Friday, 10 July 2026

(10.30 am)

(Proceedings delayed)

(11.37 am)

MS MALHOTRA: Could the witness be sworn, please.

ZOE BUNTING (affirmed)

Questioned by MS MALHOTRA

MS MALHOTRA: Thank you very much.

Now, you've provided a witness statement to the Inquiry dated 29 May this year. Have you had an opportunity to read your statement recently?

A. I have, yes.

Q. Thank you. And do you have any corrections or clarifications that you wish to make in your statement?

A. Yes, I do.

Q. And I think you have a list in front of you there of some --

A. I do.

Q. -- corrections you'd like to make. Would you like to read out what those corrections are?

A. So paragraph 130, the correction, so the sentence should read "Ward staff would explore" not "exploration".

Paragraph 166, the correction should read "The 72-hour care plan needs to be inputted onto the EPR", and not "transferred".

Paragraph 240 should refer to "overnight leave".

Paragraph 265, correction, the date was around 2021, not 2017.

And paragraph 326 should read "felt pressure" not "pressured"; and paragraph 327, correction, this should read "daily safe care entry" and not "MHOST".

Q. Thank you very much.

So aside from those corrections that you've made this morning can you confirm that your statement is true?

A. Yes.

Q. Thank you.

Now, you're a qualified Registered Mental Health Nurse and you registered in September of 1997; is that right?

A. That's correct.

Q. You currently work as a Professional Nurse Educator at EPUT, a role that you've been in since September 2024; is that right?

A. Yes.

Q. Can you explain to us, please, what does a Professional Nurse Educator do?

A. So Professional Nurse Educator is a new role. It was rolled out as part of a pilot in 2022, via NHS England. EPUT was one of the pilot areas, and a Professional

Nurse Educator is really a focus of support for staff, that the role predominantly is around three factors: education, support, and quality.

Our role is to be visible on the floor, on the shop floor, on the wards, with the staff, role modelling, supporting them with their competencies, supporting them with education and their wellbeing.

Q. So you started this role in September of 2024, I think you say in your statement that there are six --

A. Yes.

Q. -- Professional Nurse Educators. Is that within EPUT?

A. Yes.

Q. And those are full-time roles, are they?

A. They are full-time roles.

Q. I'd like to ask you about your past experience. Prior to taking up your current role as a Professional Nurse Educator you worked in a number of roles within EPUT. We can see this, perhaps we can ask for it to be brought up, page 2, paragraph 4 of your witness statement.

We can see here that from 2016 you were the Charge Nurse at the Ruby Ward, the Crystal Centre?

A. Yes.

Q. You became Ward Manager of the Ruby Ward in 2017 and you remained Ward Manager until November 2020; is that right?

A. Yes.

Q. Then we can see here you moved to the Peter Bruff Unit as a Ward Manager in November 2020 and you were then Acting Matron of the Peter Bruff Unit in 2022 and 2023. And you returned to Peter Bruff as Ward Manager in January 2024 and you stayed there until your current role in September 2024?

A. Yes.

Q. And so would it be fair to say that from November 2020, you've been in various roles within the Peter Bruff Unit --

A. Yes.

Q. -- until your current role started --

A. Yes.

Q. -- in September 2024?

Could you briefly describe for us the Ruby Ward and the Peter Bruff Ward during the time that you worked there, for example what I mean by that the type of patients that were within those two wards, whether they were male only, female only, or mixed wards. Can you help us with that?

A. Yes. So Ruby Ward was a mixed-sex ward, it was a Functional Assessment Unit. I think there are around 18 beds, and patients were 65 and above.

Q. So that's the Ruby Ward?

A. Yes.

Q. What about the Peter Bruff Unit?

A. Peter Bruff, the assessment unit in Colchester, so the assessment unit was for working adults from 18 to 65 and it was a mixed-sex unit and people could be admitted with a range of mental health difficulties.

Q. Is it correct to say that you've got quite a number of years of experience working in older adult inpatient settings?

A. Yes, yes.

Q. You also say and we can see this at page 2 to 3, paragraph 7 of your witness statement, that you hold a Professional Nurse Advocate qualification. Can you explain what the role of a Professional Nurse Advocate is, please?

A. Yes, so Professional Nurse Advocate is a supportive role for staff, as part of the PNA qualification, I'm equipped to deliver restorative clinical supervision so that's a structured process, and -- and it follows the A-EQUIP model which is based on advocating for patients and staff, education and quality improvement. So that's part of that role.

But really, predominantly the focus is to be there to support staff with their clinical roles and their own resilience.

Q. So this is separate to the -- to your current role? This is an additional qualification?

A. It's an additional qualification but it does form part of the PNE responsibilities.

Q. Do all PNEs have to have this additional Professional Nurse Advocate qualification?

A. It is an expectation, yes.

Q. You may not be able to answer this but your role as a PNE, I think you said it started off with NHS England initiative; is that right? Do you know when that started?

A. PNE, that would have been 2022 and EPUT was one of the pilot areas, yes.

Q. I'd like to ask you about page 3, paragraph 8 of your statement, so just the next paragraph down there. You talk about restorative clinical supervision, RCS. What is restorative clinical supervision?

A. So it's really a process, a structured process, to follow with staff. It's not mandatory. It is very much about the staff member being willing to engage in that process. It aims to mitigate the burnout and compassion fatigue and sustained personal resilience for staff. It's about supporting nurses to do their job properly and effectively whilst also considering their own wellbeing. So RCS, as I said earlier, it follows the

A-EQUIP structure, so it's about advocating for patients and staff, education for staff, and quality improvement.

But it would generally be for an hour. You would set ground rules with the member of staff at the beginning and it is a supportive conversation.

Q. Okay. You haven't done anything wrong at all, I'm just going to ask if you could slow down slightly.

A. Sorry.

Q. We have a transcriber who is taking a note of everything that you say so I just wonder if we could slow down slightly.

You explain that restorative clinical supervision is not currently mandatory within EPUT, but that it's available to any nursing staff who either requires additional support or who wishes to access it proactively, as a means of maintaining their wellbeing in their role.

As far as you're aware, what proportion of staff take up the restorative clinical supervision.

A. I would say that the uptake is poor. In my local areas I've promoted it to my Ward Managers and my Matrons. I talk about it with staff so that they're aware that it's in place and that they can access it, but the uptake is poor.

Q. When you say poor, are you able to put a number to it,

a percentage?

A. I'd say extremely minimal. Since I've been in post I think I have delivered RCS three, maybe four times. I do try -- I have supported the wards with clinical supervision, and supported the Ward Managers to do that when they've been struggling with their teams. So that's the mandatory supervision. And I do try to focus very much on the RCS process while I'm doing those supervisions. But I would say formally, three or four times I've done it since being qualified.

Q. So three or four times, would that be to an individual staff member?

A. Yes, an individual.

Q. Do you know why that might be?

A. I think time is a factor. Staff being able to access any protected time for training or supervision is extremely difficult. And I'm not sure it's been effectively promoted by the Trust.

Q. And just in terms of the promotion, the protected time, is that something that you've been able to raise as a concern or escalate at all?

A. I may have had conversations with the Matrons and the Ward Managers but not that I can recall at the moment.

Q. And as a result of those conversations, have you noticed anything changing?

A. No, it's really very difficult for staff to access any protected time.

Q. Would it be beneficial, in your view, if restorative clinical supervision were made compulsory?

A. Yes, yes, but it would need to be supported with the resources so that staff could actually commit to it.

Q. I'd like to ask you next about technology, and specifically Oxevision and Oxeobs.

I wonder if we could have up, please, page 62, paragraph 286 of your witness statement.

You talk here about technology and the changes you've seen to technology in the time that you've worked within the Trust. At paragraph 286 you talk about mobile devices and then, again at 287, mobile devices for recording observations. Can you help us at all with when that came about.

A. So when I joined PBU, that was 2020, I believe the recording of observations in terms of the documentation, I believe that was around 2022.

Q. So these mobile devices for recording observations, to the best of your recollection, came in around 2022?

A. Yes. We had -- initially on PBU there was just a screen in the office, but -- an Oxehealth screen in the office. I don't recall having any access to tablets. I believe the tablets became available around 2022.

Q. So can you help us, just in terms of these tablets, and we're talking about the Peter Bruff Unit, were they part of Oxevision or Oxeobs or was this something separate?
A. Yes, that was part of Oxevision and Oxeobs, yes.
Q. So can you help us with what your understanding of Oxeobs and Oxevision are?
A. Currently?
Q. Yes.
A. Currently.
Q. Yes.
A. Currently it's an additional tool. They're there to, as an -- they're not a replacement; they're there as an addition to support staff. You can take pulse and breathing rates with the technology. There's alerts that alert staff to either movement in the room or they may have left their bedroom, but currently, I think their intended use, it is to be very minimal.
Q. And I think you're addressing that as the current position --
A. Yes.
Q. -- because it has changed, has it?
A. It has.
Q. Okay. And can you tell us, give us an overview, of how it's changed, from your perspective and in your experience?

A. I think -- well, my first experience of Oxehealth, Oxeobs ever, was when I worked on PBU when I joined. I had no previous experience, and when I joined, I don't recall immediate provision of any training. So I had to familiarise myself, really, by speaking with colleagues to try to get an understanding of how it was used and how it worked.

I think, certainly initially, the technology was used much more commonly than it is now.

Q. And you talk about this in your statement. I wonder if you can help us, before we go to your statement, just help us understand from your perspective what are the benefits of this increase in technology of Oxevision?

A. My personal view is that the benefits are minimal. The only clear benefit I can see is that it reduces the scope for retrospective entry of documentation. We can only use it under very specific circumstances now. It's very limited. It's very clear that it's an additional tool. But I would say the benefit is minimal.

Q. And can you just explain a little bit about why it's minimal for those of us that might not be familiar with it? Why is the benefit minimal?

A. As I say, the only benefit I can see is that you cannot make a retrospective entry. So the entries are timestamped. But I would say that I don't see that it's

any quicker or swifter to use. I don't see that you complete patient activity any more effectively using the technology.

Q. So really, it's avoiding situations of retrospective entries of notes --

A. *(The witness nodded)*.

Q. -- of observations -- that's the benefit that you can see to it?

A. Yes.

Q. And you also say, perhaps we can bring it, page 48, paragraph 224. You say here that it adds a barrier to engagement. Can you help us with understanding that.

A. I think one of the issues is when staff are completing observations using the technology is actually quite a bit of time is spent focusing on the tablet, which of course you would have to do with your paper documentation. But I do feel it adds a barrier. I feel that staff are focused on the tablet and selecting the correct options, trying to type in interventions. Yes, yeah. That's my view.

Q. So it's sort of the functionality of it?

A. *(The witness nodded)*.

Q. And the process of having to input within a tablet --

A. *(The witness nodded)*.

Q. -- takes away from that sort of patient engagement; have

I understood?

A. Yes, and I would say, in my view, it takes slightly longer to do that using the tablet than it would if you were handwriting an entry.

Q. I see.

You say at page 62, at paragraph 287 of your statement, that moving to electronic recording was a positive development and I just wondered whether you could explain that distinction to us.

A. Again, I think that is around the reduced scope for respective completion of records that might be completed several hours after they were due.

Q. I see. I'd like to ask you about the Oxevision pilot. You worked at the Peter Bruff Unit from November 2020. Were you working on the Peter Bruff Unit when it was identified as a pilot area for Oxevision?

Can you recall?

A. I believe -- so the e-observations, that was a pilot. So yes, I would have been.

Q. And just help me understand the distinction between the Oxevision and the e-obs?

A. Oh. So the Oxevision system itself would have been in -- it was already installed when I arrived, but we didn't have -- we were still completing paper documentation for the observation rounds.

Q. I see.

A. So the e-observations was when we had tablets introduced to the ward, as part of a pilot.

Q. And that came later, I think, you've said in 2022, from recollection?

A. Yes.

Q. So focusing, then, on Oxevision, did you know why the ward had been identified as a pilot area for Oxevision?

A. I may have done at the time, but don't recall now.

Q. Are you able to help us with what the purpose of it being a pilot was? Is there anything that you can remember?

A. I don't, sorry. No, I don't recall.

Q. Do you recall whether decisions about whether to test the use of Oxevision were taken by reference to patient-specific risks, suitability and consent, or not?

A. Would you be able to repeat the question, please?

Q. Yes, of course. Do you remember whether testing the use of Oxevision was to test patient-specific risks, suitability, or their consent? Or can you not say?

A. I cannot say.

Q. Can you recall ever providing any feedback on the pilot of Oxevision?

A. I may have done but not that I can recall now.

Q. So you wouldn't be able to say whether you provided

positive or negative feedback?

A. No.

Q. You've mentioned training on and around Oxevision and I just want to explore that a little bit more with you. So if we look at page 64, paragraph 296 of your statement. You, say here that when you joined the Peter Bruff Unit, the Oxehealth system was completely new to you and you took it upon yourself to familiarise yourself with it by asking colleagues:

"This involved understanding its layout, how to take vital signs using the technology and how to interpret alerts. I do not recall what formal Oxehealth training was available to me at the time by way of mandatory training, but I know that it was not immediately available."

So when you joined the unit, there wasn't formal training on the use of Oxevision at that time that you can recall.

A. No, there was not.

Q. There was not? Not, that you can't recall; there was not?

A. I can't recall.

Q. But the system of Oxevision you mentioned had already been installed at that time when you arrived?

A. It had.

Q. And can you help us with whether other staff members were using Oxevision at that time?

A. Yes, they were.

Q. They were?

A. Yeah.

Q. Do you know if staff that you were working with or overseeing whether they were trained on the use of Oxevision?

A. I can't remember when Oxehealth mandatory training became first available. It may be that staff that were already on the ward had completed that but I can't remember when it first became available.

Q. Okay. And you say that you familiarised yourself by asking colleagues?

A. Yes.

Q. Can you recall sort of what role, what colleagues you were asking, what their role was?

A. I think it was a variety, actually. I think it was a variety of my Charge Nurses and my Staff Nurses.

Q. And they were able to help you with the use of the system?

A. Yes, yes.

Q. You also say, page 65, paragraph 298 of your statement, that there was little by way of guidance. Can you help us with that, please?

A. Which paragraph is this, please?

Q. Sorry, it should be -- it's page 65, paragraph 298. So it should be the section in front of you. At the very bottom of that paragraph:

"I do not recall the provision of such detailed guidance when I first commenced work on the [Peter Bruff Unit]."

Can you see that?

A. Yes, I can.

Q. Then at the top of the paragraph, as well, if it helps:

"When I arrived on the [Peter Bruff Unit] there was little by way of guidance available to staff and patients regarding Oxehealth in bedrooms and its functionality."

A. Ah, I see. Yes.

Q. Does that help at all?

A. Yes.

Q. So that was your experience, was it --

A. It was, yes.

Q. -- that there was -- was that guidance by way of the Trust, the unit, or just any guidance from anyone at all?

A. As far as I can recall, I would say there was very little from either Oxehealth or the Trust.

Q. Okay. I just want to understand a little bit more about

that. "Little" suggests that there might have been some. Can you help us perhaps with what there might have been?

A. I know that there were some early materials available on the Internet -- on the intranet, sorry the Trust intranet --

Q. The intranet. Yes.

A. But I can't remember when I first saw those.

Q. Okay. I wonder -- I'd like to take you to page 47. I wonder whether this might help.

Page 47, paragraph 219. You say here:

"I have some recollection of the initial Oxehealth promotion materials specifically promoting Oxehealth as a tool on which patients sleep hygiene could be improved, due to less disturbances for the patient."

Does that help your recollection at all?

A. It does a little. I'm still not certain how early I saw those promotion materials.

Q. Okay. Can you help with what sort of promotional materials you saw?

A. So on the intranet there was a video and it talked you through the technology and its benefits, and how it could be used.

Q. And that was the extent of the material that you saw, the promotional material that you saw?

A. Based on my recollection, yes.

Q. At -- sticking with page 64 -- going back to page 64, sorry, page 94 you say:

"The intended purpose was to support interventions, particularly overnight, in a less intrusive way, by allowing staff to monitor patients without repeatedly entering bedrooms."

Can you see that?

A. Yes.

Q. Did you acquire this understanding of the intended purpose at the time of implementation or subsequently?

A. I think that was my understanding fairly early on after joining the assessment unit.

Q. The Inquiry has obtained documentation surrounding the rollout of Oxevision which describes the operational value of Oxevision as: fewer one-to-one observations, positive risk taking and stepping down observations, and faster observation rounds, are saving time for staff to redeploy into other therapeutic areas.

Is that consistent with your experience of how Oxevision was used?

A. Would you be able to repeat that? I'm so sorry.

Q. No, no, please don't apologise. Quite a long question.

So essentially, in your experience, did you see that the use of Oxevision led to fewer one-to-one

observations, positive risk taking and stepping down observations, faster observation rounds, saving time, saving staff time?

A. No, I wouldn't agree with any of those.

Q. You refer at page 45 -- I'm sorry, we're skipping around your witness statement but go to page 45, paragraph 212. You talk here about mandatory training on Oxevision, and that staff are required to take. And you explain that the training addresses, amongst other things, how to use Oxevision and Oxeobservations to conduct observation rounds, periodic observations and managing observation levels. Can you help us with when that training was introduced?

A. No, as I said earlier, I can't remember how -- when I became available of Oxevision mandatory training -- when that was available.

Q. If I was to try to put a time frame to it, to say that it might have been years later or months later, would you be able to help us at all?

A. I wouldn't have said it was years. I would narrow it down.

Q. Do you know if there's a requirement to refresh training periodically?

A. The Oxevision training, yes, there is, but I can't remember the frequency.

Q. Okay. Can you help us with -- you may not know the answer to this -- but whether staff could work on the ward without undergoing Oxevision training?

A. That could be quite possible, particularly with bank and agency staff.

Q. And presumably, as well, with your experience that you've described, you started on the Peter Bruff Unit --

A. Yes.

Q. -- without the training?

A. Yes.

Q. Having undertaken that training yourself now, can you help us with whether the training covers the Trust's Standard Operating Procedure on Oxevision?

A. I haven't done the Oxevision e-learning for some time and I can't remember, so the most recent occasion that I completed the -- so the -- Oxehealth is now known as LIO.

Q. That's right.

A. So I recently completed that mandatory training. However, I can't remember if it refers to what you're asking.

Q. Can you remember when you did the most recent LIO training?

A. It would have been in the last few weeks.

Q. Do you know, are you able to help us, with whether staff

are made aware of -- how staff are made aware of new versions of Standard Operating Procedures?

A. They may be released on the Trust intranet.

Q. I'm just trying to understand whether, if a new Standard Operating Procedure comes into force or existence, do staff get emailed? Is there a bulletin that it might come out on, or is it sort of uploaded on the intranet for the staff member to then find it?

A. I do believe that emails do get sent out to staff, but I think, as I've said elsewhere in my statement, staff have very little protected time. Emails are incredibly voluminous and staff either don't get time to access their emails or if they do, they're really trying to prioritise which ones they look at.

Q. I'd like to ask you a bit about Adam Steel and your understanding of findings following his death.

At page 47, paragraph 220, you say here, in the context of findings in relation to his death, you say that reliance on Oxevision to conduct level 2 checks instead of face-to-face observations was contrary to policy.

A. Yes.

Q. Are you referring to a policy that was in force at the time of Adam Steel's death in October '21?

A. Could you just direct me to the paragraph again? My

apologies.

Q. No, no, no. Please don't apologise.

So here at paragraph 220 at the top of the page, you talk about the Patient Safety Incident Review into Adam's death and it:

"... concluded that although he was on level 2 observations requiring four random checks per hour, he was not physically checked face-to-face overnight. Instead staff relied on Oxehealth technology rather than conducting in-person checks contrary to policy."

A. So I believe I'm referring to the Therapeutic Observations and Engagement Policy.

Q. Was that the policy that was in force at the time of his death, presumably?

A. Yes.

Q. The first Oxevision Standard Operating Procedure, I believe, was in March 2020, and it outlines that Oxevision can be used for patients risk assessed as being nursed under level 1 or level 2 observations.

Firstly, were you aware of this standard operating, the first Standard Operating Procedure with regard to Oxevision in March 2020?

A. Not in March 2020, no. I joined PBU, in the latter part of 2020.

Q. There was a Standard Operating Procedure version 8,

possibly in October 2022, that refers to using Oxevision to reduce disturbance to patients during nighttime observations or general observations; can you recall that?

A. Can you repeat the question, please?

Q. In fact we may be able to look at your paragraph 294. So I think if we go through a few more pages, it's paragraph 294. I'll see if I can find the page number.

Thank you. You say here:

"The intended purpose of the technology was to support observations, particularly overnight, in a less intrusive way ..."

And the question I'm asking you, perhaps slightly clumsily, is: was that what your understanding of the guidance was at the time?

A. At the time, yes.

Q. But more recently, that it doesn't replace --

A. Yes.

Q. -- observations?

And so I think you have said earlier that there has been quite a number of changes in the way -- the use of Oxevision in the way it's been used over time?

A. Yes.

Q. Would you say that the guidance given by the Trust on the use of Oxevision has been clear to staff?

A. No, I would not.

Q. I'm going to move on to recording of vital signs but I think before we do that we'll take a break.

A. Okay.

(12.18 pm)

(A short break)

(12.30 pm)

MS MALHOTRA: So we're going to -- I said we're going to move on to a recording of vital signs, still sticking within the topic of Oxevision.

At page 8 of your statement you discuss recording vital signs of patients and I wonder if we can have that brought up, paragraphs 30 to 33 here. Vital signs are recorded once per shift as a minimum, and then you go on to talk about new scores here.

What is your understanding of the purpose of recording vital signs?

A. It's to recognise, to be able to recognise whether or not there's a deterioration in a patient. It's important to have a baseline, so a baseline understanding of what normal is for that patient on admission. And then to monitor that over the course of their stay.

Q. And are you aware that one of the features, or the marketed features of Oxevision is that it's a tool at

monitoring vital signs?

A. Yes.

Q. Are you aware that Oxevision attempts to continually take vital sign measurements, specifically pulse and respiratory rate?

A. Yes.

Q. Before Oxevision was introduced, how frequently were a patient's vital signs checked, in your experience?

A. The minimum is once per shift.

Q. As you say here at paragraph 30?

A. Yes. But it could be more frequently and that would be dependent on either direction from the doctor or the nurse's own observations of that patient over the course of a shift.

Q. Were staff spending significant amounts of time on these checks?

A. It could be timely to undertake physical health checks. To complete a whole ward, I would say that that would usually take around an hour.

Q. Are you aware of limitations in the ability of the Oxevision system to take those measurements?

A. Yes.

Q. Can you tell us about them?

A. Yes. So you can only take them if the patient is still on the bed and then there's two circles that will appear

on the patient. They have to both be on the patient. You press the vital signs button and it will appear. If the patient is moving around in their room, you won't be able to use that function.

Q. I see. Do you know of any training for staff on the interpretation of the Oxehealth vital sign readings, including the identification and interpretation of abnormal readings?

A. Could you repeat that, please?

Q. So essentially what I'm trying to understand is whether staff are trained, so taking it a step back, as a trained Mental Health Nurse working in a mental health ward or a unit, is there a different training pathway as opposed to a nurse that specialises in physical health in a medical ward, for example?

A. Are you asking if staff are trained with regards to taking vital signs? Is that the question?

Q. Yes, and understanding what to do, signs to pick up on deterioration?

A. Not simply just Oxehealth, simply vital sign checking?

Q. Generally, and then I'm going to ask you about Oxevision as well.

A. Okay, okay.

Q. If there's a difference between the two.

A. So certainly I think with the regards to my own training

I don't remember any training with regards to vital signs. It was a very long time ago. And that may have changed now for nurses that are undertaking their mental health training now. I think the only training that I have accessed formally with regards to vital signs is the NEWS2 e-learning.

Q. And then in respect of Oxevision, Oxehealth, is it any different?

A. So the Oxevision or LIO e-learning, it does show how to take vital signs but it doesn't provide, as far as I can recall, an outline of what a normal threshold might look like.

Q. And so the training is, to the best of your recollection, the training is about the functionality and the use of it as opposed to what you do?

A. Correct.

Q. And so the part, the training about the 'What to do', where would that come from? Would that come from your initial nursing training or would it be as part of a refresher training, for example, that comes later?

A. I think certainly in terms of my own experience it was skills that I'd picked up over time very early on as a Staff Nurse. I don't recall any provision of training in that regard in my early career.

Q. And just thinking about your role as a PNE, whether you

have any understanding or awareness of what it might be now?

A. I don't, I know that as PNEs we're really encouraging staff to complete the NEWS2, the e-learning model which isn't currently mandatory, although I do think the Trust is looking to make it so, and we're doing a lot of work with staff to help them to use that correctly on the wards and really try to encourage their understanding of that as a tool for recognising deterioration. But I don't know what the training offer is, pre-registration.

Q. So the e-learning you mentioned is not currently mandatory?

A. It isn't.

Q. Do you have a view on whether it should be?

A. It absolutely should be.

Q. And you have mentioned that it's not at the moment. Have you spoken to anybody or raised any concern about that?

A. Yes, as a team of PNEs we work quite closely with the -- I can't remember his title -- he is the --

Q. That's okay, is it somebody who is in a senior role?

A. It is. It's somebody that's in a position, and they play a really broad role with regards to physical health and deterioration. And I believe it is him that has said that they're looking to make it mandatory.

Q. I'd like to ask you about another topic, still sticking with Oxevision and Oxehealth, but turning to consent. Paragraph -- so page 65, paragraph 298 of your statement. Thank you.

You say here that you cannot say with confidence -- with any confidence that all patients will have been aware of the presence of Oxevision and its use on admission and throughout their stay.

Now I've inserted the word "Oxevision" there, but tell me if that's wrong. Is that what you're referring to here?

A. Yes, yeah.

Q. Do you agree that patients have a right to know about Oxevision being used in their bedrooms, given the implications regarding their privacy?

A. Yes, I do.

Q. What information was provided to patients upon admission on the use of Oxevision? So are they alerted to the fact of continuous recording the period over which data is retained, for example?

A. So when I first joined PBU, again I think information available was limited, but I do think that the need to have a conversation with patients on admission about Oxehealth was present in an admission checklist. I can't recall if staff were provided with any sort of

script at that time to help them with that conversation. And I recall posters regarding Oxehealth becoming available much later in my time on PBU. So they were posters that were intended to be in notice boards around the ward and then in patient bedrooms, but that was much later. They certainly weren't available initially.

Q. So I think you've answered my next question, which is that the information would have been available on notice boards?

A. Not initially in my time on PBU, but later on, yes.

Q. And so I think what you're saying is before, there wouldn't necessarily have been a script --

A. *(The witness nodded)*.

Q. -- or sort of a way for staff to communicate that as sort of standard practice?

A. *(The witness nodded)*.

Q. But your understanding is that it is now?

A. Yes, I think it's much clearer now. All patients have to have an Oxehealth conversation and they need to understand its use and consent to it.

Q. So given that you say that -- you can't say that all patients would have been aware of the use of Oxevision, is it right to say that consent from patients was not always obtained?

A. Yes, I would say that's right.

Q. I've asked you about paragraph 299, I think we've already gone to it before, but it's page 65. I'll just refer you again to it.

Page 65, paragraph 299. Thank you.

You talk here, just to orientate you to the part that we're speaking about, that the benefit, the only benefit, in your view, of Oxevision was a timestamping of the entries.

A. *(The witness nodded)*.

Q. We spoke about that at the start of your evidence, and you go on to say that you've not personally been able to see any therapeutic benefit to patients but equally, you do not think that it hinders the provision of mental health treatment either.

I just want to explore that a bit with you. What about the impact of the use of Oxevision on patients' rights to privacy?

A. Yes.

Q. Would you recognise that that could impact?

A. Yes, yes.

Q. To what extent is the use consistent with the principle of least restriction in mental health?

A. Could you repeat that, please?

Q. So applying the principles of least restrictive means --

A. Yes.

Q. -- which you will be very familiar with, how is the use of Oxevision consistent with that? Do you have a view? Are you able to say?

A. I think it's directly contrary to it. I think Oxevision is incredibly intrusive.

Q. Do you consider that there's any therapeutic benefit to the use of Oxevision?

A. No.

Q. I'd like to move on to another topic, but related. Therapeutic engagement and supportive observations.

You describe in your statement, this is page 38, paragraphs 183 and 184. You describe here how observation levels are set. You say that:

"On admission [this is paragraph 184, second line] patients are placed on level 2 observations for no less than 24 hours."

A higher level of observation is undertaken if the admission assessment indicates this, and you go on to say that.

Was it a policy or a practice on all wards, all wards that you are comfortable and confident being able to speak about, that patients are, on admission, placed on level 2 observations or higher for at least the first 24 hours?

A. Yes.

Q. You say that decisions on observations are revisited in ward reviews and so we can have a look at page 39, paragraph 188, if it helps to refresh your memory.

That observations would be revisited in ward reviews, handovers and huddles. When incidents occur, observation levels are not automatically increased. The circumstances would be considered in the round.

You then say there is an expectation that risk assessments are updated following each incident, but that this need not always occur due to, amongst other things, the number of incidents, staffing, and time constraints.

What impact did the failure to update risk assessments consistently have on the appropriateness of decision making in relation to observation levels?

A. Well, there's of course a need to update the risk assessment every time but I think the frequency of incidents, it simply wasn't possible. I think conversations would occur about risk and safety and decisions about observation levels, but those wouldn't necessarily be reflected within the risk assessment documentation.

I think the potential impact for that is that anybody looking at those documents is not necessarily going to have the most up-to-date and accurate

information regarding that patient.

Q. You mention the discussions might happen before the formalisation of it within a document?

A. Yes.

Q. Would there be scenarios where the discussion itself could be delayed because of the sorts of indications that you give here: staffing, time constraints the number of incidents?

A. Yes, yes.

Q. So if there was a delay to a discussion, a review, what sort of impact could that have on a patient?

A. That could potentially be quite significant.

Q. And the potential for that to transpire in practice, is that quite high?

A. Yes, I would say so.

Q. And so how was that mitigated or how can one mitigate that?

A. Could you repeat the question, sorry? Just so I can get my head around it.

Q. Of course. So if the predictability, shall we say, of not being able to have discussions post an incident that requires a review of observations to take place, if that discussion amongst clinicians can't happen quick enough and that there's that possibility of real harm arising to a patient and that possibility is very real in a ward

setting, what mitigations can be put in place on the ward to reduce any impact happening to a patient in the interim?

A. Certainly improve staffing levels. I don't know if that's -- that they aren't -- the angle you're looking for an answer, but I would say certainly, unless staffing levels are improved, that that will continue.

Q. Can you help us with what factors led to the reduction in observation levels? So, sorry, what factors lead to a reduction in observation levels?

A. It would depend on the observation level. So as I've explained, a patient is admitted, when they're admitted, they're on level 2, initially, and then they'd be reviewed by a doctor, a conversation about their observation levels, their presentation since they came in, a conversation with the patient. If it was deemed appropriate and safe at that time to reduce observations, then that would happen. Or if a patient needed to stay on level 2 for longer, then that would happen.

It was often quite difficult, when patients were on either level 4 or level 3, to make a decision about when was the right time to reduce those observation levels. Those discussions would usually be part of a team, and again, with the patient. But it was often quite

difficult.

Q. And so who would have the authority to reduce observation levels?

A. So I think for much of my career it would be the doctor. So a nurse would have to have -- a qualified nurse would have to have a conversation with the doctor. I do believe that subsequently changed but possibly only for a period of time, where a Band 6 or above could use their clinical judgement to reduce observations.

Q. You say -- and we can have a look at it, this is again page 39, paragraph 186 -- you say:

"Ideally [this is the second sentence] prior to a patient being discharged or taking leave, the patient would be on level 1 observations, to satisfy and support that they are consistently able to keep themselves safe over an assessed period."

In your view, what period of time should a patient remain on level 1 observations before they are considered safe for leave or discharge?

A. I think it should really depend on the patient and the observations from the team. I'll just re-read my paragraph.

I would say that in order for it to be safe, if a patient's been admitted, and they're taken down to level 1, I would say that a reasonable length of time

would be 48 to 72 hours before they took leave because I think what we like to see is that the patient is able to consistently keep themselves safe on the ward with that minimal observation from staff before they then go on leave. However, of course, informal patients do have the right to take leave sooner than that.

Q. And in your experience, how often was that period achieved in practice? Are you able to say?

A. On the assessment unit when I first joined, it was in the operational policy that once a patient was admitted, that they shouldn't take leave for at least 72 hours, I think. I believe that was the result of a previous incident that had occurred on the unit where a patient had only been on the ward a very short amount of time, I think it may have been around 24 hours, and they took leave and subsequently were harmed.

So, yes. I've lost my flow. I'm so sorry.

Q. That's all right. Would you like to take a break?

A. I can continue.

Q. That's fine. I was asking about the, you say sort of 48 to 72 hours is a time that you would like to observe a patient before they are then discharged or take leave, and you were explaining that following an incident concerning leave where a patient harmed -- came to harm, the policy operating on the PBU, I think you're talking

about --

A. That's correct, yeah.

Q. -- at the Peter Bruff Unit, that there was a policy, a Standard Operating Procedure, from your recollection it was about 72 hours --

A. Yes.

Q. -- they needed to be observed --

A. Yes.

Q. -- before that happened.

And are you able to say whether that was consistently applied?

A. In my experience yes, it was. It was adhered to quite strictly.

Q. You say that staffing constraints had a direct impact on the ability to deliver observations as prescribed, and in order to help you, let's have a look at page 40 of your statement, paragraph 192. First sentence there:

"Staffing constraints had a direct impact on the ability to deliver observations as prescribed."

Can you describe how staffing constraints impacted observations?

A. Yes. So each ward has its own establishment of staffing, so as an example, if a ward has six members of staff and, say two level 3 or 4 observations, that takes the staffing level down to four because you

automatically have two staff that are engaged in continuous observations. I think also one of the challenges is, particularly with the long days, you need to be able to accommodate staff breaks.

And if you have six staff on a long day, that's six hours of break you have to accommodate. So you would be down to five members of staff for the long day for six hours while you're accommodating breaks. It could be a real challenge. It could be a real challenge avoiding allocating staff back-to-back observations, making sure they got their breaks, staff being able to exchange observations, because you may be with one patient for an hour but then directly after that you're with another patient.

It could be really challenging.

Q. Did staffing constraints have an impact on whether observations were increased, especially outside of core hours or when direct ward management was not on site?

So did the staffing constraints have an impact on whether observations were increased?

A. Although I can't think of any specific incidents, I would say that would be a real possibility overnight, and, as you say, out of hours.

Q. In your experience, were staff routinely unable to deliver timely observations as a result of

understaffing?

A. I would say yes. I would say certainly with regards to level 2s and level 1s there would have been delays on occasions with getting around to completing the checks when they were due.

Q. At page 41 of your statement, paragraph 193, you say that:

"Overall, decisions relating to observation levels were ... clinically driven ..."

Were there circumstances where decisions were driven by staffing challenges instead of clinical need?

A. No. I think -- it's really difficult to say but I would say that staffing certainly had an influence. I think we would need to think very carefully about whether a patient did need level 3 or whether it could be managed in a least intrusive way. And I've written in my statement about mixed observation levels, trying to think about when there is an actual need for observations and if there is, maybe a time, a period of time in the day where that could potentially be reduced.

Q. So I wonder whether you can help us, then, with a scenario where you have a staff shortage for whatever reason, illness, let's say, for example, and the pressure's on the staffing, on the unit to cover the acuity, to cover observations in a situation where you

haven't got sufficient staffing numbers to make -- to meet the requirements of the observations. What do you do as somebody on the ward or managing the ward? How do you manage that without reducing or reviewing the observation levels?

A. Yeah.

Q. Can you help us?

A. So certainly in terms of if you find yourself on a shift and you haven't got your baseline staff or the number of staff that you need, and you have high observation levels, it can be really, really difficult. I think certainly as a Ward Manager and also as a Staff Nurse and Charge Nurse it would be incumbent on us, really, to ring round and try and see if we can get some staff from another ward, see if the site officer can support us, maybe make some phone calls to see if we can get staff to come in.

I think in the case of having level 3 and 4 observations already in place for patients, we certainly wouldn't be reducing observations just because we had a staffing challenge. But what that would mean is that, actually, those observation levels had to be honoured, but you would have far fewer staff to be able to do things with all of the other patients, and the general day-to-day running to the ward.

Q. Just help me understand a little bit more, for level 3 and 4, you wouldn't be reducing their observations.

A. (*Witness shook head*).

Q. So where would the extra staff come from in order to maintain their observations?

A. So if you have level 3 or level 4, those have to be allocated. Those have to be allocated at the beginning of a shift. So they would be honoured. But what would happen is you would have far fewer staff to do all the other day-to-day tasks, just as vital signs, supporting with mealtimes, supporting with leave risk assessments -- all the general day-to-day things would be on the shoulders of far fewer staff unless you could get additional help in from elsewhere.

Q. I see.

Sticking with observations, then, you describe -- this is at page 41 of your statement, paragraph 194 -- and also at 196. So you describe staff falling asleep when conducting level 3 observations. And you note that this is mostly with temporary staff, in your experience.

How frequently did you observe or were you made aware of this issue?

A. There was a period of time on the assessment unit, and I don't recall the dates, but where it was a frequent issue, I think it was at the same time that it was -- it

was a real hot topic across the Trust, actually. But certainly for a period of time on PBU, and again, I do not remember the dates, but it was a real problem, and I'd receive either reports from colleagues, patients, or I'd receive a Datix report to say that someone had been noted asleep on their level 3 observations.

Q. So there was a period of time. Can you help us with when that might have been?

A. I think it would have been in my earlier days on PBU. Certainly not straight away, but after I'd been there for some months.

Q. And you say here that on one occasion, this is at paragraph 195, concerns were bought to your attention sometimes patients have approached you directly to report staff sleeping, and that sometimes staff would have informed you, and that you would also receive Datix notification?

A. *(The witness nodded)*.

Q. Can I take from what you say there at paragraph 195, this was a common occurrence?

A. For a period of time it was a common occurrence, yes.

Q. And you say at 196 that you ensured that a Datix was raised and that Senior Management also became aware and that you would speak to the patient as well.

You say that it was an issue across the Trust for

a period of time. What was done as a result of that?

A. As far as I can recall, Matrons were tasked with overseeing sleeping-on-duty incidents. So they were tasked with having oversight of that.

I believe, as well, we introduced, certainly on our ward, and I think it might have been more broadly introduced across other areas, as well, a Fitness to Work book. So staff had to sign to say they were fit to be on duty at the beginning of their shift. Site officers were asked to complete spot checks and the Trust were also provided some guidance.

I think there was a sleeping on incident -- sorry, a sleeping-on-duty incident flowchart that was provided at some point with regards to steps to take if a member of staff was found asleep on duty.

Q. You may not be able to answer this, but do you think there's some correlation between instances of staff sleeping whilst undertaking observations and the length of shifts?

A. Yes, I do.

Q. Is it your understanding that shifts are 12 and a half hours?

A. Yes.

Q. And that's been the case throughout your career, has it?

A. No. So certainly, initially, when I started, for much

of my career, actually, it has been quite the opposite. We worked --staff, including myself, worked on early and late shifts.

Q. So how long were those shifts?

A. Seven and a half hours.

Q. Then it changed to 12 and a half. Can you remember when it was changed?

A. It was whilst I was on Ruby Ward. I believe it was maybe 2018, 2019.

Q. Do you think it's safe for staff to be working 12-and-a-half-hour shifts?

A. Not with the staffing levels and current working conditions, no.

Q. Returning to observations, did you observe healthcare assistants undertaking observations? Is that something that you would have done as part of your role?

A. I would have observed them undertaking observations. I don't think I had a formal way of doing that. It would have just been as I was going about my own duties.

Q. Did you ever observe inaccuracies in reporting, such as recording observations that had not taken place?

A. No.

Q. If you had, what would you have done?

A. I would have spoken to that member of staff and escalated.

Q. At page 38 of your statement, paragraph 183, you say that the process for decisions in relation to observations are outlined in the Engagement and Supportive Observation Procedure, and you have highlighted that there are some relevant policies.

How did the Trust monitor compliance?

A. Would you be able to repeat the question, please?

Q. Of course. So with regards to the Engagement and Supportive Observation procedures, do you know how the Trust monitored compliance with that policy? So for example, ensuring that observations were being undertaken as they ought to be?

A. I'm sure there will have been auditing procedures but I can't fully recall what those would have been now.

Q. So, sorry, there would have been auditing, did you say?

A. I'm sure there would have been but I can't fully recall what they are now.

Q. And that would have been -- you may not be able to remember and that's absolutely fine, but auditing by who?

A. By the Ward Manager or with the support of Charge Nurses. It was quite often the Ward Manager or the Charge Nurses that did auditing on the ward.

Q. Do you know, again, you may not be able to recall, but was there a formalised process for that? Would it be

part and parcel of when the audits would take place, the frequency of them?

A. I don't think I can answer that because I can't recall.

Q. Your overall view is that -- in your statement, is that Engagement and Supportive Observation was not adequate.

A. *(The witness nodded)*.

Q. And one of the reasons you give for this is the issue of staff falling asleep on level 3 observations. Let me take you to your statement, page 42, paragraph 201, and you give some reasons there as to why you say it's not adequate: staff falling asleep on level 3 observations, which we've already discussed.

And then (b) to (f), you go on to give some further explanation about why it is that you say they're inadequate. Can you summarise for us, really, what -- why you say that observations are not adequate.

A. I think, when you're in the situation, you don't necessarily see it, as you see it -- as I see it in front of me now, and from this vantage point. But I think when I look at the issues that I observed over a period of time, it can only be seen as inadequate.

Q. And for the reasons that you --

A. Yes.

Q. -- that you say here. So we've already talked about falling asleep.

If we have a look at (b), "Delays in meeting patient gender preferences."

You go on to say:

"Other issues [including] patients being kept on observations for prolonged periods [of time]."

(d) Documentation challenges for staff who were required to observe high numbers of patients.

Then (e):

"Reliance on temporary staff who were not always familiar with patients or Trust policies, and limitations in bank shift planning."

And then at (f), you go on to talk about the Peter Bruff Unit during the pandemic, the Covid-19 pandemic and Senior Management produced a system of logging cover for each site over several days to identify any shortfall in cover which was highlighted red on a staffing table, but I think essentially what you're saying there is that the impact of the pandemic on staffing levels --

A. Yes.

Q. I'd like to ask you about training. So training with regard to therapeutic engagement and supportive observations, this is page 48 of your statement, paragraph 223 to help orientate you.

You say here that:

"All inpatient qualified and unqualified staff are required to complete mandatory training on Therapeutic Engagement and Supportive Observations. The training is completed online every three years and addresses methodology as well as the importance of engaging and observing patients to reduce risk."

How did the training change over time?

A. This may be my recollection but I don't think I recall provision of training with regards to observation levels earlier in my career. That may be my recollection, but I think the Therapeutic and Engagement Supportive Observation training that is available now is fairly recent.

Q. How recent, can you say? Years? Months?

A. Years, years, yeah.

Q. Within the last decade or within the last --

A. Yes, I'd say so.

Q. -- five years?

A. Decade, I would say.

Q. You may have already answered this, but are staff ever observed while completing observations on their induction or at regular intervals for training and assurance purposes? Say you've got a new member of staff whose joined on the ward, is there any mechanism by -- or any formalised procedure that would have them

observed undertaking observations?

A. It may well be in the induction, but in reality, I have not seen that practised.

Q. You say "in reality". Can you explain what that reality is?

A. I think I've written elsewhere in my statement about induction and the length of that document, and the ability to be able to complete it. I think, in reality, what we often -- what I often saw is that induction was limited to an orientation, really, of the ward. The induction document would be started, but nine out of ten times, I would say that it wasn't fully completed.

Q. I'd like to ask you about Doris Smith. Doris Smith sadly died on the Ruby Ward in October 2020, and at page 43, paragraph 202, and it comes later, as well, in your statement, and you say that there was confusion around her observation levels. How might confusion in a patient's observation levels arise?

A. I think certainly in this case the written recommendations provided by the physiotherapist, it didn't use what I would consider to be universally recognised language in terms of whether it was level 1, 2, 3 or 4. But I do believe that subsequent clarification occurred and the physiotherapist confirmed that what they intended by that was level 3 when

mobilising and level 2 at all other times, which would -- that requires thought with regards to how those recommendations can be applied, given that they differ, depending on activity.

Q. And just help me understand, then, how that risk of confusion arising is mitigated. You say -- you made reference to standard language. Is that perhaps one aspect where situations like this can be avoided in the future --

A. Yes.

Q. -- using standard language?

A. Absolutely. I think staff need to use -- all staff need to use that universally recognised language around observation levels so there can be no scope for either interpretation or ambiguity.

Q. Are there any other ways that you have experience of or that you might have observed confusion arising in a patient's observation levels?

A. Sorry, could you repeat that?

Q. Are you aware of any other confusion in observation levels, situations that might give rise to confusion of observation levels?

A. Where a handover doesn't take place?

Q. And so at page 44 of your statement, paragraphs 205 and 206 you explain huddles were not well established --

A. They were not, no.

Q. -- at the time of Doris Smith's death.

What do you mean by "huddles"?

A. So in the next section just below I've gone on to explain what huddles were intended to be. So a huddle was intended to be a short gathering of the team on duty in order to discuss, not necessarily all patients, but those patients that were considered to be at a high risk on that shift. I think the problem with huddles was that, actually, there was never an opportunity for the whole team to be in a huddle, because the activity of the ward needed to still be completed and patients on the ward still needed to be cared for.

Q. And so what was the impact of huddles not being well established?

A. Significant.

Q. You say, you have no direct personal knowledge of any changes to observation practices on the Ruby Ward following Doris Smith's death, this is at page 11, paragraph 47 of your statement. Were you involved in the root cause analysis investigation as a witness?

A. I don't have a memory of it but I know I must have been because I can see that there are some responses -- some of my responses within the RCA, but I don't recall being involved. So it must have been limited.

Q. Did you receive any debrief following the root cause analysis?

A. I didn't, no. I'd moved on to a different unit by then, but no.

Q. And at the time of the root cause analysis investigation, the time that it was published, you were no longer a manager on the Ruby Ward; is that right?

A. That's correct.

Q. And by that time you had moved to the Peter Bruff Unit?

A. Yes.

Q. Do you expect that the learnings would have been shared with you, given the relevance to other wards?

A. Yes.

Q. Do you recall learning from other root cause analysis reports being communicated to you as a Ward Manager?

A. Not specifically from root cause analysis, but we did receive, as staff, we would receive alerts from the Trust. So that would be overall learning from incidents, but no, I don't recall receiving specifically with regards to root cause analysis.

Q. So the alerts that you would receive, would that be on the intranet?

A. It would be, yes.

MS MALHOTRA: Thank you very much, I think we're going to take a break now.

THE WITNESS: Thank you.

MS MALHOTRA: We'll come back at 2.15.

(1.22 pm)

(The Short Adjournment)

(2.17 pm)

MS MALHOTRA: I'd like to ask you next about Adam Steel. And at page 45, paragraph 213 of your witness statement you observe observation practices in the context of his death, including the fact that you issued reminders to staff of the need for face-to-face checks for level 1 and level 2 observations.

We can see that there, 213 of your statement.

So was that practice as a result of Adam's death or was that a practice that was done before?

A. That advice was given following Mr Steel's death.

Q. So:

"Staff were reminded at daily huddles and at the team meeting that they should reassure themselves, and document clearly on the observation record that they had observed the patient was breathing and exhibiting natural movement. Where breathing and natural movement could be seen properly through the vision panel on the bedroom door, this was acceptable."

A. Yes.

Q. "However where it was not possible to see the patients

through the vision panel or if there was any doubt about the signs of breathing, then staff were reminded that entry into the room to undertake the observation was expected, even where opening the door might rouse the patient."

A. Yes.

Q. What we've heard -- we've read there about observation panels. Can you explain, provide us with a bit of a -- perhaps I can summarise it in this way, that the vision panel we're talking about is a glazed window set within the door frame and in your statement you explain that the vision panels were fitted with a privacy blind that could only be lifted manually by a member of staff using a key allowing staff to observe a patient from the outside without needing to enter.

A. Yes.

Q. You say that following Adam's death you became aware of an issue affecting seven of the bedrooms, including Adam's room. Is it correct that mental health wards are typically designed to allow patient beds to be seen from the bedroom door?

A. Yes, certainly that was my experience throughout my whole career. I think prior to PBU I'd only ever worked on wards where the beds were directly in front of the vision panels.

Q. And that's a safety feature, is it?

A. Yes.

Q. And you explain that you raised the vision panel issue with your Matron; is that right?

A. I did.

Q. Who advised you to arrange a vision panel meeting?

A. Yes.

Q. And you say that you also asked the Matron to add the issue to the ward risks register and discussed interim mitigations with the Estate and the Risk team.

After identifying the issue with the vision panel, do you know whether it was escalated beyond ward level?

A. Yes, so I would have done that myself by organising the vision panel meeting. As I say, I spoke with my Matron, spoke with my Service Manager. I don't recall those conversations but I am clear that they did happen and they were conversations that I had certainly more than once.

Q. Were you ever informed why permanent remedial works were not implemented immediately?

A. Yes, so as part of the vision panel meeting it became clear that the Oxehealth cameras were directly aligned with the current position of the beds in at least seven of the bedrooms. So one reason would be that we couldn't simply move the beds because we needed to make

sure that they were aligned with the cameras. And another reason that did come up in the meeting, as well, were cost pressures.

Q. You say it was not possible for the layout of the majority of the rooms affected to be changed because of limitations in the physical environment, like you've just mentioned with the cameras, in addition to other adverse implications such as loss of the use of a busy, needed and functioning ward for a significant period, the cost, as you've said implications needed significant funding.

Was the lack of visibility of Mr Steel's bed from the door an issue that existed prior to the introduction of Oxevision on the ward? It may be that you can't help with that.

A. I don't know.

Q. Because you came to the Peter Bruff Unit after; is that right?

A. I did, yes. I did -- I don't know if it's helpful but I did previously work on the ward when it was an older adult ward so before the refurbishment, and as far as I can recall from my memories of working on that ward, all the beds at that time were directly situated in front of the vision panels.

Q. So it didn't use to be an issue?

A. No, as far as I can recall, no.

Q. And that was post-refurbishment?

A. Yes.

Q. Before --

A. Yes.

Q. Yes. And so you're not able to say whether it was as a result of the Oxevision installation that the bed changed, the position of the bed changed?

A. No. I didn't have any -- I don't have any awareness of the decisions around refurbishment.

Q. Okay, but certainly your experience is they used to be visible from the vision panel?

A. *(The witness nodded)*.

Q. And then later when you went back to be on the Peter Bruff Unit, it wasn't?

A. Yes.

Q. It may sound like an obvious question but I'm going to ask it anyway, what impact did beds being out of view have on the way in which staff conducted observations? Did it, for example, increase their reliance on Oxevision?

A. I would say it did, yes.

If I can expand, I think one of the reasons that that might have been the case, which I have touched upon in my statement, is that the doors were very heavy, they

were very noisy and we did have patients from time to time approaching us saying that that was really disturbing their sleep.

Q. And so was there anything or, as far as you're aware, were there any discussions about making changes to the doors so that they weren't so heavy, if that was an issue?

A. I don't recall that, no.

Q. You say that the Peter Bruff Unit, in your statement, this is page 22, paragraph 96, that the Peter Bruff Unit presented a more significant set of environmental challenges. Can you describe what those challenges were?

A. It was -- so PBU, the assessment unit, was a mixed-sex environment. We did have a swing zone, which I've referred to in my statement. I believe that the reason for the swing zone was so that we could swing the beds to either male or female, depending on demand.

Q. And you say that that was a concern, the fact that it was a mixed-sex area in the Peter Bruff Unit caused you concern and that you would allocate a nurse to the area to monitor it as well. We can see that at paragraph 96 where you talk about the swing zone.

A. Yes.

Q. How frequently did admission into mixed-sex areas occur?

A. I'm not sure I can say with any precision how frequently it occurred, but while I was there it certainly occurred on several occasions.

Q. Several occasions?

A. Yeah.

Q. If you were to try to put a number to it, could you say five times, ten times, 20 times, or you can't say?

A. I'd be greatly speculating. I'm not sure I can say.

Q. Can you explain with a bit more detail what the actual concerns were in that regard?

A. So the swing area was intended to be for either male or female. In terms of sexual safety, patients are supposed to have environments that are single sex so they can access facilities, bathrooms, toilets, et cetera, without having to walk past a room of someone of the opposite sex. Certainly the swing zone on PBU, although it had three bedrooms, the communal area outside was incredibly small, so we wouldn't have been able to achieve that, but how we mitigated it was to place a member of staff in the swing zone and we would allocate that as an observation, so that a member of staff wouldn't be in there for hours on end. It should be shared.

Q. Was having an allocated nurse always possible or did the staffing pressures affect responses?

A. As far as I can recall, we had managed to achieve that.

Q. And did you raise with more senior staff your concerns about the use of mixed-sex spaces and if so, what was the response?

A. Yes, I'm sure I will have had conversations with my Matron and I'm sure I would have raised concerns with Bed Management as well, but I can't remember a response.

Q. I'd like to ask you next about the environment on the Ruby Ward. You describe several times in your statement, let's look at page 17, it goes to page 17 and 18, paragraph 72 to 77, and then at 79 as well, and at page 19.

But essentially, the Ruby Ward is an older adult ward, as you've explained to us before, and that it cared for patients who were frail, elderly, and who presented with complex physical and mental health comorbidities.

You explain that overall, the environment was spacious and well equipped for physical health needs and that consideration was given to handrails in communal areas and corridors. You explain that, however, a decision was subsequently taken to remove handrails from en suite bathrooms in patient bedrooms and that this was an error in decision making.

To help you, that's page 19, paragraph 83.

Then you say that falls risks were discussed at local falls meetings and that Datix incident report system would have been an available system through which concerns about the handrail removal could have been recorded, and that's page 20 and 21, paragraphs 90 to 91.

You may not be able to help us with this, but what was the rationale for the removal of the handrails?

A. I don't recall being consulted about this decision. My first memory of handrails being removed was coming across the -- a membership of the Estates team who was doing it on the ward at the time. As I've said, I believe it went through the Ligature Risk Reduction Group to mitigate against the risk of ligature in those toilet spaces. That's my understanding.

Q. And you weren't part of that group?

A. No.

Q. Was the risk of increase in falls acknowledged? Or presumably you don't know; you weren't part of those discussions?

A. No, I'm not able to say.

Q. Can you recall any response to your concerns or any action being taken as a result of your concerns about the handrails being removed?

A. No, I do not.

Q. You don't recall a response or there was no response?
A. I don't recall a response. I can't be certain that I escalated it via the Datix system, but I don't recall a response, no.
Q. You say you cannot recall whether any specific adaptation was made to the ligature risk inspection process for older adult wards to account for the interaction between the ligature risk and the falls risk. That's at page 20, paragraph 85, of your statement.

You also explain that the Ruby Ward functional ward operational policy did not contain specific guidance on managing the interaction between ligature risk and falls risk for older adult inpatients. That's at paragraph 87, there. And that you cannot recall a process by which ligature risk and falls risks were considered together. And that's at paragraph 89.

Do you have any views as to how the balance between falls risks and ligature risks might be struck?
A. On functional wards, I would consider that the ligature risk inspections need to be completed alongside a falls risk inspection, so looking at it through that dual lens with people with the relevant specialisms conducting those inspections.
Q. You may not be able to recall, but did you raise the

issues of the interaction between ligature risk and falls risk, including guidance or the lack thereof, at the environmental ligature risk inspections coordinated by the Risk team?

A. I don't recall. I may have done but I don't recall with any certainty.

Q. You explain that older adult wards have assisted technology in patient bed spaces, and in particular in the early 2000s and 2010s, this is page 16, paragraph 70, sensor mats became available. These were secured under a patient's mattress and would alert staff to movement in the bed?

Then you explain at page 17, paragraph 71:

"The effectiveness of assisted technology in reducing falls risk was dependent on the correct activation by staff ..."

In the role of Ward Manager, did you have the authority to determine whether the falls sensor in a patient's room would be turned on or off?

A. No, not as far as I recall, no.

Q. In relation to the case of Doris Smith you explain that following her fall overnight on 8 and 9 October, this is at page 10, paragraph 39, you surmised that the assistive technology in her bed space had not been activated?

A. Yes.

Q. Can you recall that? Why would the assistive technology not have been activated?

A. It would have been required to have been activated once the patient was asleep in bed so I can only assume that there was inadequate communication about the fact that that needed to be activated at that time.

Q. I see. So would it be the case that the staff member would have to specifically turn it on?

A. That's right, they'd have to turn it on once the patient was settled into bed, yeah.

Q. Following a patient's admission, what factors lead to the determination that assistive technology should be activated?

A. So on Ruby Ward we had between four and six high-falls risk rooms so they weren't -- the technology, as far as I can recall, wasn't available in each of the bedrooms, so whether or not a patient was allocated one of those rooms would be dependent on their risk assessment and our judgement of their mobility. And it may well be not necessarily straight away on admission, but the physiotherapist may suggest that that room would be suitable for a patient as well.

Q. So that would be on admission, would it?

A. Yes, not -- the physiotherapist wouldn't necessarily be

available on admission, but the nursing staff would be able to determine whether or not a patient would require a high-falls room.

Q. Would notifying family members of whether assistive technology had been turned on or not be something that fell within the duty of candour and that would be reported to family? Can you help with that at all?

A. It should have been, but I can't say that that was consistently done, no, but it should have been.

Q. Do you know if that is consistently done now, or you're slightly further removed from the patient side?

A. Yes, I'd say I'm too far removed from that to know.

Q. To what extent did the Peter Bruff Unit and the Ruby Ward have characteristics that encourage good therapeutic -- a good therapeutic environment?

A. Ruby Ward I remember was -- I would consider it to be highly therapeutic. It was spacious, there were lots of different areas that patients could choose to use. There was a large activity area just off of the communal space. High ceilings. There was lots of natural light that came in. The bedrooms were large. As far as I can recall, all of the beds were positioned suitably to the vision panels from outside of the rooms. They all had en suites. Each of the bedrooms, as far as I could recall, had a good view of the garden. Yes, I would say

that Ruby Ward was highly therapeutic.

Q. Your overall conclusion on the Peter Bruff Unit is that it was not fit for purpose.

A. That's correct.

Q. Approximately when did you reach that conclusion?

A. While I was there. So no significant funds ever seemed to make their way to the assessment unit, which I think I've referred to in my statement. The environment was small, the corridors could be quite dark. There was no -- there was limited natural light into those areas. There was large communal space which was a dining room and lounge, which was adjacent to the garden, but in terms of private spaces, patients either had their bedrooms or they had a quiet room, or a female lounge. And those areas would double up quite often as consultation rooms because, aside from the visitors' room which was just off of the ward, just outside of the ward, there really were no spaces to consult with patients.

Q. And can you recall whether you raised any concerns about the Peter Bruff Unit, including to senior leaders, whilst you were in that role within the Peter Bruff Unit?

A. Yes, I would. I would speak to my Matron, speak to the Estates Team when they visited, certainly with regards

to upkeep and redecoration. I remember a time, I can't remember exactly when, but we were promised funds. We were given the impression that we -- that the assessment unit itself would be receiving significant funds for some refurbishment. But those funds, they never came. The only significant changes that occurred while I was on Peter Bruff Unit was really a lick of paint, repair to any damage that occurred, and the murals that I was able to gain funds for, and the beverage bay.

Q. I'd like to ask you next about investigations and investigations that you may have been involved in.

Can you tell us what types of investigations you were involved in?

A. I believe, from the point of becoming a Charge Nurse, I gained experience of completing root cause analysis investigations. As far as I recall, that was largely in relation to falls incidents. My first experience of an investigation into death by suicide was when I was an Acting Matron.

Q. How were investigators allocated cases?

A. I can only speak of my experience. My Matron approached me and asked me to complete the investigation. I did express some initial concern, having not done one before, and also not having sufficient experience of the service that was going to be investigated.

Q. Was that process that you've just described, was that effective? Did it result in appropriate investigators being selected, in your view?

A. No.

Q. At page 80 of your statement, paragraph 372, you address here your involvement in the Patient Safety Incident Response Framework, PSIRF, investigation.

You say here you had to conduct an investigation without any training -- this is at paragraph 374 -- which you found extremely challenging. And this was in respect of Christopher Nichols.

A. Yes.

Q. You say it was after the inquest process that you realised you should have pushed back on conducting the investigation and that you felt you had let the family down and you refer to this at page 80, paragraph 377.

A. Yes, I did.

Q. You also refer to being given the impression, when you spoke to your line manager before taking on the task, that you had to take it on because it fell within your duties as an Acting Matron, and that's at 375.

Did you consider that a PSIRF investigation was within your job description?

A. I was an Acting Matron at the time. I think I felt that it was something that I was certainly expected to do and

that it would be within my capabilities, but I did have concerns about completing it. But I certainly went about it the best I could at the time.

Q. Do you consider you should have been allocated to complete the investigation into Christopher Nichols, given your limited experience of conducting pre-hospital assessments and investigations?

A. I don't think it was appropriate for me to be allocated that investigation, no.

Q. Did you raise any -- you say that you raised a concern with your line manager?

A. Yes.

Q. But there was, by the sounds of it, you were told that it was within your duties and you needed to do it?

A. I think that was certainly the message that I received, yes.

Q. Did you receive any guidance from more experienced staff, or anyone else that you could reach to for support?

A. No, I went about completing the investigation. I referred to national guidance at the time, in terms of assessment of suicide, so I felt that I'd given it due diligence and that the recommendations were valuable, but -- and I did ask for some -- so when I completed my draft, I did ask for some feedback. I emailed it to my

line manager and asked for some feedback. But I didn't get any feedback. And it got to the point of deadline, and I needed to submit it, and the only feedback that I received, as far as I can recall from the Patient Safety Team, was with regards to layout. A few minor changes. That was the extent of the guidance I received.

Q. Were you given protected time to complete that review?

A. I may have been given some protected time but it would have been limited and I do remember doing some of it in my own time as well.

Q. And is training now available?

A. I believe it is. I have seen emails circulated.

Q. And have you undertaken that training?

A. I haven't, no.

Q. Were you aware of the extent to which the other staff are trained and supportive to conduct PSIRF investigations?

A. No, I'm not.

Q. Were you given any guidance or direction as to the involvement of families in PSIRF investigations?

A. I can't recall with any certainty but I think my understanding at the time, and certainly now, is that the Family Liaison Officer links in with the family.

Q. So it's not something that you, as -- that you would directly do, but there would be a Family Liaison Officer

that would?

A. Yes, that's my understanding, yeah.

Q. Are you aware of any steps taken to ensure that families are involved in investigations?

A. So Mr Nichols' investigation was the last -- the first and the last PSIRF I completed. I'm not sure I can comment on that.

Q. I want to ask you about Doris Smith's investigation. We've touched upon it before, and you've explained that your recollection is that your involvement was extremely limited, and that as Ward Manager, you would have expected to be a sort of central figure in any investigation?

A. *(The witness nodded)*.

Q. As far as you're aware was that a common occurrence where significant individuals aren't involved in an investigation?

A. I think I can only comment on my experience. I'm not sure how widely that's a problem.

Q. It's not something that you've heard happening to others, for example?

A. No.

Q. Okay. Have you, to this day, ever been given any explanation as to why you didn't have a greater involvement in the investigation?

A. No.

Q. You explain, and this is, to give you the context for your witness statement, page 82, paragraph 387. You explain that:

"The Duty of Candour obligation to be open and transparent ... with families when something has gone wrong, was understood in principle but not always applied consistently or promptly by all staff."

Was that a cultural issue within the Trust?

A. From my experience it was due to time constraints, possibly a lack of staff skill. I'm not sure if I can speak more broadly about whether or not it was a cultural issue across the Trust.

Q. You say at page 62, paragraph 285 of your statement, that:

"The Learning Lessons Team disseminate learning from investigations via the Trust intranet newsletter shared by email and governance processes. The effectiveness of this dissemination to frontline staff was limited and I would say remains limited. Frontline staff are time-pressured, email communications are and were voluminous and cannot always be read thoroughly or digested, and team meetings did not always provide sufficient time or opportunity for meaningful reflection and embedding of learning."

And we touched upon this earlier.

Do these observations also apply to documents such as action plans, which are created in response to findings?

A. Yes, I would say that they do.

Q. Do you know how widespread this issue is? Is it across the whole Trust or is it particular teams?

A. I think I can only speak to my -- the teams that I worked, in or been aware of.

Q. Are you able to say whether any steps have been taken to identify whether it's a wider issue?

A. No, I'm not aware of any steps.

Q. And beyond intranet updates, newsletters and emails, what system is in place to ensure staff are told when there is a learning which is relevant to their role?

A. I'm not aware of any process other than what I've spoken about in my statement. And I think there is over-reliance on Ward Managers to communicate those messages to their staff and the teams, but the reality of being able hold protected, undisturbed team meetings is -- that's extremely limited.

Q. Whose responsibility is it to implement learning and who monitors whether it happens?

A. I would say that the Matrons, Ward Managers, have a responsibility for their local areas. But certainly

individual staff have a responsibility themselves, as well.

Q. You say that your suggestions for improvement include better support for the Ward Manager --

A. Yes.

Q. -- in leading, learning and the provision of protected time.

In your role as a Professional Nurse Educator, have you endeavoured to advance these proposals or is that outside of your remit?

A. So certainly myself and my colleagues, we do work very closely with our Matrons and our Ward Managers so that we can try and support them in that role, lead in certain things, for example, as I said earlier, we've done quite a bit around NEWS2, care planning. So yes, certainly the PNE role is really important with regards to supporting learning.

Q. What has been the Trust's response to you trying to promote, as it were, protected time and engaging staff with learning?

A. I think we have limited direction at the moment as PNEs. I think we do have quite a bit of autonomy -- sorry, can you repeat the question --

Q. Yes, I'm just wondering if there's been a response by the Trust or Senior Leadership within the Trust to

support giving staff protected time and to sort of embed the learning, the sorts of issues that we've just been discussing?

A. I mean, I think the Trust can see value in the Professional Nurse Educator role. But I haven't seen any changes with regards to staff having access to increased protected time, no.

Q. I'd like to ask you next about the case of Bethany Lilley.

A. Yes.

Q. This is one of the cases that the Inquiry is investigating. Bethany died on 16 January 2019 on Thorpe Ward following a transfer from the Peter Bruff Unit. She had periods of admission on the Peter Bruff Unit between 2016 and 2019. And the root cause analysis investigation following Bethany's death identified various failings, including in relation to transfer between wards, safeguarding, and observations.

Thurrock Clinical Commissioning Group also commissioned an independent investigation into Bethany's death. An inquest, there was an inquest with a jury that returned a conclusion of neglect in relation to the circumstances of Bethany's death, and identified contributory failings, including the handover by the Peter Bruff Unit to the Thorpe Ward in care planning and

risk assessment.

At the time that you worked on the Peter Bruff Ward, which was November 2020, were you made aware, or told about, the findings of the root cause analysis or the Thurrock Clinical Commissioning Group or the jury findings from Bethany's inquest?

A. I don't remember receiving that much detail about it, but I do remember that my Matron mentioned the patient and a particular learning around her transfer and handover of observations. And following on from the RCA, I believe one of the actions was that Peter Bruff Unit and Thorpe Ward would have an interface meeting, I think it was once a month, and that would give them the opportunity to talk about whether or not there'd been any issues with transfers.

I attended those meetings once I was on PBU and they were still -- they were still scheduled when I left PBU, as well. I believe that's something that continues. As far as I can recall, that is the only point that I'm aware of.

Q. So that was the only point that you were made aware of?

A. As far as I can recall, yes.

Q. One of the recommendations in the root cause analysis was that there should be regular audits of observation charts to ensure compliance with Trust policy. Can you

recall if that occurred whilst you were working on the Peter Bruff Unit?

A. I can't actually recall the audit process for observations when I was on PBU. I think, during my time there, there were audits on the Perfect Ward Tendable platform.

Q. Can you just explain what that is?

A. Perfect Ward is a platform where nursing staff can complete their audits and then those results pulled through to a central dashboard so that the Trust is able to see what the compliance with those audits is like.

Q. So aside from that?

A. I can't remember the process for auditing of observations when I first started on PBU, no.

Q. When you started, what about towards the time that -- did it change at all, in the time that you were there from when you started to when you left, the auditing process?

A. Yes, as I say, I believe there was an observations audit on the Perfect Ward Tendable platform.

Q. I see, sorry, and that came later.

A. That came later, yes.

Q. When did that come?

A. Gosh, I think it may have been at some point in 2021. I can't be certain, though.

Q. Was that something that you initiated?
A. No. So the Perfect Ward is something that -- sorry, the Perfect Ward Tendable platform is something that all wards use now to do their audits.
Q. Are you familiar with how that audit process works?
A. In terms of the observation records, I can't now remember.
Q. There were safeguarding issues that were identified in Bethany Lilley's case including she may have been intimidated and receiving illicit drugs from patients. To what extent was action being taken to ensure that staff on the Peter Bruff Unit identified, recorded and referred safeguarding concerns?
A. Can you repeat the question, please?
Q. Yes, so when you were on the Peter Bruff Unit --
A. Yes.
Q. -- can you help us with what action was being taken to refer any safeguarding concerns?
A. I believe we did refer safeguarding concerns as and when they arose. It would be incumbent upon us to identify those issues in the first instance and then discuss them as a team and complete the referrals.
Q. And where would they be recorded?
A. So initially they were on part of a paper document that we would then scan on to the Paris system. And then

I think more recently, those safeguarding forms are within -- they're at -- the templates are actually within Paris.

Q. So would that be the individual staff member's responsibility to identify any issues arising?

A. It would be incumbent upon all staff, if they identified anything or had any concerns, then they would need to highlight that to the MDT so that we could decide what we wanted to do, and then a qualified member of staff would raise the safeguarding form.

Q. I see. So it would be for the individual member of staff within the multidisciplinary team --

A. Yes.

Q. -- and then for that discussion to take place and then escalation --

A. Yes.

Q. -- if required. And who would that be escalated to?

A. So we would complete the safeguarding forms, we would usually consult with the Safeguarding Team. That's -- and usually complete a Datix, as well.

Q. Was the Peter Bruff safeguarding training records audited, do you know?

A. So all mandatory training at my point of starting on PBU was all on Mandatory Training Tracker. I, As a Ward Manager, would have a responsibility to check compliance

with regards to each e-learning topic for staff. I don't think I completed an audit as such, but I would regularly check the trackers and then as part of supervision, if there was something outstanding for a member of staff, including the safeguarding training, I would flag that with them to make sure that they booked that as soon as they were able.

Q. Would you then check that it had been booked and that they had undertaken it or would you trust that once you had raised it, it would be done.

A. I think there was a degree of trust, if you've asked someone to do something, but certainly in the next supervision, that would be something that would be checked: "Have you booked that?"

Q. So safeguarding would be a mandatory training?

A. Yes.

Q. Were there reflections on lessons learned in debrief meetings on the Peter Bruff Unit?

A. In team meetings there was, yes.

Q. In team meetings.

A. Yes.

Q. The root cause analysis investigation also recommended that the Ward Manager and the Consultant Psychiatrist should ensure that the agreed plan of care has been followed and that staff are documenting whether

one-to-one has been offered or taken place and this should be reviewed during multidisciplinary team discussions. Did that occur on the Peter Bruff Unit when you were there?

A. No, it did not.

Q. A number of recommendations were made in relation to transferring patients between wards, including a risk assessment and transport form should be completed prior to every transfer. All emails sent with regards to the transfer of patients are to have a subject line, patient's name, date of birth, National Health Service number, from where they were being transferred to -- from and to, and the Ward Manager or security lead should carry out regular audits to ensure inventories are completed on admission to the ward. Staff should be provided with further training on the Trust discharge and transfer guidelines.

Can you help us with whether that happened on the Peter Bruff Unit when you joined?

A. I was aware of the requirement to complete the transfer form and risk assessment prior to the patient leaving the ward. I don't remember the rest -- I don't recall the rest of the detail that you've mentioned there, though.

Q. And do you recall being offered further training on the

Trust's discharge and transfer guidelines?

A. No, I don't recall that.

Q. I'd like to turn next to another topic, clinical assessments. You describe your experience of clinical assessments, you say primarily from the ward receiving patients?

A. Yes.

Q. And you explain that pre-admission assessments were primarily the responsibility of the Community Mental Health Teams and the Bed Management Teams.

This is page 4, paragraph 14 of your statement.

You explain that the inpatient teams would receive assessments from the community teams. Were there issues with the accuracy and completeness of the assessment undertaken by community and crisis teams, in your experience?

A. I don't recall issues with accuracy or completeness. I think the most prominent issue that I can recall is when we received patients from out of area, so where the majority of their records might sit on Mobius. I didn't have access to the Mobius system and many of my team didn't either. The ward clerk did, I believe, and how we would overcome that would be to request copies of those assessments from the Bed Management Team. That's the most prominent issue I recall.

Q. And the Bed Management Team, was that a clinical team or a mix?

A. I think it is a clinical -- a more clinical team now. I'm not sure how the team is made up, though, in its entirety.

Q. Okay. But they would have access?

A. As far as I'm aware. Either that, or they would request copies from the ward themselves, and then would be able to relay them on to us.

Q. Did inpatient teams provide any feedback? So did your teams, for example, provide any feedback about quality or reliability of Community and Crisis Team assessments?

A. Not that I can recall, no.

Q. If there was an issue that you saw, is there a mechanism for you to provide feedback?

A. Had there have been an issue, I would have probably spoken to my Matron about that so he could speak to his equivalent for that service.

Q. You've already spoken about the differences in recordkeeping systems, the Paris system was used in the North --

A. Yes.

Q. -- whilst the Mobius system was used in the South. Did the existence of these different electronic systems create delays or gaps in risk information reaching

inpatient staff?

A. I would certainly say it made it more complicated. And occasionally, patients would be admitted to us with -- at relatively short notice, and although on few occasions we would occasionally receive an admission that -- where we hadn't had a handover from that team, I think that may have been a result of communication, possibly transport issues, I don't know.

Q. Were there any electronic records which enabled risk information to be accessed quickly and at a glance, aside from the Mobius system?

A. Not that I recall, no.

Q. It would just be the Mobius system?

A. It would be Paris or Mobius, yeah.

Q. At page 4, paragraph 15 of your statement, you explain that on admission to the ward, nursing staff use a range of assessment tools, including risk assessment, falls assessments, and neurological observations.

Are you aware of a risk stratification system that was used?

A. No, I don't think I was.

Q. A Mobius risk stratification system, that doesn't sound familiar to you?

A. It doesn't, no.

Q. And you explain that the timing of admission assessments

was governed by Trust policy but in practice the pressures of admission and staffing levels at night impacted the timing of assessments.

This is paragraph 15, there.

Are you aware of any incidents where delayed admission assessments contributed to patient harm, deterioration, or missed risk identification?

A. Not that I can recall but that may be -- that's based on my recollection alone.

Q. Did the Trust recognise delayed nighttime assessment as a breach of expected standards?

A. So in terms of the assessments, certainly more recently, we have a dashboard, the Trust has a dashboard. So they are able to monitor if assessments are being completed on time and whether or not they are breached. I don't know -- I'm not sure if that answers your question.

Q. You explain that risk assessments were expected to be completed within four hours --

A. Yes.

Q. -- and that falls assessments were conducted on admission using the Paris assessment. Would you accept that some of those assessments were sometimes delayed?

A. Yes.

Q. I think -- well, perhaps, if you can summarise for us what are the reasons for those delays, which might

include delays of over a week.

A. Communication issues, staffing levels, frequency of incidents. Again, I don't think the long day rotation helps because it interrupts with consistency of care. So you might have a member of staff that's on for two or three days in a row and then they're not on again for another four or five days.

Q. Is that because the 12-and-a-half-hour shift you would work, is it three shifts?

A. Not necessarily. So you would, certainly in my experience, you'd never work more than three long days in a row. That was not advisable. But yes, you'd need a block of time off in between shifts.

Q. I see.

What influence did you have in your role as Ward Manager, for example, on the timely completion of assessments?

A. Well, influence from the point of view that I would have completed a recordkeeping audit, and I would have seen what was outstanding, been able to email the team and the named nurses, remind the staff in team meetings that the assessments need to be completed on time. So I guess, in terms of promoting standards, that would be my influence.

Q. So you say recordkeeping, you would check. Is that for

every patient?

A. I think at one time it was for every patient. I think progressively, though, one would pick a group of patients so you wouldn't necessarily be looking at all records.

Q. And would a patient's family be informed if there was a delay in an assessment being undertaken?

A. Not in my experience, no.

Q. And what about the duty of candour, how does that sit with that?

A. Yes, they should be informed. Absolutely.

Q. So aside from you undertaking that sort of record check, how else would a clinical team become aware of the fact that an assessment that was required hadn't been completed?

A. I'm not sure I can answer that. Obviously we would allocate named nurses on admission. So a named nurse would have responsibility for ensuring that the caseload was up to date and if anything was -- had been delayed or was overdue, then they had a responsibility themselves, as well.

Q. You explain that falls risk assessments were completed by nursing staff. You say this at page 45, paragraph 209. Are there circumstances in which a falls risk assessment is completed by other members of staff,

so for example, a healthcare assistant?

A. I am aware of occasions where falls risk assessments have been completed by other staff, yes. Healthcare assistants or nursing associates.

Q. Should that happen?

A. No. No, it should be a registered nurse.

Q. And what reasons might there be for an assessment to be undertaken by a nursing associate or a healthcare assistant and not a nurse?

A. I don't know. I don't think I can answer that.

Q. Was it your responsibility, as a Ward Manager, to ensure that nursing staff and healthcare assistants working on wards followed Trust policies, including those relating to falls risk assessments and post-fall protocols?

A. Yes, I would have had a responsibility. That would have falled (sic) within my job description.

Q. How do you do that in practice without supervising every action?

A. It would be incredibly difficult to enforce.

Q. What about conducting audits?

A. Yes, so I would conduct audits myself or I would allocate them to my Charge Nurses to complete those.

Q. What about supervision?

A. And supervisions, yes.

Q. Shadowing? Is that something that happened?

A. Shadowing in the sense of completing assessments?

Q. Yeah.

A. For newer members of staff, yes, they would be supported with that.

Q. In your view, were staff adequately trained to follow Trust protocols? So were they adequately trained on what the protocols were?

A. No. I think that quite often with regards to policies, again, I think -- obviously there's a responsibility for each member of staff to familiarise themselves with those but it's the time that they're able to do that. There's no protected time. They may see a policy, they may be able to read it, but I wouldn't say that they had protected time to be able to read, digest, and certainly probably limited opportunity to revisit, looking at those as well.

MS MALHOTRA: Thank you. I think now is a good moment to take a break.

(3.16 pm)

(A short break)

(3.31 pm)

MS MALHOTRA: I'd like to ask you next about adequacy of assessments, and at page 6, paragraph 25 of your statement, you say that the overall design of assessment processes was appropriate, but that the adequacy of

assessments in practice was inconsistent and several recurring concerns affected the quality of assessments throughout the period.

Was this throughout the period that you were working on the Ruby Ward and the Peter Bruff Unit, or there particular periods during which the quality of assessments was poor?

A. I believe that, certainly on PBU, with regards to the issue I mentioned with regards to Mobius, that was an issue there. I don't remember that being such an issue on Ruby Ward.

Q. One of the reasons you give for the adequacy of assessments being inconsistent is the variable quality of information that was arriving, as you say, the issues with Mobius that we've already discussed. To what extent was this recognised as a risk to patient safety?

A. I'm not sure it was adequately.

Q. Were these issues escalated to Board or executive level, would you know?

A. I don't know.

Q. You note that the quick turnover of patient admissions, this is at page 7, paragraph 27, the quick turnover of patient day admissions increased staff workload and impacted patients' next of kin experience of admissions. What impact did this quick turnover have on assessments

and information gathering?

A. I would say it would have a significant impact. As I've explained in my statement, we could have several admissions in quite a short period of time. We would really try to work with Bed Management to try to stagger those admissions but I think several factors influenced whether that was possible, transport arrangements, but certainly on PBU, when that did occur, that was incredibly challenging to manage.

Q. What impact did it have on immediate patient safety at admission, and on early discharge planning at the point of admission?

A. Could you repeat that, please?

Q. Yes, so what impact did that quick turnover have on the immediate patient safety?

A. Certainly with patients arriving in quick succession to one another, they would have really limited time with nursing staff. Yes. They'd have incredibly limited time, and engagement is really important for us to develop a rapport with the patient and try and understand their needs on admission.

Q. Would that, in turn, impact on the quality of the assessment?

A. Yes, I would say that it did.

Q. You say that on occasion, this is page 10, paragraph 38

of your statement, you say that on occasion, the delivery of assessments fell significantly below the standard required.

That's the last sentence in paragraph 38 there. Could you give an example of when assessments fell significantly below the required standard?

A. I would say in the case of Doris Smith that we have just below there.

Q. How were the issues with assessments identified?

So the sorts of inadequacies that we've talked about with Mobius, for example, or staffing pressures impacting -- or the high turnover, how were those issues identified so that action could be taken to mitigate them?

A. I'm not sure that they were identified.

Q. Did you yourself, or are you aware of anyone else, raising concerns higher up the chain to management?

A. No, I'm not.

Q. Given your evidence on the inadequacies of the assessment process, would it be fair to say that overall, you consider the assessment process was safe in theory but not reliably safe in operation?

A. Yes.

Q. I'd like to ask you next about admissions. You say, and this is page 12, paragraph 53, that:

"Admission decision making was not consistently adequate and that the process was heavily influenced by bed capacity constraints and systemic pressures, rather than being driven by purely clinical need."

You explain that:

"Bed capacity pressure was a significant and persistent feature of both the Ruby Ward and the Peter Bruff Unit."

Can you elaborate on how these constraints and systemic pressures impacted the admission process?

A. Well, I think I've spoken to one example already. Certainly on PBU, when patients would arrive in quick succession, it would be very difficult, very challenging, to complete all of their required documentation in time, give the patients time, and certainly be able to reach out to families, and make that initial contact.

Q. You say that the pressures were more pronounced on the Peter Bruff Unit than older adult wards?

A. Yes.

Q. This is at page 13, paragraph 54. We're already there.

Why were the pressures more pronounced on the Peter Bruff Unit?

A. So the assessment unit, it's an assessment unit. So the turnover would be much higher. The assessment unit was

intended to be a short-stay assessment unit, and so the turnover of patients would be much more frequent than that of Ruby Ward.

Q. And as far as you're aware, did the Trust ever formally assess whether sustained bed pressures were impacting patient safety, timeliness of admission or outcomes for patients waiting in the community?

A. Not that I'm aware of, no.

Q. And in your experience, were patients who required repeated admissions or frequent support ever viewed as placing pressure on services?

A. I would say that on reflection, we did have patients that would re-present quite frequently and I think that staff, and as a team, we could have some preconceived ideas about how those admissions may be challenging. So we weren't necessarily seeing individual patients through a fresh lens.

Q. So how would not seeing a patient through a fresh lens impact on decisions about admitting them, for example?

A. So with regards to patients that frequently presented, occasionally our consultant would ask us to push back to Bed Management and would query why a patient perhaps needed an assessment so close to a previous assessment and how effective that assessment might be.

Sorry, I've lost track of your question.

Q. No, let me ask you this: were there any formal or informal processes for identifying or reviewing such patients? So the example that you've given is the doctor might ask you to push back on --

A. *(The witness nodded)*.

Q. -- to the bed capacity team for sort of repeat, frequent attenders. Was there a formal or an informal process for identifying or reviewing those patients as a group? For example, multidisciplinary or cross-agency discussions?

A. I am aware of a meeting, I'm trying to remember what it was called, I'm not sure how frequently it occurred but it was called High Intensity User Group. I don't think I attended that regularly at all.

Q. Were you aware of any approaches or strategies aimed at reducing admissions among patients with repeated crises, for example behaviour contracts?

A. I may have been at the time, but I am unable to recall now.

Q. Were you aware of any situations where access to certain interventions, admissions, or crisis responses was limited or modified in response to a pattern of repeated behavioural presentations?

A. No, not that I can recall.

Q. Were you aware of any Trust policies or practices

between 2018 and 2021 that facilitated a working relationship with the police which had the effect of managing what might be considered high use or frequent access to inpatient services?

A. Within the community?

Q. Within Trust policies.

A. Within Trust policies, um no.

Q. And you say bed pressures meant that admission decision making was not consistently adequate and you say that a system that is consistently under bed pressure cannot reliably make admission decisions that are in the best clinical interests of patients. You later explain the process -- this is in your statement, page 12 to 13, paragraph 53. And then you go on to explain, at paragraph 64, the process of Bed Management decision making. And you suggest sufficient and appropriate systems were in place to support the admission process.

How does one reconcile that, if admission decisions were being made that were not in the best clinical interests of patients, how can the systems in place to support admission have been sufficient? Can you help us with that?

A. I'm -- am I looking at paragraph 53?

Q. Yes.

A. Yes.

Q. So having -- let's have a look at paragraph 53. You say:

"My overall view is that admission decision making was not consistently adequate. The process was heavily influenced by bed capacity constraints and systemic pressures, rather than being driven purely by clinical need. A system that is consistently under bed pressure cannot reliably make admission decisions that are in the best clinical interests of patients."

Then if we go to paragraph 64, which I think is -- yeah. You say:

"Overall, sufficient and efficient systems were in place to support the admission process."

Then it goes on, if you just want to refresh your memory of what you say there.

A. Yes, and could you repeat the question, please?

Q. Could you just explain the distinction there? Decisions that are in best clinical interests of a patient, how does that sit with overall there being sufficient and appropriate systems?

A. It doesn't. It doesn't. It's a contradiction.

Q. And so which of those two is it?

A. I'd say the systems were not sufficient or appropriate.

Q. I'd like to ask you about capacity flow and escalation policy next. Are you familiar with EPUT's Capacity Flow

and Escalation Policy which was implemented in February 2022?

A. I'm not familiar with it, no.

Q. Okay. You state -- next, out-of-area placements, if it helps, we're going to page 12, paragraph 51 of your statement initially.

You state that bed availability determined out-of-area placements and then that patients and families -- this is page 13, paragraph 55 -- that patients and families could speak to the Ward Manager and the nursing staff about preferences in relation to transfers, and that's page 14, paragraph 60.

What was your understanding of the extent to which patients and families were involved in the out-of-area decision-making process?

A. Prior to admission?

Q. No, on admission.

A. On admission. Um --

Q. Let's start with -- let's start with the -- initially, a placement being -- would you have had any involvement in that?

A. No.

Q. No. So when we're talking, then, once they are placed and then you're looking at an out-of-area admission from there.

A. Yes.
Q. So what would your understanding be about the extent to which families would be involved in that?
A. I think it could be rather reactive. So I think -- I certainly don't recall reaching out to every family member where their loved one was placed out of area. I'm not sure that's answered your question.
Q. Just explain to us why that might be.
A. Time pressures.
Q. Was there recognition of the importance of patients being closed to their family --
A. Yes, there was.
Q. -- geographically?
A. There was, there was, there was. And our Matron would have a list of out-of-area patients and we as Ward Managers would meet fairly regularly as a group with our Matron to attend those out-of-area meetings, and there would be a list and the Matron would attend the Bed Management call and then be able to communicate how many out-of-area patients we had on a particular ward.
Q. Did bed capacity issues in practice limit weight that could be given to patient preference?
A. Sorry, could you repeat that?
Q. So because of the pressures with beds, did that mean that a patient's preference would carry less weight?

A. Yes.

Q. And is bed capacity a concern that you have raised, or that you know has been raised with Senior Leadership?

A. I don't know if it's been raised with Senior Leadership. I certainly would have had conferences with my Matron and Service Manager regarding bed capacity and flow through the assessment unit but I don't know, I don't know if it's gone to Senior Leadership, no.

Q. And is it fair to say that that issue still persists?

A. It's more difficult for me to comment, I think, on that now because I don't attend the Bed Management calls at all. It's not part of my role.

Q. Okay. I want to ask you next about discharge. You describe the discharge planning process and how decisions in relation to discharge are made. At page 48, paragraph 228, you explain that:

"Decisions relating to discharge were discussed during the period of admission, in reviews and [multidisciplinary teams] in consultation with the patient ..."

How early, in practice, was discharge planning actually initiated and how accurate was the initial expected discharge date?

A. So on both wards we were expected to identify a discharge date on admission. I don't -- I'm not sure

how reliable -- how realistic those dates were when they were identified.

Q. How consistently did MDT discussions determine discharge decisions in practice?

A. Yes, I would say consistently.

Q. You explain the discharge review process. This is page 49, paragraph 229. You say that patients were invited to participate in discharge review discussions. In your review -- in your view, how meaningful was patient participation in discharge review discussions?

A. I'm not sure that would have been consistent. I think the intention would have been there and would have been good but I'm not sure that was consistent in terms of how meaningful it was for the patient.

Q. And when you say consistent, as in it actually happening, or something else?

A. As far as I can recall, patients would always partake in a discharge discussion. How heard they felt as part of that discussion, I'm not certain.

Q. What factors, if you can help us, please, determined whether families were involved in discharge planning?

A. I think it would be from person to person, really, from patient to patient. How involved they'd been throughout the admission, the patients' wishes, I think certainly on PBU, in my experience, I, on reflection, I think we

had possibly an over-confidence in people's informal status, and their ability to keep their relatives updated themselves.

Q. You say that at Peter Bruff Unit, the geographical complexity of covering multiple areas added an additional layer of challenge for discharge, and that attendance by the Home First Team at discharge meetings was variable.

This is at pages 49 to 59, paragraphs 232 to 233.

How did inconsistent Home First Team involvement affect discharge planning and the continuity of care?

A. Well, the intended arrangement for Home First would be that -- for the North East Home First Team would be that they would be in every single MDT. Where that wasn't the case, and certainly towards my latter time on PBU it was more frequently the case they weren't in attendance. We would usually be able to come and complete an assessment separately, of the patient, and they would be able to attend at a later time. But certainly on occasions I think that would have meant that patients would have been waiting for them to attend to come and see them.

Q. With regards to leave, you explain that overnight leave was used to test discharge arrangements for some patients. How reliable was overnight leave as

a predictor of successful discharge?

A. On Ruby Ward I would say it was quite a good indicator that the discharge was going to be successful. We didn't, on PBU, we didn't allow overnight leave quite so much.

Q. Page 39, paragraph 187, you describe the changes to the leave policy at the Peter Bruff Unit following which informal patients were entitled to leave whenever requested, owing to their voluntary status.

What, in your view, has been the impact of that policy on patient safety?

A. I think it's significant because I don't think it allows us an opportunity to get to know the patient, an opportunity to assess the patient. So I would say that's significant, that's a significant risk.

Q. And what impact has the policy had on discharge decision making, in due course?

A. I'm not sure it has. I mean it's been a while since I've been in that particular post but I'm not sure it has had an impact on discharge.

Q. And in the time that you're able to speak about, have you observed an impact on readmission rates following discharge?

A. I'm not sure I can comment.

Q. Page 51, paragraph 240 of your statement, you say that

leave was generally not permitted on the Peter Bruff Unit although this changed, and we've talked about that. How did the differences in leave policy between the Ruby Ward and the Peter Bruff Unit affect discharge pathways?

A. So this is actually one of my corrections. So I'm referring to overnight leave.

Q. -- (overspeaking).

A. Yeah. Could you repeat the question, please?

Q. Yes, the question was how did differences in leave policy between the Ruby Ward and Peter Bruff Unit affect discharge pathways? And I think your correction is that you're speaking about overnight leave.

A. Yes.

Q. Not leave in general?

A. Yeah. I'm not sure it did affect discharge pathways. The only comment that I can think that might be relevant is where a patient was taking repeated leave, and they were away from the assessment unit for long periods of time, then that may prompt a decision to think about discharge for that patient.

Q. You explain that Bed Management relied heavily on discharges occurring as planned. Did that pressure, in practice, impact on the safety of discharge planning and decision making?

A. No, I would say that even though there was pressure to discharge, and it never went down very well when we had to put down -- when we had to put a discharge date back, but I would say that we were quite firm in doing that where there was a need to do so.

Q. It didn't go down well with who?

A. Bed Management.

Q. Bed Management?

A. Bed Management.

Q. Did the Bed Management Team put pressure on you to move patients through the system?

A. There was pressure in the sense that flow through the assessment unit was expected to be swifter than perhaps other wards. But certainly if we'd made a decision that a patient needed to remain on the ward, then that was accepted, I would say.

Q. I'd like to ask you about temporary accommodation. You say that -- let me give you the reference, page 50, paragraph 234. You say that patient accommodation issues were a frequent cause of discharge delay and that where a patient was ready for discharge and had no accommodation, they were sometimes temporarily placed in bed and breakfast, hotel-style accommodation funded by EPUT.

How significant was housing availability in delaying

discharge decisions?

A. It was significant. It was a significant factor throughout my time on PBU.

Q. How often -- can you say how often that happened?

A. I would say incredibly regularly.

Q. Was it --

A. There wasn't a week, I don't think, that went by, where we didn't face accommodation issues for several patients.

Q. Can you say whether that's continues, that persists now?

A. I'm unable to say.

Q. Have you ever visited this type of accommodation?

A. I haven't.

Q. And do you know whether ward staff visited the settings to assess the suitability for patients being discharged?

A. They did not.

Q. What steps were taken to ensure patient safety while they were in the bed and breakfast accommodation?

A. So the discharge coordinator would be responsible for identifying the temporary accommodation. Risk assessment in terms of suitability of the accommodation, I'm not sure I was aware of a process.

Q. Is it possible that there was one, you didn't know about it, or that there wasn't one?

A. Possibly. Possibly there was one and that I simply

wasn't aware of it, but it's not something that I've come across.

Q. And would you have expected to be -- would you have expected to come across it in --

A. If there was a process in place, I would expect to be aware of it.

Q. Is there any review of the number of patients being discharged to these settings and how often it results in a deterioration of their mental state or a serious incident?

A. I'm not aware of that, no.

Q. And are you aware of any cases where patients have died after being discharged to these settings?

A. Not that I can recall.

Q. If there wasn't pressure to discharge patients, would they still be discharged to these settings?

A. No.

Q. I'd like to move on to another topic, about Allied Health Professionals. You explain that access to Allied Health Professionals such as occupational therapy, physiotherapy, was not always consistently available or timely. What systems were in place to mitigate patient risk when Allied Health Professional input was delayed or unavailable?

A. I'm not aware of one.

Q. You state that SALT, Speech and Language Therapy, provision is essential for all older adult wards, but you cannot remember whether SALT was commissioned for the Ruby Ward when you worked there?

A. No, I'm unable to remember.

Q. How were patients with swallowing and communication risks safely managed when SALT provision wasn't available, then?

A. They wouldn't have been.

Q. I'd like to move on to care plans. You expressed the overall view that care plans are not adequately formulated, shared, and reviewed. Can you explain the barriers to the adequate sharing, formulation and review of care plans?

A. I think time constraints are significant. I think -- I've spoken a lot about protected time for staff, certainly it was incredibly difficult for named nurses to get any time to sit with patients to complete care plans. And the EPR, the electronic systems, as well, were cumbersome, not particularly easy to navigate.

Q. That's the electronic patient record?

A. Yes.

Q. The EPR. And that included care planning, as well, did it?

A. Yes.

Q. And you state that care planning should be a collaborative formulation, and you also say that electronic care planning modules were less conducive to collaborative care planning with patients and families than paper-based tools. Can you explain why that is?

A. So for the majority of my career, certainly the early half of my career, care plans would be developed on paper. And therefore you would really -- readily be able to sit with a patient, identify the needs, have a look at the goals, what you might need to do as a nursing team to implement, and you would do that with the patient. And then they would have a copy, they would sign it, and they would have a copy.

Now, with the EPR systems, it's much more difficult to do that. Limited access to laptops. The fact that you can't just open an EPR system in front of a patient because you need to make sure that you are -- you're not breaching any confidentiality or governance standards. There is -- (overspeaking) --

Q. Just pausing -- forgive me for interrupting you, but just pausing there. If you were -- if a member of staff was on their computer on the EPR system, on the electronic patient records system, but with the patient to whom it related, why would there be -- why would there be sort of data protection or privacy issues?

A. I think, in terms of whether or not a patient can see their records, it always needs to go through the Access to Records Team.

Q. I see. Forgive me, I interrupted you.

A. That's fine.

Q. One of the barriers to adequate care planning that you identified is that staff do not have time to complete care plans to a desirable standard. What impact does this have on patient safety, including the assessment of readiness for discharge by their target discharge date?

A. It's significant. I think care plans are really important so that the staff and the patient, and the family, have a shared understanding of reason for admission, progress, and plans for discharge. So inability to do that effectively is significant.

Q. And are you aware of a culture of using boilerplate care plans which only provide basic generalised or copy-and-pasted information?

A. Yes.

Q. What impact does that have on patient safety?

A. It's not person-centred care.

Q. You've highlighted that care plans rarely involved family input and are sometimes captured without the involvement of the patient. One of the points you make in your statement in relation to lack of patient input

is that nurses cannot simply open a care plan in front of the patient, and I've asked you about data protection considerations in that regard.

What is the impact of lack of patient or family input in care plans?

A. Significant, because there isn't a shared understanding of the risks, of the needs.

Q. In your statement you say that a care plan that exists to satisfy an audit requirement but does not reflect the patient's current presentation, needs, and risks, provides a false assurance of safety. Apart from the matters you've already identified, are there other examples of how failures in care planning impacted on patient safety?

A. Not that I can recall at the moment, no.

Q. I'd like to move on to another topic, notification of death to family members.

A. Yes.

Q. Can you explain what the process is for notifying the family following the death of a family member?

A. So the most senior member of staff would need to contact the next of kin at the earliest opportunity.

Q. The Inquiry understands that some family members are informed of the death of a patient by a telephone instead of in-person.

A. Yes.
Q. Do you consider it appropriate for families to be informed of the death of a family member by telephone?
A. No.
Q. You say that you do not recall receiving any comprehensive training on the delivery of such messages. Was there any training on the location in which this should be done, or the services best placed to do it, for example, the police?
A. Not that I recall, no.
Q. You say that there may have been some training on delivering bad news in the duty of candour e-learning?
A. That's right.
Q. Is it the case that ward staff received no in-person training on delivering bad news?
A. That's correct, as far as I can recall, yes.
Q. Do you know if that's still the position?
A. As far as I'm aware, yes, it is.
Q. And you say that there are gaps in training on notifying families of a patient's death. What further training do you think would be beneficial?
A. I think in-person training would be really valuable. I've written in my statement about TASI training and ILS. They are in person, they're scenario based, they're really useful. I think they're two of the most

useful examples of really good training in the Trust. And certainly communicating with families and notifying them of a patient's death should be treated with as much importance as those particular topics.

Q. And just in terms of staff welfare and having to make those difficult, or have those difficult conversations, what support does the Trust offer to you as staff members having to do that?

A. There would possibly be a debrief afterwards. You would potentially get a notification from the Trust psychology team to see if you wanted any -- needed any particular support. But I would say it's incredibly limited and I think sometimes, when you're managing experiences like that, I think that the impact can be accumulative, possibly not show itself until a little bit later along. And so I think really the onus of responsibility is on the individual staff member to reach out, rather than that being provided in a more adequate way.

Q. I'd like to ask about the adequacy of engagement. You, and this at page 55, paragraph 259 of your statement, you say your overall view is that engagement with patients and families was not consistently appropriate or adequate. Aside from the aspects that you've already highlighted, are there other barriers to adequate and appropriate engagement that you would like to mention?

A. No, I think I've spoken of the examples that I can think of.

Q. I'd like to ask you next about training. This is page 78, paragraph 363. You identify defensive and dismissive approaches to changing entrenched practices as a challenge to adopting safer processes, even when backed by evidence and policy.

Does it follow that additional training programmes were insufficient to change practice on the wards?

A. Yes, and I would say that change generally isn't supported well enough. It's not paced well enough. It is often -- change is often directed from outside of the team so the teams need to be more involved so they can have ownership in that change, time to familiarise themselves with why the change is important, time to raise any concerns.

Q. And does this affect your current role as a nurse educator and do you see the same barriers to change reoccurring?

A. I think certainly in my role I see it from a different vantage point now. I think this role is an additional role and from my experience of the staff that I've worked with, they're actually really keen to learn and develop and think about change, and discuss it with somebody. But again, I would say that the challenge is

around time constraints, protected time to engage.

Q. What do you think was or has been effective in implementing changes in practice in the end?

A. Sorry, could you repeat that?

Q. So what do you think has -- has been effective in implementing changes, in practice?

A. When teams were involved, when the change is fully explained, they're supported to raise any concerns, discuss those issues, and have time to engage with any guidance that might be helpful, as well.

Q. We've touched upon New Early Warning Score 2 training. I'm not going to ask you about that.

In respect of neurological observations and trainings, you say that there had been a low uptake and had been offered only on an *ad hoc* basis to the Ruby Ward team. It was not listed as mandatory training for staff. Do you consider that neurological observation training should be mandatory?

A. Absolutely.

Q. I'd like to ask you next about support. You say in your statement that over the years of practice, you've experienced varying degrees of support. And at page 62, paragraph 285, in the context of learning lessons, you say that better support is needed for the Ward Manager role in leading learning.

And at page 74, paragraph 344, you explain that clinical supervision was supposed to be provided on a regular basis, but in practice, supervision was often the first thing cancelled when staffing pressures required the prioritisation of clinical activity.

In your experience, how often was clinical supervision cancelled?

A. Fairly frequently. I would say it was a fairly frequent occurrence that it would be cancelled.

Q. Weekly? Monthly? Daily?

A. Monthly, yes. Within the month it would quite often need to be rescheduled.

Q. What was the impact of inadequate supervision of staff on patient care?

A. Significant, because staff need to be supported in order that they can do their own -- do their very best in their role.

Q. What about clinical supervision for healthcare assistants, bank and agency staff?

A. So that wasn't something that I completed as a Ward Manager. That was completed by, I believe, the Matrons had a schedule and they completed that supervision for those staff.

Q. At page 75, paragraph 345, you explain that you made great efforts to ensure that all staff received

supervision. Are you able to say whether other managers in your position similarly sought to ensure that staff were supervised?

A. I'm not.

Q. You say that the impact of traumatic incidents on staff was not consistently well managed. In what ways was the management inadequate?

A. I think there was an over-reliance on staff's own resilience, that that would get them through. And perhaps an underestimation of the impact that repeated exposure to traumatic incidents would have.

Q. How can management of the impact on staff be improved in the future?

A. They must have access to regular supervision that isn't repeatedly rescheduled. I think RCS is really important, as well, as I spoke earlier about the importance of restorative clinical supervision and I do really believe that staff do need to have protected time that is honoured in order that they can engage with that.

Q. At page 77, paragraph 358, "Speaking Up and Raising Concerns", you state that:

"The culture of speaking up was not consistently safe or effective."

You say you experienced a culture where staff feared

the consequences of speaking up particularly about other senior staff.

Are you able to provide any more detail about the situation where you felt unable to challenge a Matron's behaviour towards you in 2019 or 2020, and why you felt unable to raise concerns initially?

A. Yes. So, as I say in my statement, I haven't spoken openly about this before. I and other staff found our Matron's approach intimidating, humiliating at times, and I believe that approach was quite deliberate. I had a situation, I can give you an example, if that's helpful. We were on shift, it was summer, it was hot, we were in PPE with -- I and the staff had had a busy shift. The staff had been working really early -- really hard since early that day. The Matron would always come around to do a walk around to check on the order of things. It happened later in the day on this particular occasion, and the Matron just walked in and really criticised everything.

There were drinks bottles on the nurses' station, and she was really not happy with that, really wanting that to be sorted out. I did try to say the staff have been really busy, they haven't stopped, it's hot, they need their drinks, but I just got tore off a strip, really, in front of the team. So they scurried off and

I just tried to tidy up the nurses' station as she wished. I didn't challenge her at the time. I did try to defend the staff but I didn't challenge her approach. It was only when I got home later that day, I thought about it, I spoke to my Service Manager the next day, who was really supportive but actually I didn't feel comfortable with my Service Manager having that conversation with my Matron.

I didn't have confidence that actually, if my Service Manager spoke to the Matron, that that would actually have the desired effect. In fact, I think it probably could have made my life a little bit more uncomfortable.

Q. And so would you say that that incident wasn't appropriately handled, because you weren't able to rely on your Service Manager being able to speak to the Matron?

A. I didn't want them to. So I didn't want the Service Manager to speak to the Matron.

Q. But in that scenario that you've explained to us, the behaviour wasn't challenged?

A. No. As far as I understand, no, it wasn't.

Q. I'd like to ask you finally about recommendations. I wonder if we can look at page 86 of your statement, paragraph 406.

So you list here and over the next page the recommendations that you invite the Chair to make for improving safety and quality of inpatient mental health care, the first being staffing.

A. Yes.

Q. Safe levels must be maintained at all times. Observation practice?

A. *(The witness nodded)*.

Q. Distinction between in-person observation and technology-assisted monitoring must be clear --

A. Yes.

Q. -- in policy training and documentation, and there should be regular clinical review and escalation.

Ward environment: inpatient environments, must be fit for purpose, adequate sight lines.

Mixed-sex accommodation breaches must be eliminated.

A. Yes.

Q. Then over the page, Training: mandatory training, specialist training, and PSIRF training; Allied Health Professional input, access and timely access to SALT, occupational therapy, physiotherapy, tissue viability, psychology.

And then you go on, care planning. It must be genuinely collaborative, patient-centred, and used as a living clinical tool, not merely a compliance

exercise.

Culture. A culture of openness, learning, support and respect must be actively promoted and modelled by leaders at all levels.

And learning from incidents. Learning from investigations must be effectively disseminated, with protected time for staff to engage with it.

Family engagement. Communication with families must be timely, compassionate and transparent.

Technology. That it should be used appropriately and with thought to staff-to-patient ratio, has the potential to improve safety and to make observations less intrusive and more therapeutic.

I think that concludes the recommendations that you would invite the Chair to consider.

Is there anything else that you would like to say in respect of those recommendations that you haven't already dealt with in your statement?

A. No, thank you.

MS MALHOTRA: Thank you very much. That concludes all the questions that I have for you.

THE WITNESS: Thank you.

(4.26 pm)

(The hearing adjourned)

I N D E X