ILS and to appropriate ILS medication and equipment. The CQC guide also refers to the recommendations within the RCUK's Quality Standards ~~MHIC~~. EPUT have already informed the Inquiry that for a period of time, at least from November 2019 to March 2023, they interpreted NICE Guideline NG10 for a setting where restrictive interventions may be used, as requiring access to *BLS* trained staff, rather than ILS trained staff.

36. As previously outlined Chair, one of the issues this Inquiry intends to look at in relation to this topic, particularly given the need for staff to be able to identify immediately signs of deterioration in a patient to prevent a secondary cardiac arrest if possible, and the importance of the role of those who are first at the scene, is *what* level of training could, or should, be given to *which* staff working on a mental health inpatient unit.

37. We will hear for example, that whilst RCUK does not expect all healthcare assistants working on mental health wards to have ILS training *"as a blanket requirement"*, their Quality Standards do set out

what RCUK consider to be the minimum skills required for "*staff who respond immediately*". Staff who respond immediately are the ward staff or other locally designated staff who are expected to provide the initial resuscitation response to a patient who has collapsed or is in cardiorespiratory arrest, **before** the arrival of the cardiac arrest team, ambulance clinicians or other staff trained in advanced resuscitation skills. RCUK recognise that these first responding staff may well include healthcare assistants. The Inquiry is aware, through evidence from Bereaved Families, through staff witness accounts such as that of Brian O'Donnell, and through its illustrative cases, that healthcare assistants will often be first on the scene.

38. RCUK provides education and training through its own resuscitation courses and associated guidance issued to RCUK-registered course centres. These course centres include NHS Trusts, private healthcare organisations and providers of mental health inpatient care. RCUK are not however, the only providers of Life Support Training.

39. According to RCUK, their ILS training was developed for healthcare professionals who may have to act as the first responder in an emergency. Its purpose is to give individuals the skills to recognise deterioration, identify cardiac arrest, start immediate resuscitation, use defibrillation where appropriate, summon expert help, and manage the patient until a cardiac arrest team, ambulance clinicians, or other advanced responders arrive. It is not designed to provide comprehensive training in the definitive management of every special circumstance listed.

40. Within its ILS training, RCUK has developed mental health-specific ILS course materials and simulation scenarios for healthcare professionals working in mental health inpatient settings. We will hear

that these include scenario-based training content, assessment materials and instructor resources intended for mental health environments. We will hear evidence as to RCUK's view of the importance of simulated and scenario-based training, for all those working on an inpatient mental health unit, and of the importance of that training taking take place as a team, if at all possible.

41. As previously stated, RCUK is a non-statutory professional body and is not a regulatory or inspection organisation. It does not mandate, oversee nor monitor implementation of its Quality Standards within individual providers. RCUK does not routinely liaise directly with NHS Trusts or private providers of mental health inpatient care regarding implementation of the Quality Standards.

42. Implementation and Organisation Responsibility sit with providers. Health Service Circular Series Number: HSC 2000/028, published as far back as September 2000 stipulates that chief executives of all NHS trusts should give a Non-Executive Director designated responsibility on behalf of the trust board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework.

43. Chair, the Inquiry has requested and received evidence on this topic from each of the Core Participant trusts and providers. Our aim, as directed by you, is to ascertain and examine, where possible, the reasons behind apparent systemic failures in emergency response and attempts to resuscitate. Those focused evidential requests therefore included:
    a. Requests for relevant policies and procedures in place at each of the Core Participant trusts or providers, with focus, as directed by you, on recent years and current provision;

b. Requests for each trust or provider to identify where those policies and procedures departed from and/or modified RCUK Standards, national policy or NHS England Guidance; to include any departure from guidance or quality standards produced by NICE;
c. Requests for evidence in relation to any local variation included in trust/provider policies and procedures in respect of individual mental health inpatient units or specific wards and any local agreements that were in place between such units or wards and acute services or nearby Accident and Emergency departments;
d. Requests for evidence relating to the training of staff on mental health inpatient wards in respect of emergency response and resuscitation. We have asked questions about all staff – clinical and non-clinical, nurses, doctors and healthcare assistants, bank staff and agency staff – and we have requested information on the courses that were available; whether they were mandatory; when staff were required to complete them and how regularly they were required to repeat them. We have asked about practical elements and scenario training, assessment of trainees and monitoring of training completion. We also asked about any adaptations that were made to training to make it ward, unit or patient specific and, where applicable, any differences in the policies, procedures and training provided in respect of adult patients and child patients;
e. Requests for evidence about any modifications to trust/provider policies and procedures made during the COVID-19 pandemic and whether those modifications are still in place.

44. This is also an area Chair where you considered it important to identify how arrangements in Essex compare with provision in other

trusts across the UK, and to explore whether any challenges identified in trusts and providers in Essex are, in fact, national challenges. The Inquiry therefore asked the same questions of 4 other UK NHS trusts: North Staffordshire Combined NHS Trust; Northamptonshire Healthcare NHS Foundation Trust, Hertfordshire Partnership University NHS Foundation Trust and East London NHS Foundation Trust. You consider that evidence from comparator trusts will assist you in setting the evidence you receive about practice and procedure in Essex into its proper national context.

45. Furthermore, given that the Inquiry has identified cases illustrating apparent systemic issues at EPUT, the Priory Group and St Andrews, the Inquiry asked those providers to set out details of where and how learning from any failings was identified, disseminated and what action was taken, including how those actions were implemented, reviewed and monitored to ensure that learning was effectively embedded, sustained and applied in practice.

46. In respect of EPUT more specifically, where a systemic issue had been identified in one case, but apparently repeated in later cases, we asked for an explanation of why that systemic issue had reoccurred and whether any action had been taken now to prevent future reoccurrence.

47. Those witness statements, recently received from both Essex providers and from the comparator trusts I have referred to, have already been disclosed to Core Participants, with a significant number of exhibits to follow.

48. The Inquiry intends now to undertake appropriate analysis of whether and how, the policies, procedures, practices for emergency response and resuscitation in place at the trusts and providers in

Essex, reflect proper standards and guidance. We also intend to explore whether the provision now in place is sufficient for the safety of current patients, taking into account, where necessary, appropriate local operational needs, and the reality of day to day working on a mental health inpatient ward.

49. We intend to review carefully whether lessons have been learned from previously identified systemic failures in relation to emergency response and resuscitation, or whether history has been allowed to repeat itself.

50. The Inquiry will not hear evidence from individual trusts and providers during this hearing. The Inquiry intends to explore these matters, and consider any analysis more broadly, as part of the re-framed Interim Recommendations Hearing in October. The Inquiry is also in the process currently of engaging with others, including those with other relevant expertise, who we consider *may* be able to assist you. We are actively exploring what data is available.

51. Finally Chair, the Inquiry is grateful to the Core Participants for their input and engagement into this topic so far.

Rebecca Harris KC

Katie Sage

20 July 2026