Wednesday, 15 July 2026

(10.00 am)

(Proceedings delayed)

(10.03 am)

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Good morning, Chair.

This morning the Inquiry will hear from Mr Brian O'Donnell who is currently employed by EPUT as the Clinical Lead for Compliance and Assurance. He was previously the Clinical Lead for the St Aubyn Centre, a Child and Adolescent Mental Health Service in Colchester.

He will give evidence about his experience of working at the St Aubyn Centre, the Larkwood and Longview wards. He will be the only live witness giving evidence this morning after which the Inquiry will resume again tomorrow at 10.00 am.

Before we hear any evidence this morning, and as with previous days, Chair, there may be aspects of today's evidence that are difficult to listen to, and for some, it may not be possible to sit through a session. Anyone in the Inquiry room should feel free to leave at any time.

May I take this opportunity to remind those engaging with the Inquiry that emotional support is available for

all who require it. Present here again today, as with other days, are emotional support staff from Hestia, an experienced provider of emotional support at these types of hearing. They are currently in this room and can be identified by their orange scarf.

There is a private room downstairs for anyone who needs emotional support where they can talk to the Hestia support staff.

If you prefer, you can speak to a member of the Inquiry Team, and we will put you in touch with the emotional support staff. We should all be wearing purple-coloured lanyards.

For those following the hearing online, information about the emotional support that is available can be found on the Lampard Inquiry website @lampardinquiry.org.uk. The "Support" tab is near the top right-hand corner.

We want everyone engaging with this Inquiry in whatever way to feel safe and supported.

Chair, could I ask that our witness this morning is sworn, please.

BRIAN O'DONNELL (sworn)

Questioned by MS MALHOTRA

MS MALHOTRA: Thank you.

You've provided two witness statements to the

Inquiry, one dated 2 December 2025 and a shorter clarificatory statement dated 22 April 2026.

Have you had an opportunity to read both statements recently?

A. Yes, I have.

Q. Do you have any corrections that you would like to make to those statements?

A. No.

Q. And can you confirm that the contents are true?

A. That's correct.

Q. You are currently employed by EPUT as the Clinical Lead for Compliance and Assurance; is that correct?

A. Yes, that's correct, yeah.

Q. When did you commence that role?

A. That was in June of last year.

Q. You were previously the Clinical Lead for the St Aubyn Centre, a Child and Adolescent Mental Health Services, known as CAMHS, in Colchester between August 2021 until June 2025; is that right?

A. Yeah, that's correct, yeah.

Q. Can you explain what Child and Adolescent Mental Health Services are?

A. Yes. So we are an inpatient service, and we provided mental health support to young people aged 13 up to their 18th birthday.

Q. You have spent your whole career working in CAMHS, starting as a healthcare assistant in 2003 until 2004, and then 2004, you were taken on as a permanent healthcare assistant; is that right?

A. Yeah, that's correct, yeah.

Q. Between 2006 and 2009 you studied to be a nurse, qualifying as a Registered Mental Health Nurse in 2009; is that right?

A. That's correct, yeah.

Q. And you worked as a Band 5 and then a Band 6 Registered Mental Health Nurse on the Longview Ward until 2012; is that correct?

A. Yeah, that's correct, yeah.

Q. What type of ward is Longview Ward?

A. Yeah, Longview Ward is, it's a general acute ward for young people who are experiencing mental health problems. We used to, on the old unit, take young people from aged 11 up until their 18th birthday, but that was changed at some point up from their 13th birthday up to 18.

Q. And the Longview Ward, the old unit that you've referred to --

A. Yeah.

Q. -- was on Turner Road?

A. That's correct.

Q. Until it then moved to the St Aubyn Centre in 2012; is that right?

A. Yeah, yeah.

Q. So summarising it, if I can, in terms of your experience, 2003 to 2006 and then 2009 to 2012 you were on the Longview Ward; is that right?

A. Yes.

Q. And that was under NEPT, was it, the previous Trust?

A. That was, yeah.

Q. And in 2012, a second CAMHS ward opened, as we -- you have already agreed, the St Aubyn Centre, the second ward was called the Larkwood Ward.

A. Yes.

Q. You tell us in your statement it was a PICU ward?

A. Yeah.

Q. Can you tell us what that is, what's a PICU ward? What does that stand for?

A. Yeah, that's a Psychiatric Intensive Care Unit, it provides a higher level of security, more intensive therapies, and the admission pathway is different to an acute ward. So you'll take young people who are at higher risk of violence, higher risk of suicide, higher risk of self-harm and absconding.

Q. And in 2012 it still remained under NEPT until the merger in 2017; is that correct?

A. That's correct.

Q. And then the St Aubyn Centre came under EPUT?

A. Yeah.

Q. In around September 2012 you say you worked on the Larkwood Ward originally as a Band 6 Charge Nurse, have I understood that correctly?

A. Yeah, that's correct, yeah.

Q. And then you were promoted to Larkwood Ward Manager from between 2014 to 2020; is that right?

A. That's correct.

Q. And then between 2012 to 2020 you worked on the Larkwood Ward; have I understood that right?

A. Yeah, that's correct, yeah.

Q. And then from 2020 until 2021 you were the Ward Manager of Longview Ward; is that right?

A. That's right, yes.

Q. So you went back to the Longview Ward?

A. Yeah.

Q. And then in 2021 you were promoted to a Band 8 Matron for the St Aubyn Centre?

A. Yeah.

Q. Was that as a Matron for both wards?

A. For both wards, yeah.

Q. Then you were further promoted to the Clinical Lead of the St Aubyn Centre -- was that in August 2021?

A. Yes, yeah.
Q. Until you took up your current post in June last year?
A. Yeah, that's right, yes. Yeah.
Q. So over two decades of experience in CAMHS; is that right?
A. Yeah.
Q. Does that sound about right?
A. Oh yeah, it does, yeah.
Q. What is your motivation for giving evidence to this Inquiry today?
A. Yeah, I initially came forward when it was a non-statutory inquiry a few years ago, when they were looking for volunteers to come forward and speak about things that had happened in the Trust and I wanted to be helpful. Then obviously it turned into a public inquiry, and I'd seen some other things that concerned me, as well, so I thought, yeah, I'd volunteer and come and speak today, as well. I think we owe it to the families.
Q. You say "other things". What other things?
A. Yeah. So -- yeah, issues around staffing, for example, issues around investigations. Issues around Datix reporting. Issues around staff coming forward to speak up and the consequences of that.
Q. Were you, in coming forward, concerned about safety at

the St Aubyn Centre?

A. Yes.

Q. Are you still concerned about safety at the St Aubyn Centre?

A. Yes, yeah.

Q. Now I want to explore a bit of those topics you've mentioned. I can take you to it if you would like, at page 20, paragraph 82 of your witness statement.

We should be able to get that up on screen if that's easier.

A. Oh yeah, that'd be great, thank you.

Q. Page 20, paragraph 82.

A. Oh yes.

Q. You say that:

"If staffing levels were low, we could raise concerns by doing a Datix. However, that was frowned upon."

And you go on to say:

"We are encouraged to report stuff during training and I am sure there were policies about it. But when you did report problems, you are made to feel like you are being a nuisance."

A. Yeah, that's true.

Q. In your experience, what was the culture under NEPT?

A. Yes, under NEPT, yeah, it felt -- yeah, NEPT felt very

disorganised. Staffing levels were very low. It didn't feel safe. If you wanted to raise concerns, you were seen as a nuisance, as a troublemaker. Especially if you raised issues about staffing. That was really frowned upon, you know, if you went and spoke to a manager, it's like "Well, we can't talk about this, we can't get more staff. You need to get on with it." It was that sort of attitude.

Q. And in your experience, what was the culture under EPUT?

A. Yeah, EPUT, again, it's -- staffing is a major problem and it's as if you're not allowed to talk about it. A similar pattern, actually, with myself and lots of other people I know, when you raise issues about staffing or concerns about the environment, you're seen as a nuisance and a troublemaker.

Q. So would you say that the culture was the same regardless of whether it was under NEPT or EPUT?

A. Yeah, I think so EPUT is better and trying to make improvements. I want to give a balanced account today. But there are still a lot of problems.

Q. Okay. And perhaps we will come on to explore those.

You've mentioned Datix. Can you explain what that is?

A. Yeah, sure. So that's an incident reporting system. Anyone can do a Datix. You don't need permission to do

a Datix. Everyone's encouraged to do one in their training. And you can report anything that is a concern, or could be a concern, anything from a broken door to shortages of staff to incidents of self-harm. Anything. There's lots of dropdown menus on there, and then you can add free text, as well, to give more of a narrative.

When you submit it, depending on the category, that will go round to all of the relevant people who need to see it.

Q. Okay. You say that anybody can raise a Datix. I wonder if I could ask you to turn to page 11, paragraph 43, please. I wonder if we can get that up on screen. Page 11, paragraph 43.

You say here the training -- we are able to get it up on the big screen as well now.

A. Oh good.

Q. "The training for dealing with Datixes is terrible. In the old Trust it was better."

Can you tell us, firstly, what you mean by "The training for dealing with Datixes is terrible"?

A. Yeah, under the old Trust, someone used to come round and sit with you and show you how to do them, especially when you went into a management position and I thought it was really comprehensive training on how to process

Datixes.

Now in EPUT, I know the Datix Team, they're very good people, they work very, very hard. They're just a very small team. There's not many of them and Datix is a huge thing in the Trust and yeah, I don't think there's enough of them to do the training that we used to receive on it, is my view.

Q. So in terms of anyone being able to raise a Datix, does that extend to a healthcare assistant?

A. Yes, healthcare assistant, support services staff, anyone who is working in the Trust can raise one.

Q. So when you were a healthcare assistant, thinking back some time now, did you have training about how to raise a Datix?

A. No, when I started it was a book with the carbon paper in it. It weren't very comprehensive. A nurse would just show you how to do it sort of on the job. So it wasn't any sort of official training, and they weren't very comprehensive.

Q. And you won't have done the most recent training that HCAs receive, presumably you can't comment on what happens now?

A. No, I'm not sure now, no.

Q. And just help me, then, understand if a healthcare assistant did know how to raise a Datix, how would they

be able to do that? Do they have access to the computers on the wards?

A. Yeah, you just log in to the intranet and then access it from there.

Q. And the computers would be in the nurses' office, would they?

A. Yeah, in the nurses' office, yeah.

Q. And are the nurses' offices locked?

A. Yeah, they are, yeah. You can come and go but they do lock behind you.

Q. Who would have keys to the nurses' office?

A. They are normally on swipes now, but every member of staff should have one.

Q. So you've explained what a Datix is. Perhaps a very simplistic question, but are they important?

A. Yes, very.

Q. Why are they important?

A. It's -- they go to all the relevant people, which is really important, so they have oversight of what's happening. So if it's an Estates issue, Estates will be copied in, managers will be, Directors of Patient Safety and so on. They do go to the relevant people.

If you're raising Datixes about self-harm for a patient, actually, that goes to the manager, clinical leads, doctors and so on. And you could see patterns,

you could see that the patient is deteriorating for example, increases in risk.

So it's really important you've got oversight of them, it's your record that you've reported it, and you might need them a year, two years, several years later if there's an inquiry or an investigation.

Q. Or to learn and identify risk?

A. That's one of the keys. We have to try to identify learning. There's -- when the manager processes the Datix, they look at what's happened and then they have to acknowledge if there's any new learning from that, and then it's important to try to share that learning as well, in team meetings or supervisions, or ...

Q. Would you say that the Datix process is really the heart of patient safety?

A. Yeah, it's a massive part of it, yes. Yeah.

Q. I want to take you to page 32, paragraph 128, please, of your statement. You describe here -- it should be on the big screen, as well, to help you, just to refresh your memory -- you describe here being approached to review Datixes by the former Interim Director of Nursing. You describe being asked to undertake a Datix project with the aim of closing around 4,000 unresolved reports which included incidents of self-harm, poor practice, security issues, violence and racial

incidents.

And we can see that at 130 at the bottom of page 32.

What was your understanding of what you were being asked to do?

A. Yeah, it was -- there was a sense of -- yeah, the Director of Nursing at the time said that they need to -- we need to get these gone.

Q. Just pausing there for one moment, I'm sorry to interrupt you. You say in your statement "We need them gone"?

A. Yeah.

Q. The word "gone"?

A. Yeah.

Q. What did you understand that to mean?

A. Yeah, my sense at the time, the first thing that popped into my head was: there's an inquiry going on and they're panicking about these because no one's looked at them. That was my first thought and actually that's what I still think.

Q. So to make them disappear to --

A. Yeah.

Q. -- or to process them quickly?

A. Process them quickly, get them gone. There wasn't "We need a thorough investigation of these" and then "Can you feed back any learning" or anything like that; it

was "We need these gone. We need these processed, we need them gone."

Q. Okay. What would your expectation, I think you've touched upon this already with Datixes. So I think you've described that they would be reviewed by the Ward Manager, for example, by Patient Safety, to learn lessons, to identify escalations in risk, for example?

A. Yeah.

Q. You say that many of the Datixes, this is paragraph 130, still on page 32, related to Basildon Urgent Care and that they went back to 2021; is that right?

A. Yeah, that's correct, yeah.

Q. Also Datixes from the Early Intervention Psychosis Team in Colchester, Kelveden Ward, the Mental Health Assessment Unit in Basildon, Crisis Response at The Lakes, the Mental Health Liaison Team in Basildon, and there were over 100 from each of those units. Given that they were 4,000, that was your understanding --

A. Yeah.

Q. -- and there are a number of units and hospitals mentioned here. Where did the others come from?

A. Yeah, so I wasn't -- the plan was for me to get them in batches, so they're all the initial ones that they sent from those areas that I discussed, but I'd heard they were from all over the Trust. So could have been adult,

acute, other community services, everywhere.

Q. And were they in respect of mental health patients?

A. Yes, mental health patients, yeah.

Q. Not physical health Datixes?

A. Not that I was shown. Obviously, EPUT does have physical health services. All of the ones I sent were mental health ones.

Q. Right. And this number of 4,000, were you sent 4,000? Were you told they were 4,000 --

A. Yeah.

Q. -- or did you assume there were 4,000?

A. No, I was told there was 4,000, yeah, absolutely. I remember very clearly from -- the Director of Nursing said there's 4,000. The guy in charge of the Datix Team, you know, he's very helpful, but he just oversees, like, the mechanics of Datixes and things, so he was nothing to do with this, but he said 4,000 as well, and another Deputy Director of Patient Safety I spoke with said 4,000, and another director. So I'm very -- yeah, convinced there was 4,000.

Q. Okay. Did any relate to patient deaths?

A. Yeah, there was some about deaths. And there had been the full investigation that should happen. It's just the Datix wasn't closed, if you see what I mean. So yeah, deaths were investigated from the coroner's and

things like that, but they hadn't had final closure on the Datix but there had been an investigation about that, yes. But just a final Datix hadn't been closed off.

Q. And so the closing off of the Datix would signify that it had been investigated and action --

A. Yeah, that's correct.

Q. -- had arisen.

A. Yeah.

Q. So the fact that they weren't closed suggested that actions hadn't been actioned, or that the investigation was incomplete?

A. Yeah, that's right. I mean I have got some other information where I've been trying to help the Trust recently with action plans around deaths that have been investigated, but there's no evidence that the actions have been completed. I know that there's -- this is a separate issue. It's not with these Datixes, but the Trust are trying to go back, and these are from 2021 up to about 2024 again, as well. So there's a thorough investigation took place, and recommendations. But the box where there's supposed to be evidence that these actions have been done are all empty and my job was to go and look through and find those and report back.

Q. So there's no record that the actions --

A. Yeah.

Q. -- have been actioned?

A. Yeah, that's correct, yeah. But I know people are working on it. Again, I want to be balanced with this, but they should have been done at the time.

Q. Yes. You say that there were some that related to patient deaths.

A. Yeah.

Q. Roughly how many?

A. Yeah, there wasn't very many that I saw, to be fair.

Q. What does that mean?

A. I mean, maybe five out of, you know, all the ones that I saw, which is several --

Q. How many did you see?

A. I probably saw about 600, 700, off the top of my head.

Q. So you saw 600 or 700?

A. Yeah.

Q. And out of those 600 or 700, possibly five?

A. Yeah, roughly, yeah. Yeah.

Q. Can you recall now -- I appreciate that you may not be able to recall the detail -- but were there any similarities that were reported in those Datixes?

A. What, around deaths?

Q. Yes.

A. Yeah, I can't really remember all the detail of those,

I'm afraid.

Q. So you can't say, in respect of those older Datixes, whether lessons have been learnt?

A. No, no.

Q. What's happened to those? You say you looked at about 600.

A. Yeah.

Q. What happened to the rest?

A. Yeah, so I closed quite a few, until I got really concerned about it and said that I can't do this any more, because I don't work on these services. Yeah, there was some, yeah, self-harm, attacks on staff, racial incidents, things happening in the community that really concerned me. I thought I can't put my name to this and say that I've thoroughly investigated it, because I haven't.

So I don't know what happened. I said I wasn't going to do any more. I don't know if they were ever dealt with or not. They sat on my dashboard for a very long time and then disappeared one day. So whether they'd been dealt with, I personally doubt it. They're probably still sat there.

Q. Why do you say you personally doubt it?

A. It's a huge number of Datixes going back to 2021, 2022, '23, '24. I don't know how anyone could now even

attempt to investigate them. Some of the ones I tried to look at, I'd call the wards, people had left two or three years earlier, patients had moved on. You know, like there was a racial assault on a member of staff, and I've called her about three years later to see if she's all right, because there's a process you're supposed to follow about racial incidents to make sure the staff are supported. None of that was done. A patient absconsion, that was from Basildon that got Datixed. I tried to look on their notes, they weren't on there. I've got no idea where this patient is. I don't know if they came back or what happened, so -- yeah.

THE CHAIR: What did you do about the ones that you looked at? Did you just close them down on the Datix? Did you say that actions had been taken?

A. Yeah, there's some that I could. There's some that I could look back on the notes and see that things had been done. So I was able to close some off. Others, I just left. But in the end, I -- I have got it in writing somewhere. I emailed the Director for Specialist Services, told him I'm not doing any of these any more, telling him it's not safe, I told him I was going to the CQC with it, which I did, and told them that I was going to take it to the Lampard Inquiry,

which I did. That's how worried I was.

MS MALHOTRA: So you did report it to the CQC.

A. Yes, I did, yeah. I don't know what happened with that. I didn't get any feedback on what had happened, but I did report it to the CQC, amongst some other things that I reported at the time, as well. Which I'm sure we'll come to.

Q. Can you help us roughly, the time period, when did you report it to -- (overspeaking) --

A. Yeah, I think that was -- it was probably the end of 2024, probably. Yeah.

Q. You mention, and this is to help you, at page 33, paragraph 133 of your statement, that you could potentially predict a patient death with a Datix --

A. *(The witness nodded)*.

Q. -- for example, if there are reports of someone self-harming more and more?

A. *(The witness nodded)*.

Q. How effectively was the Datix data used to identify patients whose levels were increasing?

A. Yeah, so actually, from a CAMHS perspective, we were good at incident reporting and closing Datixes down. That I will say. If we got up to a certain amount of Datixes, me as the manager would pick it up and say: we need to be investigating these -- or my manager would.

And they were going round to the relevant people, and you were -- everyone would see patterns. If someone was starting to ligature more and more and more, Datix was an avenue that we could see, as well as ward reviews and patient notes and things like that. I thought we were quite good at incident reporting and looking at Datixes.

I don't think I can say that for every service, though. I think they're often seen as a bit of a chore. People leave them, because people are very busy. Ward Managers and people on acute wards, for example, are completely swamped with demands coming from everywhere. And the Datixes wrap up to 70, 80, 90, 100 and then they desperately try and close them.

I was with the CQC recently and there was Datixes that had no learning identified. And the CQC -- this is only last week -- said that, actually, there was learning to be had from these Datixes.

So they are quite often seen as a bit of a chore.

Q. And so, as a result of being seen as a bit of a chore, would you accept that there are missed opportunities for learning?

A. 100 per cent, yeah.

Q. And you say in CAMHS you were quite good at reporting Datixes --

A. Yeah.

Q. -- but they would build up, would they?

A. Oh yeah, that's right, yes. Yeah, they can build up. Because we were probably one of the highest areas for Datixes, CAMHS, because we have a huge number of incidents.

Q. And with the benefit of hindsight, do you still hold that view?

A. I think so. We definitely -- I'd be lying if I said we captured every single incident, yeah. That's not the case at all. But I think out of a lot of the units, CAMHS are -- and I would still stand by that -- they are good at reporting, yeah.

Q. And I think your -- well, you tell me if you agree with this -- your sort of measure, if I think what you say in your statement, you didn't have Datixes lying around for three years?

A. No, no, and out of all the ones I got sent to process, there weren't any CAMHS ones, yeah.

Q. So is that the barometer that you're using: is that they weren't years out of date?

A. Yeah, that's right, yeah.

Q. Okay.

A. Yeah, I can definitely say that with some conviction, that CAMHS do stay on top of their Datixes.

Q. Can you share any positive examples where Datix

reporting that is been used in a way to identify patients whose levels were increasing?

A. I mean, it's not the only avenue we use to increase -- are you talking about their obs levels increasing or their levels of risk?

Q. Well, in the context of someone -- in the context of what you say in your statement here about Datixes being a predictor --

A. Yeah.

Q. -- where a patient is self-harming more and more --

A. Yeah.

Q. -- can you give us a positive example of where a Datix has been used in that way?

A. Yeah, I mean I can think of lots of episodes in my career in CAMHS, especially in more recent times, where I might come in as the manager on a Monday and see there's lots of Datixes for a particular patient, and they may be two weeks into an admission, and then there hadn't been any, and then suddenly you'll come in and there's about eight. You will think: oh, what's happened here?

And then you'll investigate it further. You'll take that to the MDT meeting. You could take it to reviews. It really does stand out, actually. Because we'll get an email for every Datix that comes in, you see, and

then -- as managers, and then you can review them. So it is a helpful tool. I can think of -- not specific examples, but lots of examples, yeah.

Q. And so help us with whether there was a system to highlight repeated incidents or escalating concerns? So for example, you've just explained the emails coming through.

A. Yeah.

Q. That very much relies on it going into the right inbox, the right person --

A. Yeah.

Q. -- at the right time looking at it?

A. Yeah.

Q. Is there a more formalised process for highlighting repeated incidents or escalated concerns?

A. Yeah. So, I mean, it's not just the Ward Manager that gets emailed. The Matron does, the clinical -- the Services Manager will. The manager of the other ward will. Charge Nurses will. So lots of people see it. Risk Management will see it. The Director sees it. Deputy Directors of Patient Safety see it as well. So if one person's off, there's lots of other people who have oversight -- the consultant will, as well.

Q. I understand that there are lots of people that see it.

A. Yeah.

Q. But seeing it doesn't necessarily translate into action, though.

A. No. No, no.

Q. So is there a formalised process amongst those individuals so that there is somebody who holds the clear responsibility of investigating?

A. Yeah. No, I don't think there's any sort of formal process in place, I wouldn't say.

Q. Okay. What measures would have improved the identification of patients at heightened risk? Say, for example, a red flag system?

A. Oh yeah, that could possibly be -- yeah, be something.

Q. That wouldn't be a particularly difficult thing to implement, would it?

A. No, I wouldn't have thought so, no. No.

Q. Do you know why that hasn't been thought of before?

A. I couldn't tell you, no. No.

Q. You mention in your statement that you have never seen any policy or guidance on the time within which Datixes should be dealt with.

A. Yeah, that's right.

Q. And you say they should be dealt with as soon as possible. My question is, how promptly were Datix reports investigated and acted upon?

A. Yeah, that's a good question, I know we have to report

an incident within 24 hours. That's very clear.
I haven't seen guidance around how quickly they should be investigated. There may be some somewhere.
I haven't seen it. But certainly my experience is that they are left for a very long time.

Q. Yes.

A. Some of them.

Q. For example, the 4,000 --

A. Yeah, several years.

Q. -- that relate to --

A. Yeah.

Q. -- potentially going back three years.

A. Oh yeah, yeah.

Q. What impact did delays on investigating and actioning Datixes have on patient safety and implementation of lessons learned?

A. Yeah, I think it's massive. You could miss something. You could miss a risk that's happening on the ward and miss the opportunity to learn from it and share the learning. Something might be happening on your ward, for example, that could be a risk on other wards. And if people aren't processing Datixes and having a look and then sharing that learning with other services, that could be a massive risk.

Q. Does this require urgent attention --

A. Yes.

Q. -- in your view?

A. Yeah.

Q. What does EPUT's approach to Datix notifications say to you about its commitment to learning lessons, if anything?

A. I think it could be better. Yeah. I will say EPUT are trying, and things are improving, again, because I want to give a balanced view here today, but there's still a lot of work to be done.

Q. But what does the approach so far tell you about their commitment to learning lessons?

A. It could be much better.

Q. Okay. We may return to that in a moment.

You suggest, and I'm surmising from what you say at page 33, paragraph 134, that Datix reports were not always adequately followed up, and I think you say the impact on patient safety --

A. Yeah.

Q. -- can be significant. I'd like to ask you about the inquest of Elise Sebastian.

A. Yeah.

Q. The Inquiry heard moving evidence from Vicky Sebastian, Elise Sebastian's mother. And for those who are not aware, Elise died on 19 April 2021, at 16 years of age,

on the Longview Ward, having fatally ligatured. And we'll return to some of the topics that arise surrounding Elise's death. But I'd like to focus on her inquest for the moment.

To give you the context, this is page 45, paragraph 183 of your witness statement. You tell us that you attended -- this is so, sorry, paragraph 182 -- you attended her inquest twice. And then on the second occasion, amongst other things, you told the coroner about Datixes --

A. Yeah.

Q. -- and you gave them examples of Datixes that you had seen. What did those Datixes show? Can you remember?

A. Oh yes, I do. So obviously with Elise's -- the coroner's inquest, observations were a very big part of that inquiry. So was Oxevision, and wi-fi working on the wards. And even up to the day before I gave evidence the second time, that was May 8, I believe it was 7 May, I'd seen Datixes come through, I was on a secondment but I'd seen Datixes come through from the St Aubyn Centre about wi-fi not working properly, which the observations are connected to. Observations being missed. I'd seen numerous ones of those. One was for patients hadn't been checked for two hours on the ward, because they were dealing with another incident.

So I'd said that in the coroner's. I told the coroner that I still had massive concerns about observations being missed, and wi-fi.

Q. What happened after you did that?

A. It was a few days later, maybe four days later, my Datix access for the St Aubyn Centre got cut, so I no longer got Datixes from the St Aubyn Centre.

Q. What did you make of that?

A. That was a clear cover-up to try to silence me from speaking up.

THE CHAIR: This was after you had given evidence to the coroner?

A. Yeah, after I'd given evidence to the coroner. I'd previously, when I'd gone to the CQC about incidents, as we spoke about before, a Matron on our sister unit stopped speaking to me. I was ignored by a Service Manager, and then the Datixes were cut. I was seen as a troublemaker. I wasn't thanked for raising it. I think they spent more effort just trying to stop me talking. So I did inform the coroner that that had happened. I got in touch with the coroner's office when I was made aware.

MS MALHOTRA: Oh, I see, so you subsequently --

A. I subsequently let the coroner know that that's what happened. I thought that spoke volumes about what

happens if you are open in the Trust.

Q. Forgive me for interrupting you, but just based on this one example that you've given us, in your experience, what does that tell you about the Trust's willingness to learn?

A. Yeah, I thought that they don't want people coming forward. It was a clear attempt to silence someone who they knew would speak up about it. I did contact one of the area directors to see who had done it and she told me it was a Service Manager and a Director --

Q. That had cut your access?

A. -- that had cut the access, yeah.

Q. And can I infer from what you're saying that where wasn't a discussion about the Datixes and the information in the Datixes and what can we do about it --

A. No.

Q. -- it was more about just cutting your access --

A. Yeah.

Q. -- and that was it?

A. Yeah, that's right, yeah. If you raise concerns, the advice -- the Trust are supposed to thank you for raising your concerns, hearing your concerns, and then try and act on them. I was just silenced. I have an email trail with very clear evidence that that is what

happened.

Q. Page 44 of your statement, paragraph 181, for those following. You say that:

"... they didn't encourage me to be open."

Here you're speaking about Elise's inquest.

A. Yeah.

Q. Who is "they"?

A. Yeah, there was a Deputy Director of Patient Safety. So where I'd been -- I went on 1 May to talk about Oxevision. And I quite liked the system, and I defended it. But then I knew when I went back on the 8th I would be telling the truth about all of the concerns in the Trust, but he said, "Oh, just do what you did last week. Don't say too much. You know, don't let them trip you up."

Q. So you say -- you go on to say -- you describe being told to say as little as possible --

A. Yeah.

Q. -- at inquests.

A. Yeah.

Q. Why did you feel that they didn't encourage you to be open?

A. It's -- the Trust are very worried about their reputation. This Inquest was a high-profile one which would be in the press. So I did think they were more

worried about their reputation than someone having the courage to speak up about the very clear staffing issues and issues around missed observations and reporting.

Q. Is this your, is this an isolated experience, as a result of Elise and her inquest, or is this your experience generally at inquests?

A. Yeah. I'd been at one other inquest and that all happened very quickly, actually. I got called -- I hadn't been called and then had to come in very quickly, and I was only in the stand for about half an hour to talk about a phone call. So I didn't really have anything from that one, to be honest.

Q. So would you say this was an isolated incident?

A. Yeah, from my experience, yes. But if it has happened to me, it does make me question that other people aren't encouraged to come forward. I mean, I do some training for staff, for example, who are on the Management Development Programme and I talk about Datixes there. I talk generally about what my directorate does. We do compliance. Datix is in it, risk management, and so on. But I do talk to the people on the programme about the importance of Datixes, the importance of reporting, and the importance of: just if you're not sure, report it, and don't let anyone tell you you can't report something. If you're concerned, report. You won't get

into trouble.

There's three people have said to me "But that's not my experience. If I report something, I'm seen as a troublemaker."

Q. Okay. I'd like to unpack that a little bit with you.

A. Yeah.

Q. Three people?

A. Yeah.

Q. What's their role? Are they HCAs, Registered Mental Health Nurses?

A. No, they were on the Management Development Programme so they'll be -- they might be Deputy Ward Managers who want to become managers or managers, and they just talk about their experience when they've tried to raise concerns about staffing.

Q. So each of these three individuals --

A. Yeah.

Q. -- will have been Deputy Ward Managers?

A. Yeah, yeah, they might well have been HCAs Band 5 and 6s. This a Management Development Programme for people who are going to be 7s, so ...

Q. But of these three individuals that made this comment to you, did they make those comments to you individually or all together?

A. It was within the group. I train a group of people on

MS Teams. Sometimes there's five people in the group and sometimes there's 14 or something like that. But yeah, it's three people, and I encouraged them to report.

Q. So three people within the same training?

A. Yes, yeah, for EPUT in the Management Development Programme all said they were made to feel like troublemakers.

Q. When was this?

A. This is all quite recent, within the last few months, that they said this to me.

Q. Did they give you any insight into what they had been trying to speak up about?

A. Staffing. Yeah. All three were staffing.

Q. And what did they say about the staffing, what was the impact?

A. Yeah, they were just desperately short of staff. Things weren't safe. They wanted to report it. But they're just seen as troublemakers. You're not allowed to talk about staffing issues.

Q. Just going back to your experience at Elise's inquest. What did that tell you about the Trust's engagement with the coroner's court?

A. They -- I thought they were trying to make out that everything's okay now, that they've learnt lessons. The

day before, the same problems were still happening that led to Elise's death.

Q. Can you be specific?

A. Yes. So the wifi dropping out when you're going round, trying to do the observations. Observations being missed. You know, we know that it was an issue of observations that was one of the factors in Elise's death. So those two major things, actually: observations not being done, wi-fi issues.

Q. So the day before Elise's inquest --

A. Yeah, yeah.

Q. -- those issues were still happening?

A. Yes, yeah.

Q. And your experience at the inquest was the Trust was suggesting that everything was okay now. Have I understood your evidence correctly?

A. Yeah -- no, no.

Q. I don't want to be unfair.

A. No, that's fine, yeah. They like to focus on everything we've done since, you know: we've got more staff, we've recruited more staff; we do training about observations; that there's no wi-fi issues, that's been resolved. It hasn't been resolved at all.

Q. Has it been resolved now?

A. There's still issues.

Q. Okay. And we'll come back to the wi-fi and the tablets in a moment.

Were you provided information about the outcome of Elise's inquest and the rulings made by the coroner once it was completed?

A. Yeah. I mean, I was in a -- yeah, a different role, then, but I did see -- I did see something, I think, that was available publicly.

Q. Available publicly meaning --

A. I think so, yeah --

Q. What, a press release or a news report?

A. Yeah, something, yeah. Yeah, I haven't had any -- a copy of all of the findings or anything like that, no.

Q. So, for example, a Record of Inquest, a Prevention of Future Deaths report. Does that sound familiar to you?

A. Yeah, I haven't seen any of those, no, no. It may be that I'm in another service now, but I think it would be important for me to see that.

Q. Even though you're in a different service?

A. Oh yeah, that's right. Because one of my jobs now is to go round other services. If I see -- and that's -- I go to other services, see if they're compliant with CQC, see what they're doing well, see if there's any challenges and see if there's any concerns. So the more I know about what's happening in the Trust, the better,

because that's one of the things I look for. I sit with managers and share learning. If I know of something good that's going on somewhere, I will share that. If I know if there's a risk going on somewhere, I share that, as well.

Q. Have you ever escalated the concern that important learning was missed within the Trust?

A. Yes. Oh, yeah. I've got a very good example, actually, and it was prior to Elise's death and it was about staffing. I actually did a mock-up of a rota where all of the staff are theoretically available. So no one is on leave, no one is sick, no one's on training. And there were still gaps in the rota. Even when all of our available staff were available. That says to me that we're seriously short of staff if you can't even cover the rota when everyone's available.

I escalated that to Director and Area Director. He came back with -- he did a shift planner, like, he did a mock-up of a day shift, and said, "No, it's fine, this is all the staff that you need." But actually he'd missed out all of the staff breaks. He didn't factor that in.

Q. I see. Sorry, when you say "he", who was that? What was that role of that individual?

A. That was -- he was the Area Director of our service at

the time.

Q. So the Area Director --

A. Yeah.

Q. -- was telling you "No, it's fine", but had miscalculated staff breaks?

A. Yeah, that's right, yeah. You know. If you've got five staff on, they all need breaks, so five hours of the day has gone. That wasn't factored in. It was very clear that we were short of staff. I mean, we'd been raising staffing for a very long time, but it was only after Elise passed away and the CQC came in that anything was done about staffing. Because I do feel like the Trust only listen to the CQC.

Q. Okay. And this example that you gave was before Elise's death -- with the Area Director?

A. It was actually -- yeah, and actually even before a previous death on Larkwood in 2019, we'd raised concerns about staffing.

Q. Was this in respect of Madison Naylor?

A. Yeah, that's correct, yeah.

Q. Are recommendations for follow-up investigations tracked, so far as you're aware?

A. Well, clearly from what I've seen, they haven't been. As I touched on earlier, I was asked to look at investigations that had taken place and see if there was

evidence of the learning being embedded. So there's recommendations, but then evidence that the recommendations had been followed through. So there's a column where all of that should be in. All of them -- some had one or two bits of evidence in. Most had nothing. I think I'd only looked at one service in the community, about 28 cases from about 2021 to 2024.

They are looking at them now and there is a plan to deal with it. That's again, I want to be balanced, here. And the Trust are trying. I was liaising with a Deputy Director of Patient Safety in another area, and one of our directors, who were very good and very keen to make sure these are done, not, you know, got rid of, they wanted to make sure that these were actioned, which I will say. But certainly it's quite late to be doing it now. There's opportunities that will have been missed, but it is being dealt with.

Q. You say at page 29, paragraph 112 -- this is your first statement -- the increasing demand for audits, for paperwork, and you pose the question:

"... what happens to that info? What difference is it making?"

A. Yeah.

Q. What would your recommendations be to this Inquiry for this Inquiry to consider? What should have happened?

What should happen within the information from those audits?

A. Yeah, that's right. So it's -- yeah, this is a paragraph where I talk about a desperation for appearing to be safe. Yes. So, yeah, the Trust has put in Deputy Directors of Patient Safety in areas who have got an overview of safety issues within their area. They cover a huge remit, actually. I wonder if it's -- they're good people, all of them that I've met. They are good. They care about the patients. They want services to be safe, as far as I can tell. I think their remit is very big. Probably too big.

And they -- the Trust keep introducing checklists and audits to check this and check that. It's putting a lot more pressure on staff. I think you can do all of this, but until the staffing is right, you can do whatever you like, the staffing needs to be fixed. It's just putting more pressure on nurses to do all of these audits within their own time. So it keeps coming back to staffing. I know I'm going to say this a lot, but that's the bottom line with a lot of this.

Then I know these audits, they get -- there's Tendable audits and different checklists we do. And it does get fed back up into the directorates and it gets discussed in, you know, team meetings, if they're able

to happen -- a lot of them don't because it's busy. It does get escalated to senior people. But unless you've got the staff to implement stuff, you can do these all day long. It's just not going to make any difference.

MS MALHOTRA: Okay.

Chair, I wonder if that's a convenient moment to take a break for 15 minutes.

THE CHAIR: Fifteen minutes. Thank you.

(11.02 am)

(A short break

(11.17 am)

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Just before I move on to my next topic, which is Oxevision, I just want to ask you this about the Datixes and your access being removed.

A. Yeah.

Q. Could there have been any other reason why your access was removed?

A. No.

Q. Because you -- did you move into a new role?

A. No, I was still the -- I was on a secondment but I was still in the Matron -- the Clinical Lead position. I didn't move until I was -- yeah, until, yeah, quite sometime later. So yeah, I'm sure it was as a direct result of the coroner's ...

Q. Okay. And obviously not having access to the Datixes meant you couldn't look at them, assess risk, patient safety, for example?

A. Yeah, that's correct. Yeah. But I think, as I said, they had kept -- they forgot about my access to Oxevision reports that I used to get at midnight every night.

Q. We'll come on to that.

A. Yeah, yeah.

Q. To the best of your knowledge, then, can you help us with when Oxevision went live on Longview Ward?

A. Yeah, sure. So that would have been 2021. The exact month, I'm not sure. We were part of the Trust -- a trial. Okay? So the implementation for us was a bit different to other subsequent wards because we were trialling the system.

Q. Can you tell us about that, the trial and the implementation?

A. Yeah, sure. So there was a project lead. I believe he was employed by the Trust. And he was like our liaison between us, you know, and the Oxevision team. So we first heard about it -- might have been at the end of 2020, maybe, I can't remember the exact dates, but we were told about a system that helps you to monitor patients. It's not instead of checks; it's in addition

to checks. Okay? So it's just an extra level of safety for patients, is how it was sold to us.

Q. So you're quite clear about your recollection around that --

A. *(The witness nodded)*.

Q. -- or is it that that's guidance that was given subsequently?

A. No, that was very -- I'm very clear that that was what was given to us at the time. Yeah.

Q. Who?

A. So it was our -- he was -- would have been the Area Director.

Q. A clinician?

A. Yeah, yeah. And the director. And then the project lead of Oxevision, as well. Yeah, I'm very clear it was in addition to, not to replace, observations.

Q. And do you recall CAMHS wards not initially being supportive of participating in the Oxevision observations pilot?

A. No, I was certainly very supportive of it, and I don't think I heard anyone not supporting it.

Q. When Oxevision was installed, did you have any safeguarding concerns about the prospect of the patients who were children being video-recorded 24/7 in their bedrooms?

A. Not at the time. It was very -- the Trust were clear it's not CCTV. To be fair, though, looking back, there wasn't as much guidance about when it could be used and when it couldn't. Not like it is now. So yeah, I didn't have any concerns, because, you know, if we've got concerns about a patient, we can just go straight into their room quickly if we needed to.

I thought it might be less intrusive, especially at night, because it's got night vision on it. So I thought it might be helpful. I wasn't really concerned, is my honest answer.

Q. Okay, and you said there it wasn't clear about when it could be used and when it couldn't be used. I wonder if you could just explain what you mean by that?

A. Yeah, so -- yeah, we could just turn it on and look into the room, for example, at that time. I don't remember any guidance to say that you couldn't. Yeah. So that was happening.

Looking back --

Q. Sorry, you say "that was happening"?

A. Yes.

Q. Can you just explain specifically what was happening?

A. Yeah.

Q. Was it the checks on the tablet and that was the extent of the observation?

A. Yeah, so at the time, we just had Oxevision, we didn't have the -- the observations were still on paper, okay?

Q. I see.

A. So they brought the Oxevision panels in first. We did have tablets and we did have the screen in the office, so you could click on a bedroom and then go to take patient observation, so it was a way to look into the room. And what I found happening, a patient might be on level 2 obs, where they're checked four times an hour, but if you're a bit worried about them, people were checking them more on the Oxevision. So they might be checked more times. I saw that happening. If people were a bit anxious about someone, they were checking them more.

Looking back, whether that was a good thing or not, if we were that worried about them, should we have put them on 3, and have someone with them all the time? If we're constantly checking them on Oxevision and we're concerned -- these are things I've thought about later.

Q. Because, you tell me, you're the clinician --

A. Yeah.

Q. -- pressing a button and looking at somebody on a screen, that might give you a visual on them, but does it tell you about how they're coping in that moment?

A. No.
Q. About what their risk profile is? Whether that's increased?
A. Yeah. No, no. I think I gave an example in my statement where I was going down to check a patient and I always checked patients visually, my whole career, it was drummed into me. You go and look. And you go and talk to them. I was on my way down and I checked on the tablet to see where they were, they were in their room. They were standing up, they're actually walking round. I went to speak to them and they had a really tight ligature on.
Q. And that wasn't visible --
A. No, you would never have done -- if you'd have just checked, you'd have thought: oh, they're all right, they're standing up, they're walking around. They were far from all right. Luckily, I always checked.
Q. So you said that initially people could press a button and they were checking the patient.
A. Yeah.
Q. Can you help us with what time period that was?
A. Oh, yeah, certainly 2021, '22. People were going and doing checks, as well, but I know there were people subsequently that we found just looking at Oxehealth. Yeah. That's happened.

Q. And what would happen to that staff member once you became aware of that?

A. Oh yeah, I mean, we would -- we'd remind them that this is in addition to, not instead of, obs, if we found anyone doing that. Yeah. We really did push that, actually, that it's in addition to.

Q. Was there an escalation beyond speaking to them?

A. As far as I know, I mean, it's a while ago, but we spoke to them. I think there might have been some instances where causes for concern were raised among bank staff, I think -- that could probably be checked, there might be a record of that -- where, if a bank staff member, because they're quite often doing the obs because we get extra staff in to do the obs, if they had concerns, we could raise a cause for concern to the bank staff office.

Q. So what would happen with that cause for concern?

A. Yeah, this was -- I mean, my experience, of course, because it would go to the bank office, they'd investigate with our help, we would provide statements. But I'd often see, for various reasons, causes for concern raised and then that staff member would be back. Wouldn't be really sure what had happened. And yeah, there wasn't really a clear escalation of: right, if you see someone do this then you need to do this.

You know, they brought one in for sleeping staff, later, for example, which we might come to, but -- a clear escalation of what happens if you find someone sleeping, this is what you do. There wasn't any for -- but you would talk to someone in the first instance.

But that was a worry, the bank staff, they'd have to have a quick training session with us, initially when they came on to the ward. We've got this system now, but --

Q. Now, but at the time --

A. No, sorry. When they came on to the ward, we'd have to say, "Oh, we've got this Oxehealth system." People hadn't heard of it. "Oh, what's this?"

Q. So were people coming to work on the ward without having had that training before?

A. Yes, yeah.

Q. So you would be training them or would somebody else --

A. Yeah, we'd have to show them how to use it, yeah.

Q. Okay. And roughly when was this, or is this something that continues to happen, in your experience?

A. I'm not too sure now but for 2021, '22, '23, it did become much more common on the wards then, as time went on, and bank staff had generally worked somewhere and it is part of the induction process. But I don't think it was very good. I think a lot more training should have

been done.

Q. Why do you say you don't think it was very good?

A. Yeah. Yeah, well, people come into a ward where there's a completely new system and they don't even know about it. I don't think the information about Oxehealth was put out there enough. And we had to do a quick -- show people quickly. Because obviously, if we've got bank staff coming on to the ward, it's generally because we're very busy. Observations are high. You've done your handover, then you need to take over from the next shift, get people out on obs, and there's a quick induction: "This is how you use it", and then off people go. So that could have been better.

Q. So we talked about the Longview Ward being part of the pilot.

A. Yeah.

Q. Was that the same for the Larkwood Ward, can you help us at all?

A. I'm thinking yes, but I'd have to check.

Q. Okay.

A. Yeah, I'll have to double check. I don't know if they did both wards at the same time or not, is my honest answer. I can't remember.

THE CHAIR: Can I just ask you something.

A. Yeah.

THE CHAIR: You keep mentioning bank staff and they're not being trained adequately.

A. Yeah.

THE CHAIR: Do you mean bank staff or do you mean agency staff, the bank staff being mostly permanent staff taking extra shifts.

A. Yeah, that's correct, yeah.

THE CHAIR: So they would have been trained?

A. Yeah, permanent staff on our ward, we had -- we saw -- I think it was a Teams-type online learning thing that we did, and we had to sign to say that we'd done it. But bank staff from other areas who worked in EPUT -- other areas didn't have it.

THE CHAIR: I understand.

A. Yeah. So not all of the bank staff and certainly not the agency. Yeah.

THE CHAIR: Thank you.

MS MALHOTRA: I just want to ask, going back to privacy concerns with children being recorded or observed continually in their bedrooms, was that a consideration at the time of the implementation of the pilot that you thought about, or that those around you were thinking about?

A. Not really, no. No, looking back now, I don't remember that being considered at all, to be honest. We would

have to visually check patients, knock on the door. If we had no answer, obviously we would go in. But yeah, I don't really think that was considered at all. Not like it is now.

Q. Do you recognise, or can you help us, with what impact continually being watched might have on a patient, a child patient?

A. Yeah. It is interesting. I've thought about this a lot. Are you saying watching them on Oxehealth continually, or having a nurse with them on level 3 continually?

Q. Being watched --

A. Being watched --

Q. -- via a camera, Oxy --

A. Via a camera. Yeah, I can imagine if you've got psychosis and you're paranoid about cameras, having a camera in your room would be really distressing.

Q. Could it exasperate somebody's --

A. Yeah, I think with certain individuals, it would. Yeah.

Q. Were there posters at St Aubyn telling patients what Oxevision was, and what it did?

A. Yes. Now this, I was hoping you would ask me this because I thought of something yesterday, actually. So because we were involved in the trial, we did have -- we'd probably got a lot more information than a lot of

units did subsequently. So we did have posters, but actually I remember having to -- we got them, I think, on maybe Word format sent to us, and I remember adding to the poster because I thought it didn't give the patients a full understanding of what this system actually was. I can't remember what I added, but I do remember saying, "This isn't very clear" and I added more of a narrative about what it does. I mean, I might -- I don't know if I'd still have it now, but I certainly didn't think it was clear.

And we certainly discussed it on their admissions. If we knew an admission was coming in, we send an admission pack out that's got information about the unit and there was some stuff about Oxevision in there, as well, and then we'd explain it briefly on admission.

Again, I don't think that was enough information, looking back now. Not like it is now.

Q. Why do you say not enough information?

A. Yeah, I don't think it -- I don't think it said that it's recording 24/7. I know it only records 24 hours of footage, salient background footage. But I don't think that was clear. I don't think it was clear that anyone could just look at it, you know, in a nursing office, someone could go up and just -- and then you're there on the screen. I don't think that was clear. I think that

could have been better.

I don't think they had enough information, really, looking back now in hindsight, to make informed decisions and give informed consent. Because now they've got so much information, most of them on Larkwood don't have it on.

Q. And is that because they don't consent to it?

A. They don't consent. And I think some of it's probably because they've got so much more information now to make an informed decision. You know, young people do copy each other as well. If one person doesn't have it on, there's a knock-on effect, but yeah, I think that could have been much better, looking back.

Q. So when did that practice change? Can you help us where it's spoken about pre-admission, and then on admission?

A. Yeah. I think it's just got better slowly. 2022, I think the SOP was looked at again, bits were added to it. '23, '24. Now, it's a big thing. It's audited about consent being sought about Oxevision. Different units are doing slightly different things, as far as I can tell. St Aubyn Centre, I think it's at least three times during the week it's checked.

Q. What the audit, the consent?

A. Yeah, checking with the patients that they're happy with it or that they want it off. I think they do it in the

reviews, in key worker time. And then one other time. So at least three times it's been checked during the week to see if they're -- I think other units are doing it once a week, as far as I can tell, on some of my visits. But it is audited. And it is a big thing now. EPUT are taking it really seriously now from as far as I can tell.

Q. Would you accept the example that you've given of it being checked in key worker sessions, in reviews, that's the aspiration? You wouldn't be able to say if that actually happens.

A. Yeah, that's -- yeah. You do depend on the staff member reporting it, that that's what they've done. Reviews, though, I mean, the consultants are in there, nurses are in there, psychologists are in there, and it's all very well documented. The review process at the St Aubyn Centre is very good. That's something they do well. They've got a very good MDT, and that would be documented in there, as well. So I would say that's definitely accurate. And I would trust the nursing team to be reporting in their key worker sessions. I'd say it was reliable.

Q. How does least restrictive practice align with the use of the Oxevision system? Can you help us at all with that?

A. Yes. So least restrictive practice. It's something the CQC are very big on, least restrictive practice. So are EPUT. There are least restrictive practice groups, looking at wards, and checking that restrictions are necessary. And if they're not, you do away with them. It should all be individually care planned. You shouldn't have blanket restrictions, okay? Very important. You don't just have rules that you've kept in there for years just because that's what you've always done.

The Oxevision. I mean, it was marketed as, it would save us -- yeah, going into a patient at night and with a torch and looking at them, and waking them up and shining torches in their eyes. It's got night vision on it that's very good, that you can check the pulse and breathing every time you've seen someone, and have a record that they're breathing and they have a pulse when you leave them.

You could argue that's least restrictive, than someone going in with a torch and shining it in their face and waking them up several times. That's one argument.

But, you know, the other side of the argument is they have got a camera on in their room that people can look at whenever they want. So that's the balance. And

it's a difficult one.

Sometimes units are criticised if something happens, saying the patient wasn't monitored enough. You bring in a system that does monitor them, and then that's too much. So it's a very difficult balance. I really don't know the answer to that. I see both sides of it.

Q. Can you help us with your experience, then, of nighttime. Was Oxevision used to undertake observations at night to avoid disturbing the patient?

A. Yeah, oh yeah. Yeah, definitely. Yeah.

THE CHAIR: How does that fit with what you were being told initially about it not being instead of observations?

A. Yeah. How I did it and how I saw other people doing it, though, you're still going to the bedroom, okay? You can listen at the door, listen for breathing. You turn the night vision on, it's very effective, actually, it's very, very, very good. You get very good picture of the room. So you can see the patient. You can hear them breathing. And then you can check and have a record that they've got a pulse and they've got breathing, as well.

THE CHAIR: Can you hear the breathing through the door?

A. If it's -- a lot of young people had their door open a crack, actually, at night because they hated being disturbed all the time, and that's really bad for their

mental health if they're on four checks an hour and you're going in with a torch waking them up every 15 minutes all night. So that's a factor. Some of these kids have experienced severe trauma as well, and if you're a male going into a female's room at night shining a torch at them, that's a problem.

MS MALHOTRA: Just help us understand, then, the nighttimes.

A. Yeah.

Q. Would you say, on a mental health ward for children that nighttimes can be the riskiest?

A. Yeah, and that's what the data says as well, when we look at Datixes, from 5.00 pm when the structure ends right up to midnight, 1.00 am, incidents go up.

Q. So considering that that's the riskiest time --

A. Yeah.

Q. -- doesn't that call for more of the engagement of the actual physical observation of a patient?

A. Yeah, I would agree, it's just when they're asleep, is the thing, and there's that balance.

Q. How do you know?

A. What? That they're asleep?

Q. Yeah.

A. Yeah, some of these young people can appear to be asleep, yeah, that's true. It's a very fine balancing act, actually, a lot of it comes from years of

experience, knowing the patient, knowing the ward. I found it very good. The night vision was superb. Hearing someone breathing, getting a -- knowing that they've got a pulse and that they're breathing as well, and recording that, so you know when you left. You can get a very good -- I mean, I would still, if I couldn't see their neck, though, I would still come and go and get a female, if it was a female, and ask them to come and check with me and ask the female to peel it back just to check. That would be my practice. If I had a clear view of them on the night vision, though, and I could see everything and I could hear them breathing and the obs are okay, I'd be all right with that.

Whether everyone did that, I --

Q. You couldn't say?

A. I couldn't say.

Q. Okay. You've mentioned about the breathing, the respiratory rate --

A. Yes.

Q. -- and it tells you about when people have gone into the bathroom, as well.

A. Yes.

Q. That's one of the matters you refer to in your statement. Are there any limitations for taking those measurements, in your experience?

A. Yeah. So, yeah, I mean, it would tell us if they were in their room. It would tell us if they were in bed. It could tell us if -- we had it set up, it could tell us if someone was at their door, because sometimes kids mill around each other's rooms and we could tell. It could tell us if two people are in the room or more, and obviously the alarm would go off in the bathroom, if they are in there for three minutes or more, because lots of self-harm incidents take place in the shower, it's an en suite. We later got it set up to tell us if they were in a blind spot, as well.

The problem with it, is, especially if they're in their bathroom, or a blind spot, it says, it starts going, "Oxehealth alert, Oxehealth alert" on the screen and on the tablets.

In the morning, when they're all in the bathrooms, the screens going off, you might have multiple tablets, because people have got tablets out but you're charging up ones, as well, so you'll have multiple alerts going off constantly at certain times of the day and then the night. That could be a problem, it was very distracting.

It was -- so yes, that would be a limitation of it.

Q. That could potentially lead to muting of the alarms?

A. Yeah, yeah. Yeah, definitely. I'd heard with the Elise

case that that had happened. I didn't know that that had happened at the time, it came out during the investigations and in the Trust report, which I hadn't been aware of at the time. But yeah, you might be on a phone to a parent who's wanting to know how their child is overnight and you're trying to talk to them, and all you can hear is this "Oxehealth alert", it just says, "Alert" now.

Q. Can I just ask you to slow down, I'm so sorry.

A. That's okay.

Q. So you might be talking to a parent and it might say, "Oxehealth alert"?

A. Yeah, you're talking to a parent on the phone, and they are wanting to know how their child was overnight. It might be in the morning. And you can't hear them, you know, they're on the phone and you're hearing this "Oxehealth alert" going off on the screen. But then the tablets that are charging, as well, you're getting these multiple alerts from many different rooms.

The staff will be out with tablets who can go and look and then silence it, but in the office, you know, that's one of the challenges, definitely, that I came across.

Q. You've mentioned the morning. Obviously, Elise's case didn't concern the morning.

A. No.

Q. Should that be happening?

A. No. No, absolutely not.

Q. You've talked about vital signs and measuring. Are you aware that the Oxevision system, it doesn't detect readings outside of limited ranges, say, for example, a pulse rate 130 -- 150 to 130, and a breathing rate, 8 to 35 breaths per minute. It doesn't take those readings. Are you aware of that?

A. No.

Q. Are you, given that -- I hope you can accept from me that it doesn't alert to abnormal pulse or respiratory readings.

A. Yeah.

Q. What do you say about the benefit, then?

A. Yeah. The benefits for me, I mean, the obs at nighttime were a benefit. Patients being in their bathroom for a long time, we did catch some self-harm and ligatures because of that. That was certainly a benefit. And then, with it later being linked up with the -- you know, knowing if someone is in the room I thought was a benefit, or if two people had gone in the room, or if someone was at the door, I thought that was beneficial as well. Yeah, so that's my view.

Q. And so in your view, is there clinical justification for

continuously recording vital signs of a patient, or continually observing them?

A. I still -- when it's used properly, I still think it's a good system. I do think it can lend towards some people being lazy.

Q. Yes.

A. Yeah, a hundred per cent.

Q. You say this in your statement. What do you mean by people being lazy?

A. Checking where a patient is on the tablet and not going down to their room. I think that's happened. Not engaging with the patients. That's all part of the assessment, actually, it's not just looking to see where they are and writing it down. We want to know how they are. You can tell a lot, obviously, if you know your patients, you can take one look at their face or the way they're speaking to know that they're going to do something. So looking at them on a tablet is just not enough.

Q. And so let me just explore this with you: if staffing levels were adequate --

A. Mm-hm.

Q. -- and everybody in the ward knew what their roles and responsibilities were, patients were being checked at night, and by that --

A. Yeah.
Q. -- I mean going into their room, checking them, and there was that engagement that was happening throughout the day, what benefit does Oxevision bring?
A. Yeah, it's again, how it was sold to us, it's something additional. It should never replace observation and engagement but it was just another -- that's how I saw it. It's just another back-up that might save someone, is how I saw it.
Q. It may be described to you as a back-up --
A. Yeah.
Q. -- could the issues that you were experiencing, that you talk about in your witness statement and that you've expanded upon today, could those issues equally have been addressed by increasing staffing levels?
A. Yeah, yeah. You can't replace staffing and proper observation and engagement, yeah. I think that's a valid point.
Q. Do you accept that relying on the system or a system to observe patients can present a serious risk to patient safety?
A. It could be, if people aren't doing their job and relying on a system, yeah.
Q. We've spoken about examples of muting an alarm.
A. Mm.

Q. Are you familiar with terms of "alert fatigue" or "alarm fatigue"?

A. Oh yes, I'm familiar with those terms, yeah.

Q. And does that happen, in your experience?

A. Yeah, I could well believe that would happen, yeah.

Q. What about instances where a patient might not want to end their life but self-harm in anticipation that they might be checked.

A. Yeah.

Q. Is that a situation you're familiar with?

A. Yeah, that happens a lot, yeah.

Q. And obviously if they're not checked the consequences can be catastrophic.

A. Exactly, yeah.

Q. Could that then impact on patient safety?

A. Oh yeah, a hundred per cent, yeah.

Q. You say that Oxevision has promoted some laziness in staff and just to be absolutely clear, are you referring to the over-reliance or the reliance on the system to do the observations, then, as opposed to the human doing the observations --

A. Yeah, yeah, there's cases of that. Yeah, definitely.

THE CHAIR: Have you had direct experience of somebody either saying to you or evidently having tried to use the system in the hope that they would be stopped from

self-harming?

A. Oh yes, yeah. So what, a nurse logging in or --

THE CHAIR: No, I'm so sorry, I meant a patient who you considered had self-harmed but had done so in the knowledge or in the expectation that somebody would come as a result of the alarm system?

A. Yeah.

THE CHAIR: You said that self-harm in anticipation of being checked happens a lot.

A. Oh yes, yeah.

THE CHAIR: Have patients ever said that they have done that, been encouraged to self-harm because they know that they've been in the bathroom and the alert will go off?

A. Yeah, um, that's interesting. Not about that specifically. But I do know someone might be on level 2 obs and they're okay when you see them. You go round 20 minutes later, they know you're coming and they've just self-harmed. That does happen. I've spoken to a patient subsequently after they've been discharged, some have come back and done their nurse training and things, and they're quite open. They used to talk about some of the things that they used to do, and that was one of them. They didn't want -- they wanted care and support and help and wanted to express how bad they were

feeling and they wanted to be found. Yeah.

MS MALHOTRA: Before I move on to speak more generally about observations, you've mentioned in your evidence and in your statement about the Oxevision reports that you receive at midnight.

A. Yeah.

Q. And you say that you can still see that there are missed observations every day on the Longview -- for those following your statement, this is page 45, paragraph 185.

Does that mean that Oxevision is being used for therapeutic observations still? What does that tell us?

A. Yeah, so obviously this is after my Datix access got removed, but I still get a report at midnight every night and it will do a read-out for the last 24 hours and it will have all the patient observations on it. This is when we went to electronic observations. So we stopped recording them on paper, started recording them on a tablet.

So I was getting these through every night and they were still missed. Like, some people should have been checked four times an hour, it said two. Some of the level 1s were missed, and they're hourly. So if you miss one of those, they're not checked for another hour. Some level 3s not recorded, although they should have

a staff member with them. That's probably more about they haven't recorded it, not that they haven't been done. But yeah, there were still -- yeah, every day there was observations missed.

Often the more serious ones to miss are the level 1s, because they're deemed as lower risk, these young people. They're checked every hour. If you miss one, it's another hour. And there was a recent case at another unit where a patient died. He was on level 1. And that was one of the pieces of shared learning, actually, just because they're on 1s, doesn't mean that they're low risk. And if you miss one of them, it can be catastrophic. So yeah, it regularly still happens.

I don't get these reports any more, because I'm in another role and I have got no need to see them.

Q. So when, could you say, to give us a timeframe, when could you see that observations were still being missed?

A. Yeah, so I kept them, I think for another three weeks or so, coming through. Then I told the Trust that -- I sent an email to the Area Director and said, you know, "I'm concerned you've removed my Datix access." And she got back to me about who it was, and then I got back to her. I said, "I think this is a cover-up."

I think I put "Wow, I can't believe that this has happened. This is clear evidence of a cover-up, but

just to let you know, you continue to send me the Oxevision data every night at midnight and I can see that there's obs still missing."

And I said, "I have reported this to the Lampard Inquiry. And I am going to talk about it."

Probably a day or two later, that went as well.

Q. Were you ever given a reason?

A. No, no.

Q. And as a result of those missed observations, did you raise it, did you raise a Datix? Did you escalate it at all?

A. I didn't raise a Datix. I did put it in my email to the director and said that I'd be coming here. And I'm not sure what they do about missed obs now. When I was in post, I took it very seriously. We may come on to it later, but obviously with Elise, I saw the recorded footage of her die on her floor. So I take obs very seriously. I think people got annoyed sometimes because I was always going on about not missing obs.

So when we got the reports through, we were -- they would be Datixed. I would then write to the member of staff who had missed it, ask for an explanation about why it had been missed. I was trying to work out if it was a problem with our processes, if it was a problem with our technology, or if it was human error. You

know, I really got stuck into what was happening. You know, in the course of a few months I'd written 58 letters.

Q. To whom?

A. To the staff members, got people in for interviews, trying to understand what had happened. I encouraged people to be open and tell me what had happened: "Was there a problem with the wi-fi? Did you forget? Did you miss one? Were you distracted? Were you busy? Were you coming -- did you go off on your break and forget to record? Were you going from one ob to the next and didn't have time?"

Q. What were you told? Forgive me for interrupting you.

A. Oh yeah -- no, that's fine. I had lots of reasons. Some were our processes, you know, where people were doing ob after ob, and they just didn't -- they did the observation but didn't record it because they had to go on to the next where staffing levels are low. That was a reason that was given to me. Dealing with another incident, in case -- they didn't go and check the patient because they were dealing with something else. Being distracted. Wi-fi was a big problem. That came up quite a lot. They say they recorded it and the wi-fi dropped out. That came up a lot.

I was constantly reporting that, that was a big

issue, the wi-fi.

Q. And you mention the wi-fi in your statement as well. Has anything, so far as you're aware in your experience, changed with regards to the wi-fi?

A. Yeah, there's still blind spots that people tell me about. And I still know a lot of people that work there, and there's still blind spots especially when you go to the education department, certain corridors where it cuts out.

Q. So we've talked about observations. The Inquiry heard from Abbigail Smith's mother Lisa Wolff, Abbigail Smith died on 16 February 2022. She was first admitted to the St Aubyn Centre in July 2012 and then on 13 February 2013 she was transferred to the Larkwood Ward. Approximately, or less than six months before her death, she wrote a letter dated 21 December 2021 where she spoke -- wrote about her experiences at the St Aubyn Centre. Are you aware of that letter that she wrote?

A. I am aware that a letter was written. I don't know the contents of it.

Q. One of the matters that Abbigail spoke about is staff sleeping whilst carrying out overnight observations.

A. Mm.

Q. Were concerns raised amongst staff regarding the

standard of overnight observations undertaken by bank staff or the extent to which staffing shortages affected the quality of those observations?

A. Yeah. Yeah, that's a big one. Sleeping on duty. It was mainly bank staff or agency staff. Now, we have a lot of very good bank staff and a lot of very good agency staff, I want to make that very clear, and some of our units couldn't manage without them. But most bank shifts, a lot of people chose to do nights because, you know, you don't get paid very much being a healthcare assistant. You get paid more on a night. And obviously, nights you're more likely to be tired and --

Q. Sorry, could I just ask you to slow down.

A. Yeah, sure.

Q. It's not you, it's just that we're trying to make sure we get a note of your evidence.

A. Yeah, no worries, yeah.

So nights, yeah, bank staff were more likely to pick up because you get paid more. And obviously, nights you're more likely to get tired. But it was a huge problem, a massive problem. It was always reported.

Q. You say it was always reported?

A. Yeah.

Q. How can you know that?

A. Yeah. Well, certainly if I saw it, I reported it, and I know a lot of my colleagues would get really quite angry about it, you know, as regular staff, we have to stay awake all night, which sounds obvious, but we do. And there's people who are being paid and they're asleep and putting people at risk. You know, we were angry about it, really worried, you know. You're delegating responsibility to someone to look after one of these children, and they're asleep.

We used to have to go round and check staff were awake. That's how bad it was.

Q. When -- you seem to be talking about a particular time period; is that right?

A. Oh, I mean, it's -- certainly 2012, 2013. For a very long time it was an issue. We would do cause for concerns with the bank office. It's just very hard to prove. People would say they were resting their eyes. We had all sorts of excuses, "I didn't feel well", "I was praying", we've had as an excuse. We've had all sorts of reasons. Staff being accused of racism for reporting sleeping staff, who claimed they were being picked on.

Staff then became too worried about reporting it, thinking: well, nothing happens. I think one member of staff took a picture of a sleeping staff member on their

phone and got into trouble for having their own on the ward.

Q. Did anything happen?

A. No. No, no. The Trust eventually -- and I think this is recent, over the last maybe four years -- have put in a clear protocol about what to do if a member of staff is sleeping, but it's very hard to prove. People just deny it, point bank. Even when they're on a CC -- people sit themselves out of the way of CCTV sometimes. I think there are people who come and do nights to sleep. There's people who work for multiple -- have multiple jobs. I think it's better because EPUT have stopped using a lot of agency staff, and this isn't a slight on agency staff, but they could work at multiple agencies and have multiple jobs and work a night shift for one agency and then a day shift with another agency. So we wouldn't know.

Obviously if someone works for the Trust, you'll see, you can't book a night if you've done a day. There's safeguards. It's got better in that respect.

But it was a real worry. There was patients, I know, on other wards taking pictures of sleeping staff and it was in the papers. A real concern. It used to scare the hell out of me.

THE CHAIR: Do you think it's worse because of the now very

long shifts that are done?

A. Yeah, I think the long shifts have had an impact, for various reasons. Yeah.

MS MALHOTRA: The inquest or -- the inquest into Elise Sebastian's death found that staff falsified records and the jury found that that was one of two main factors that probably caused her death.

A. Mm.

Q. How often were records falsified at the St Aubyn Centre?

A. Yeah, so I mean, I don't know. Certainly if I knew it was happening, I would do something. But at the time, and I did flag this, that one member of staff would have to check if the young people on level 2s -- it could be four or six checks an hour -- it was one member of staff allocated to do all of those checks, and sometimes there could be 10, 11, even more of our young people on level 2s. And actually, when you look at it, it's physically impossible to go round and check every patient and engage with them, check they're okay, and then move on to the next one, and write it all down. It's actually mathematically almost impossible, I think someone worked out. It gave you a few seconds with each patient.

So when I heard that, actually, I was shocked but not surprised, actually. They changed it to one member

of staff can't check any more than three patients now.

Q. When was that changed?

A. Yeah, that was after the CQC came in following --

Q. After Elise's death?

A. Yeah. Sadly, that practice is on CAMHS, you know, it got changed, but other wards, adults, are still doing the same thing.

Q. How do you know that?

A. I've been to them. Part of my job is going round to adult wards. I've done bank shifts on adult wards, as well, and their practice changed in CAMHS but not in adults.

Q. Which adult wards?

A. The Lakes, the Linden Centre, Chelmer Ward.

Q. This is quite recently?

A. Oh yeah, yeah.

Q. How often were observations not filled in contemporaneously?

A. Oh, when they were on paper, every day. There'd be gaps. We would say at the start of shifts "You've got to fill in your obs, make sure they're filled in." We had nurses checking at the end of the day to see if they'd been filled in or not. People had already gone home. It got better once the system became electronic, because you couldn't put them in retrospectively. You

had to do it there and then. And then obviously that would all go through the electronic system, we'd get read-outs of it and we could see gaps and I could start writing to people and see what was happening.

But all over the Trust, that was a problem.

Q. What system is in place within the Trust to monitor observations to ensure that poor practice does not happen?

A. So I know that there's audits of the obs. Okay? I think there's one once a day, certainly one once a week. And they're -- at the St Aubyn Centre, they're done by -- there's a compliance admin person who's allocated just to do all things compliance and look at audits and things. They'll go through, and then they'll raise Datixes.

I know when I was there, I took it upon myself to write to people and do thorough investigations. I don't think that's happening any more.

I don't know what other units do. I think some send an email and say, "Please make sure you're doing your observations." I don't think anywhere near enough is being done about missed obs. You know, it's a really important job. For that hour that you're doing the obs, that should be the only thing you are doing.

So I think more needs to be done about that and

people being held to account if the obs are missed.

Q. Would that holding of account include referrals to the Nursing and Midwifery Council, for example?

A. Yeah, that could be an option, I think -- maybe not in the first instance -- if, you know, you could find out what's happened. If there's a repeated pattern of behaviour, that could be an option. There could be more HR involvement, as well, for non-registered staff who are missing observations, possibly. It's really serious.

Q. I'd like to take you to page 38, paragraph 157 of your witness statement. You say here:

"The Trust had been pushing us to reduce the level of observations, saying that the observations were damaging, which they can be, but it was also to try to save money. On that same night [so this is the night of Madison Naylor's death] we had someone visiting the ward to talk to staff and patients about how we could reduce obs."

A. Yeah.

Q. Can you help us with the role of the individual that told you that, to reduce obs? Was that from Senior Management?

A. Yes, senior managers, yeah. We'd also be -- we'd do a monthly finance meeting, as well. So one of the

Directors of Finance would be in this meeting with one of our directors, and then with Ward Managers and Clinical Leads, and you'd look at the budget. And the main spend is always on staff, especially if additional staff are brought in for observations. It's expensive.

There's two sides to this. So having a child on level 3 observations when they're in line of sight at all times, or level 4 observations where they're in arm's reach, okay, that may well need to be done for their safety. Their risk might be so high that they need someone with them at all times. But this does mean that this child has to be watched while they're on the toilet, while they're in the shower, when they're in visits with their family. It means they can't go out on leave. It's very restrictive.

It should be for the shortest possible time. Okay? But some people are so risky, they do need that level of intervention.

So you do want to try to reduce them as quickly as possible. So senior managers would say, "We need to get these obs down." That's a phrase you'd hear all the time. It would be in the MDT, the Service Manager might come in and go, "We need to look at these obs, we need to look at reducing them." The person who had come in that night, he was, you know, a senior member of the

Trust, and again, he was talking to patients about their obs levels and talking to staff.

I think -- the language that's used, and the times that it was said, I believe it was driven by money. Clinically, we know that we shouldn't have young people on level 3 obs for too long. We know it's damaging, but it can also be life saving. But often, this sort of language, "We need to get these obs down". It was driven by money.

Q. And so where was this pressure from -- to save money coming from?

A. From senior managers, the finance meeting, as well. We were always overspent. I'd say we were underfunded, not overspent, but we'd always be red, and it is, staffing was our main cost.

Q. And so the senior members of staff that you're talking about and the pressures, where was the pressure coming to them from?

A. That's right. I mean, I would imagine -- I don't know what happens at that very top level but it must be coming from the exec team, the Directors of Finance, those types of people who hold all the money.

Q. Do you know if the Trust had KPIs, so key performance indicators they had to meet?

A. We did have KPIs. I don't know if there were any about

not having people on obs or things like that. I don't believe that there was, around observations.

Q. You've talked about least restrictive practice. Is that a cloak behind which the Trust hides?

A. Oh, okay. Can you say more about what that means?

Q. So is the justification for reducing observations of least restrictive means something which the Trust hides behind?

A. That's my very strong impression when they're talking about observation levels. Yeah.

Q. In your statement you talk about positive risk taking on a number of occasions. And we can see this at paragraph 155 on the same page, you talk about it in the context of Madison's death, Madi's death. You say here that:

"Our role is to get kids to a place where they can leave hospital."

A. Yeah.

Q. I just want to explore that with you a moment. If you have a child who is repeatedly ligaturing, self-harming, is the focus preparing them for discharge in that moment or is it supporting them through a crisis?

A. Yeah, it would depend on the patient and depend on, yeah, lots of factors: how long they'd been there and so on. But the role of us, is, you know, these kids have

usually, you know, experienced really severe trauma in their lives, okay? And they don't deserve to be locked in a psychiatric unit for the rest of their lives with a nurse following them around. Our role is to try and get their lives back. That's very clear. That's why we got into nursing.

For some young people their life outside of hospital, they're so frightened of the world that they would stay in hospital if they could, and will do things to try and stay in hospital.

So young people can get stuck; they can get stuck in a cycle. And we need to try and take positive and balanced risks to try and get them out of hospital, give them some more autonomy, help them to manage themselves a little bit more. Help them to regulate their emotions. And if a young person has been on level 3 obs for a long time, they can become completely dependent on a member of staff, you know, 15-year-old girls being completely comfortable with an adult -- female -- watching them all the time, even when they're on the toilet and in the shower, that's really damaging.

So we're trying to hand them their lives back. So it does involve reducing observations where you can, removing some restrictions where you can. And I'm talking, these are the type of conversations that we

would have clinically. When it's nurses and a doctor in reviews, money, we're not talking about money, we're talking about doing our jobs and doing what we all want. It's a very -- it's a fine balancing act.

MS MALHOTRA: Chair, I wonder if that's a convenient moment to have a ten-minute break until 12.30.

THE CHAIR: Of course.

(12.20 pm)

(A short break)

(12.32 pm)

MS MALHOTRA: Thank you, Chair.

THE CHAIR: Ms Malhotra.

MS MALHOTRA: I would like to move on to another topic: restraint.

Had you ever had concerns or heard about concerns raised with regards to restrictive practices being used behind closed doors at the St Aubyn Centre?

A. Yes, so there was -- and I have this in my statement, actually. It was some incidents of restraint where there was no cohesion, you know, so there would be the regular staff who had had the TASID training, Therapeutic and Safe Intervention Training, and you'd be on a shift with agency staff who have had a different type of training, PMVA.

And I looked at some body-worn video footage of that

and it was -- yeah, there was no leadership there was -- one patient had, you know, the staff member had their arm, no one had this one, no one really seemed to know what they were doing. It's the sort of thing where you need clear leadership, you need to make a decision whether you're going to restrain or not. It needs to be safely. And it was -- you know, it wasn't anyone hurting patients or anything like that but -- and I think people were meaning well, but it was the -- they had no cohesion. It just wasn't done as it should have been.

Q. You say you haven't heard of people harming patients.

A. Yeah.

Q. Can you recall an incident where a young female was dragged by her hair?

A. By her hair ... I can't, I don't think, no.

Q. Would you have expected that sort of behaviour to happen?

A. No, absolutely not. No, no way. I mean, we did have -- I do recall, actually, when we transferred from -- we used to do what we called C&R, control and restraint. That was the old method that we were taught to restrain people, and there was pain compliance in that. That's how we were taught for years, there was a particular hold, the ultimate lock, and you could tweak the

patient's wrist. We moved away from that to the Therapeutic and Safe Interventions, and that's not about pain compliance; it's about talking to the patient, more about therapeutic engagement and talking them down. That sort of thing.

We did have incidents reported to me which we acted on of allegations of staff still using the old technique, some of the bank staff, which -- I remember that being reported and we dealt with that. There was an investigation into it. That was quite a number of years ago.

And, yeah, we did have -- yeah, there were incidents where young people would report they'd been hurt in a restraint, and I remember they were acted on. There will be evidence of that, investigations that were started, some that I instigated. I don't remember this one with the hair pull, though.

Q. What about where a child broke their arm as a result of restraint?

A. I don't remember that, no.

Q. I'd like to move on to ask you about strip searching. Can you confirm whether staff were authorised to conduct strip searches on the Longview Ward, either before, during or after your tenure there?

A. Yeah, there were cases where it happened. That was --

and there is a policy around it. I think it's much tighter, the policy, now, about who can authorise it and so on. It's something that could be done if there was an absolute immediate risk to the patient or other patients. So this would be something like if they had, I don't know, a load of tablets hidden in *(redacted)* that they could just quickly swallow, or a weapon. Something like that. But it would have to be where you've got a real concern regarding, yeah, the immediate safety of the patient.

There were some other instances where, if a patient -- if we've known them for a long time and we know at night they're going to continually ligature with their clothes, which involves, you know, an alarm being pulled, staff restraining them, staff cutting the ligature off, and then they do it again and they do it again, they're compelled to do it. And while they've got clothes, they will keep doing it. So there were instances where we would get the support of parents, social workers, Safeguarding, the consultant, and a decision would be made at nighttime to offer them one of our safety suits. And if not, they were put in the safety suit by an all-female team that would take five minutes, then they're safe all night. And actually, the patient is calm, knowing they can't hurt themselves.

So there was some instances that happened and we got clearance from a lot of people, and made sure that the Trust had oversight of it as well, as an absolute last resort.

Q. Just in that example, how was it that a patient was allowed to continually ligature or attempt to ligature --

A. Yeah.

Q. -- after the first incident? Were their rooms not searched and items removed?

A. Yeah, you can do that. They'll use their clothes. Some patients even use *(redacted)*, they were so desperate to harm themselves. But they might have a member of staff with them, they'll quickly run up the corridor, rip, kind of, tie it round their neck, and then that involves an alarm, a restraint. And we're trying not to re-traumatise these kids, so with an alarm going off and restraint after restraint after restraint, in certain cases we would get authorisation from lots of people, so we would be able to act in that instance.

Q. I'd like to move on to grab bags, please. We know that the Trust's Patient Safety Incident investigation into Elise's death found that delay was caused when members of staff from the Larkwood Ward arrived to assist with CPR but couldn't make sense of Longview's grab bag.

Much of the equipment was spread around the room. An additional bag from the Longview Ward had to be brought in, which took approximately ten minutes.

A. Yeah.

Q. Did the two wards use grab bags which had different equipment?

A. No, they should both have the same equipment in them.

Q. And was training on the use of grab bags sufficient?

A. I don't think so, no.

Q. Were there other incidents in which treatment was delayed because of poor management of equipment?

A. Yes. Yeah.

Q. How many?

A. Definitely the Madi incident, for sure. I can't think of any off the top of my head that's got to that level with the grab bag, but certainly Elise, definitely, and Madi, definitely.

Q. The Trust Patient Safety Incident investigation found that it took seven minutes for high-concentration oxygen to reach her room. When it was eventually administered, staff didn't have the correct mask. Were there other incidents in the St Aubyn Centre in which treatment was delayed because of poor management of oxygen?

A. I think possibly the Madi situation, again. I can't think of any others off the top of my head right now.

But that's not saying there wasn't. I just can't -- they're the ones that are sticking out in my head right now.

Q. In respect of ILS training, do you think that HCAs, the healthcare assistants, should receive the same training as qualified nurses, considering that they, the healthcare assistants, will often be the first staff on the scene to an emergency?

A. Yeah, definitely. Yeah, I think so. Yeah, I have got quite a few thoughts on this.

Q. And you've made reference to Madison Naylor and the issues in respect of the resuscitation attempts with her and you detail those in your statement.

A. Mm.

Q. Is there anything else you would like to say about that?

A. What, the Madi one in particular? Nothing that I haven't already said, no.

Q. I'd like to move on to another topic: those who are neurodivergent, autism, ASD, or those with learning difficulties. Can you help us with whether, as a healthcare assistant, you received training on those who are neurodivergent?

A. No.

Q. As a -- when you were qualifying to be a nurse, did you have any training?

A. No, no.

Q. And at any stage in your over two decades in CAMHS, have you received training about managing patients who are neurodivergent?

A. We had -- there's a very good principal psychologist at the St Aubyn Centre, and she undertook some autism training with staff. I think it was something she'd done herself. It wasn't a Trust thing. That might have been back in -- I'm trying to think of the -- I mean, dates are hard to -- it could have been 2019, maybe. I'm just thinking. So she did something which was very helpful, and more than we had ever had.

And after that, it wasn't until the Oliver McGowan training was introduced nationally, and that's fairly new, in the last two or three years. But before then, no.

We are obviously primarily mental health, but we are seeing more and more young people coming in with neurodivergence. They shouldn't come into a mental health unit just for that. The guidance is very clear; they need to have another condition that's treatable, a mental health disorder that we can treat and they're not just coming in for autism, for example.

But yeah, I don't think the training has been adequate, and it's only now we're getting somewhere with

it, I think we could still do a lot more.

Q. Lisa Wolff, the mother of Abbigail Smith, told the Inquiry that it was like trying to fit a square peg in a round hole with regards to Abbigail's ASD. Do you agree or disagree with that characterisation?

A. Yeah, I -- looking back now, I would agree with her. Yeah.

Q. I'd like to move on, please, to family engagement. You say in your statement, you give the example of Charlotte Cobbold, who didn't pass away in the unit, but did post discharge on 4 August 2014.

You reflect in your statement that there were some learnings that arose as a result of engagement with her family. In that situation, she hadn't consented for information to be shared with her father.

A. Mm.

Q. But you say -- you recognise that that didn't mean you couldn't have asked him for information.

A. Yeah, yeah. That was a major part of learning from that, actually, and something that we did, we really took on board, you know. Just because, you know, she didn't want us to give him information, he could have had valuable information for us. So we did learn from that and put that into our practice moving forward, yeah.

Q. How did you put that into your practice?

A. Yeah, so it was something that all of the MDT were very aware of. When we speak to the patients when they come in, and we look at who we can share information with, we do make them aware that we will -- unless there's some strict legal reason why the parent can't be involved, if there was abuse involved or something -- that we will get information from the other parent. Yeah, we make it clear to them. It's just become standard practice and just something that we do.

Q. Do you think that ward staff generally sufficiently recognise the role that family members can play in providing critical insight on presentation and risk factors?

A. I would say at the St Aubyn Centre, and indeed Poplar, yes. I think they do. I think that, you know, there's some very good family therapists involved in those teams, in the MDT. And that does -- yeah, the staff who work on these units are very good, and they do see the value of what parents can offer us.

Q. There are some who feel that -- having some family members who feel that having raised problems as an advocate for their family member, that they are viewed as a problem.

A. Oh, okay.

Q. Is that something that you can comment on or recognise, or have any experience of?

A. Yeah, I mean, I would hope not. I would hope that -- you know, I certainly always valued feedback from parents, and I would hope that parents didn't feel that way. They've got every right to raise concerns or liaise with us about their child's care.

Q. Was there a system or a structure in place for ensuring that there was engagement with family members during care planning, for example?

A. There is, yeah, there's certainly now, the Trust does a lot about that. There's audits around family involvement in care planning. And certainly within CAMHS it's something we have done for a long time. One of the things that was put in place while I was there was making sure that the key worker contacts the parent at least once a week, just to talk about how the care's going. They're invited into reviews. There's lots of avenues now for feedback from parents. It's a huge thing now for CAMHS.

Q. You say "now".

A. Yeah.

Q. Since when? Can you be specific?

A. Yeah, I mean, I think it's always been there, to be honest. I think it's got better over the years. And

certainly now I would say it's very good. I can't put an exact time on it. But even early in my career, though, I do remember the nurses calling parents and getting them involved, even when I was a healthcare assistant. I think they're more involved now, where they can come into reviews and there's lots of avenues. There's Family Ambassadors in a lot of the units, as well. I think it's much better.

Q. I'd like to ask you next about the CQC. In your view, is having a dedicated member of staff to undertake CQC monitoring and other auditing responsibilities a model that should be adopted more widely across the Trust in individual wards?

A. Yeah, one hundred per cent. The people we put in place at the St Aubyn Centre, that was following the Elise case, and following the CQC coming in, the compliance admin. They were invaluable. It frees up nursing time, to do other things, I think. And because they've got the time to do these audits properly, because that's their role, I think the audits are much more accurate, they're much more valuable and it frees people up to spend more time with patients.

Q. Just my final topic with you: recommendations. What steps do you think the Trust could take in order to promote a culture of reporting, candour, and

accountability at all staffing levels, particularly post incident so that lessons can be learnt?

A. Yes. So encouraging staff to come forward and be able to talk. I think some communication from the exec team and senior managers to staff. Actually, personal emails to every staff member to say, "You can come forward, you will be listened to. If you've got concerns about staffing, please raise it."

I think that would be some assurance that staff can come forward. I think that needs to filter down to directors, more middle management, Ward Managers, that "We want to hear about staffing concerns, that you're not a problem." Some assurance from Senior Leaders that it's okay to raise these things. I think that would be a huge step.

MS MALHOTRA: Thank you very much. Those are all my questions. We're now going to take a ten-minute break to see if any Core Participants have any questions. If there aren't any, that concludes your evidence. But if there are, we'll be back in ten minutes.

THE WITNESS: Okay, thank you.

THE CHAIR: In advance of that, I'd like to thank you very much for coming. It's been very helpful to hear from you.

THE WITNESS: Thank you, I appreciate it.

(12.52 pm)

(A short break)

(1.18 pm)

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Chair, we do have some questions for the witness.

Returning back to the Oxevision posters that you mentioned, you said that the patient information posters did not provide enough information about how Oxevision works and that this meant that patients were unable to give informed consent. Do you think that if a patient subsequently found out more information about Oxevision that was not in the poster, that this might harm the therapeutic relationship between patients and staff?

So perhaps if I can summarise --

A. Yeah.

Q. -- it's a long question. But I think what I'm trying to understand from you is whether the lack of information in the poster that you've already mentioned --

A. Yeah, yeah.

Q. -- and then subsequent information coming to light to the patient could risk that therapeutic relationship that they may have with those whose care they're under?

A. Okay, that makes sense and I think that could be a possibility, yeah.

Q. You said in your evidence in relation to Oxevision that there were people you subsequently found were just looking at Oxevision as opposed to undertaking the observations themselves. Was that on the Longview Ward?

A. Yeah, I saw it once, yeah, Longview Ward. I remember doing a bank shift, I think that was on the Christopher Unit, and I had to have a word with someone, just to tell them: "Make sure you go round and check the patients."

That was -- I mean, that was a couple of years ago.

Q. Sorry, you said the Christopher Unit?

A. Yeah.

Q. I asked about the Longview Ward.

A. Oh yeah, sorry.

Q. Did you see an incident happen on --

A. Yeah, I did a bank shift there, yeah, and I just spoke to this guy and made sure he was going round. It looked to me like he was just standing in the corridor and I said, "Oh, could you make sure you go round and check them."

Q. But what about the Longview Ward?

A. Yes. Yeah, we did, yeah. Not just me but other staff as well, they had to have a word with people to make sure they're going round.

Q. How did you find that out?

A. Yeah, people told me: "We've had to make sure people are going round. I had a word with them. I made sure they were checking." Yeah.

Q. So it sounds from what you're saying that this happened on more than one occasion --

A. Oh yeah.

Q. -- on the Longview Ward?

A. Yes, yeah, yeah. I mean, I'm thinking some of it may be because it's new, you know, so we had to make sure people were clear on what it was for, and that it wasn't to replace checks. Especially in the early days. Yeah.

Q. And was there a system for flagging when that happened or did you find it out by chance?

A. Yeah, the ones I saw, just by chance, there wasn't really a system in place. I think nowadays you would Datix it but it's a lot more established now and -- but, yeah, the Datix would be the appropriate thing to do. Cause for concern if someone is doing that all the time, yeah.

Q. Just on the subject of Datix, then. We talked about the 4,000 Datix that you were asked to review. Was this a data hygiene issue or was it that they were open or outstanding investigations?

A. Oh yeah, they were open and outstanding. Yeah, absolutely, definitely.

Q. In your experience, did a lack of staffing have an impact on meeting patient expectations, for example cancelling promised leave? How did this impact on patients' mental health?

A. Yeah, that happens regularly, on all of the wards. Yeah. Leave being cancelled, delays in, you know, if you want to -- the patients need to go to the toilet, patients wanting to engage in activities, yes. So staffing levels have had a massive impact on that.

The Trust tend to look at how many staff are needed, just based on observations, and I know certain areas, staff is cut down to the bone at the moment with the bare minimum that's needed to manage observations, and lots of other things aren't factored, like patients who have got two hours leave with two staff, for example. How can you facilitate that when everyone is tied up on obs? So that does happen.

Q. What about all the many other tasks that happen, risk assessments being reconsidered, physical health being attended to, providing therapeutic activities for the children on the wards? Does it mean that all of those other aspects are impacted?

A. Yes, yeah, on all of the wards. Because obviously as part of my role I travel to other wards. And there's a huge emphasis on getting paperwork done. So staff are

desperately trying to update care plans, running out to the patients. Yeah, leave's been stopped, definitely. Patients wanting to engage in activities. That can't happen. I've seen it.

Q. Regarding the adequacy of staffing generally, do you consider that a lack of adequate staffing levels and/or staff training led to a failure to recognise physical health needs and/or delays in assessing physical health care?

A. Yes, I would say so, yeah.

Q. Is there any process now for checking auditing records to ensure they had been completed correctly and on time?

A. There are lots, yeah, lots of audits in place. Yeah. But again, I've said this a lot, coming down to the staffing, so things can be done properly. It's a major concern of mine.

MS MALHOTRA: Thank you very much. That concludes your evidence.

THE WITNESS: Thank you.

THE CHAIR: Thank you very much indeed.

THE WITNESS: Okay.

MS MALHOTRA: Thank you, Chair. Tomorrow 10.00.

THE CHAIR: 10.00.

(1.25 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X