

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

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

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

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

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

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

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

22 **BRIAN O'DONNELL (sworn)**

23 **Questioned by MS MALHOTRA**

24 **MS MALHOTRA:** Thank you.

25 You've provided two witness statements to the

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

3 Have you had an opportunity to read both statements
4 recently?

5 **A.** Yes, I have.

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

8 **A.** No.

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

10 **A.** That's correct.

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

13 **A.** Yes, that's correct, yeah.

14 **Q.** When did you commence that role?

15 **A.** That was in June of last year.

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

20 **A.** Yeah, that's correct, yeah.

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

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

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

5 **A.** Yeah, that's correct, yeah.

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

9 **A.** That's correct, yeah.

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

13 **A.** Yeah, that's correct, yeah.

14 **Q.** What type of ward is Longview Ward?

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

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

23 **A.** Yeah.

24 **Q.** -- was on Turner Road?

25 **A.** That's correct.

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

3 A. Yeah, yeah.

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

7 A. Yes.

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

9 A. That was, yeah.

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

13 A. Yes.

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

15 A. Yeah.

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

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

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

1 **A.** That's correct.

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

3 **A.** Yeah.

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

7 **A.** Yeah, that's correct, yeah.

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

10 **A.** That's correct.

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

13 **A.** Yeah, that's correct, yeah.

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

16 **A.** That's right, yes.

17 **Q.** So you went back to the Longview Ward?

18 **A.** Yeah.

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

21 **A.** Yeah.

22 **Q.** Was that as a Matron for both wards?

23 **A.** For both wards, yeah.

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

1 **A.** Yes, yeah.

2 **Q.** Until you took up your current post in June last year?

3 **A.** Yeah, that's right, yes. Yeah.

4 **Q.** So over two decades of experience in CAMHS; is that

5 right?

6 **A.** Yeah.

7 **Q.** Does that sound about right?

8 **A.** Oh yeah, it does, yeah.

9 **Q.** What is your motivation for giving evidence to this

10 Inquiry today?

11 **A.** Yeah, I initially came forward when it was

12 a non-statutory inquiry a few years ago, when they were

13 looking for volunteers to come forward and speak about

14 things that had happened in the Trust and I wanted to be

15 helpful. Then obviously it turned into a public

16 inquiry, and I'd seen some other things that concerned

17 me, as well, so I thought, yeah, I'd volunteer and come

18 and speak today, as well. I think we owe it to the

19 families.

20 **Q.** You say "other things". What other things?

21 **A.** Yeah. So -- yeah, issues around staffing, for example,

22 issues around investigations. Issues around Datix

23 reporting. Issues around staff coming forward to speak

24 up and the consequences of that.

25 **Q.** Were you, in coming forward, concerned about safety at

1 the St Aubyn Centre?

2 **A.** Yes.

3 **Q.** Are you still concerned about safety at the St Aubyn

4 Centre?

5 **A.** Yes, yeah.

6 **Q.** Now I want to explore a bit of those topics you've

7 mentioned. I can take you to it if you would like, at

8 page 20, paragraph 82 of your witness statement.

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

10 easier.

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

12 **Q.** Page 20, paragraph 82.

13 **A.** Oh yes.

14 **Q.** You say that:

15 "If staffing levels were low, we could raise

16 concerns by doing a Datix. However, that was frowned

17 upon."

18 And you go on to say:

19 "We are encouraged to report stuff during training

20 and I am sure there were policies about it. But when

21 you did report problems, you are made to feel like you

22 are being a nuisance."

23 **A.** Yeah, that's true.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 **A.** Oh good.

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

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

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

1 Datixes.

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

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

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

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

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

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

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

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

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

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

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

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

8 **Q.** And are the nurses' offices locked?

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

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

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

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

16 **A.** Yes, very.

17 **Q.** Why are they important?

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

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

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

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

7 **Q.** Or to learn and identify risk?

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

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

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

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

1 incidents.

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

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

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

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

11 **A.** Yeah.

12 **Q.** The word "gone"?

13 **A.** Yeah.

14 **Q.** What did you understand that to mean?

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

20 **Q.** So to make them disappear to --

21 **A.** Yeah.

22 **Q.** -- or to process them quickly?

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

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

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

8 **A.** Yeah.

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

12 **A.** Yeah, that's correct, yeah.

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

19 **A.** Yeah.

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

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

1 acute, other community services, everywhere.

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

3 A. Yes, mental health patients, yeah.

4 Q. Not physical health Datixes?

5 A. Not that I was shown. Obviously, EPUT does have

6 physical health services. All of the ones I sent were

7 mental health ones.

8 Q. Right. And this number of 4,000, were you sent 4,000?

9 Were you told they were 4,000 --

10 A. Yeah.

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

12 A. No, I was told there was 4,000, yeah, absolutely. I

13 remember very clearly from -- the Director of Nursing

14 said there's 4,000. The guy in charge of the Datix

15 Team, you know, he's very helpful, but he just oversees,

16 like, the mechanics of Datixes and things, so he was

17 nothing to do with this, but he said 4,000 as well, and

18 another Deputy Director of Patient Safety I spoke with

19 said 4,000, and another director. So I'm very -- yeah,

20 convinced there was 4,000.

21 Q. Okay. Did any relate to patient deaths?

22 A. Yeah, there was some about deaths. And there had

23 been the full investigation that should happen. It's

24 just the Datix wasn't closed, if you see what I mean.

25 So yeah, deaths were investigated from the coroner's and

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

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

7 A. Yeah, that's correct.

8 Q. -- had arisen.

9 A. Yeah.

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

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

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

1 **A.** Yeah.

2 **Q.** -- have been actioned?

3 **A.** Yeah, that's correct, yeah. But I know people are

4 working on it. Again, I want to be balanced with this,

5 but they should have been done at the time.

6 **Q.** Yes. You say that there were some that related to

7 patient deaths.

8 **A.** Yeah.

9 **Q.** Roughly how many?

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

11 **Q.** What does that mean?

12 **A.** I mean, maybe five out of, you know, all the ones that I

13 saw, which is several --

14 **Q.** How many did you see?

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

16 **Q.** So you saw 600 or 700?

17 **A.** Yeah.

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

19 **A.** Yeah, roughly, yeah. Yeah.

20 **Q.** Can you recall now -- I appreciate that you may not be

21 able to recall the detail -- but were there any

22 similarities that were reported in those Datixes?

23 **A.** What, around deaths?

24 **Q.** Yes.

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

1 I'm afraid.

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

4 A. No, no.

5 Q. What's happened to those? You say you looked at about
6 600.

7 A. Yeah.

8 Q. What happened to the rest?

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

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

23 Q. Why do you say you personally doubt it?

24 A. It's a huge number of Datixes going back to 2021, 2022,
25 '23, '24. I don't know how anyone could now even

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

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

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

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

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

3 **A.** Yes, I did, yeah. I don't know what happened with that.

4 I didn't get any feedback on what had happened, but

5 I did report it to the CQC, amongst some other things

6 that I reported at the time, as well. Which I'm sure

7 we'll come to.

8 **Q.** Can you help us roughly, the time period, when did you

9 report it to -- (overspeaking) --

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

11 2024, probably. Yeah.

12 **Q.** You mention, and this is to help you, at page 33,

13 paragraph 133 of your statement, that you could

14 potentially predict a patient death with a Datix --

15 **A.** *(The witness nodded).*

16 **Q.** -- for example, if there are reports of someone

17 self-harming more and more?

18 **A.** *(The witness nodded).*

19 **Q.** How effectively was the Datix data used to identify

20 patients whose levels were increasing?

21 **A.** Yeah, so actually, from a CAMHS perspective, we were

22 good at incident reporting and closing Datixes down.

23 That I will say. If we got up to a certain amount of

24 Datixes, me as the manager would pick it up and say: we

25 need to be investigating these -- or my manager would.

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

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

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

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

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

22 **A.** 100 per cent, yeah.

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

25 **A.** Yeah.

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

2 A. Oh yeah, that's right, yes. Yeah, they can build up.

3 Because we were probably one of the highest areas for

4 Datixes, CAMHS, because we have a huge number of

5 incidents.

6 Q. And with the benefit of hindsight, do you still hold

7 that view?

8 A. I think so. We definitely -- I'd be lying if I said we

9 captured every single incident, yeah. That's not the

10 case at all. But I think out of a lot of the units,

11 CAMHS are -- and I would still stand by that -- they are

12 good at reporting, yeah.

13 Q. And I think your -- well, you tell me if you agree with

14 this -- your sort of measure, if I think what you say in

15 your statement, you didn't have Datixes lying around for

16 three years?

17 A. No, no, and out of all the ones I got sent to process,

18 there weren't any CAMHS ones, yeah.

19 Q. So is that the barometer that you're using: is that they

20 weren't years out of date?

21 A. Yeah, that's right, yeah.

22 Q. Okay.

23 A. Yeah, I can definitely say that with some conviction,

24 that CAMHS do stay on top of their Datixes.

25 Q. Can you share any positive examples where Datix

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

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

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

9 **A.** Yeah.

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

11 **A.** Yeah.

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

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

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

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

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

8 **A.** Yeah.

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

11 **A.** Yeah.

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

13 **A.** Yeah.

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

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

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

25 **A.** Yeah.

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

3 A. No. No, no.

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

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

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

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

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

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

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

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

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

21 A. Yeah, that's right.

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

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

1 an incident within 24 hours. That's very clear.

2 I haven't seen guidance around how quickly they should

3 be investigated. There may be some somewhere.

4 I haven't seen it. But certainly my experience is that

5 they are left for a very long time.

6 Q. Yes.

7 A. Some of them.

8 Q. For example, the 4,000 --

9 A. Yeah, several years.

10 Q. -- that relate to --

11 A. Yeah.

12 Q. -- potentially going back three years.

13 A. Oh yeah, yeah.

14 Q. What impact did delays on investigating and actioning

15 Datixes have on patient safety and implementation of

16 lessons learned?

17 A. Yeah, I think it's massive. You could miss something.

18 You could miss a risk that's happening on the ward and

19 miss the opportunity to learn from it and share the

20 learning. Something might be happening on your ward,

21 for example, that could be a risk on other wards. And

22 if people aren't processing Datixes and having a look

23 and then sharing that learning with other services, that

24 could be a massive risk.

25 Q. Does this require urgent attention --

1 **A.** Yes.

2 **Q.** -- in your view?

3 **A.** Yeah.

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

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

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

13 **A.** It could be much better.

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

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

19 **A.** Yeah.

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

22 **A.** Yeah.

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

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

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

11 **A.** Yeah.

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

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

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

4 **Q.** What happened after you did that?

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

8 **Q.** What did you make of that?

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

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

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

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

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

1 happens if you are open in the Trust.

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

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

11 Q. That had cut your access?

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

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

17 A. No.

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

19 A. Yeah.

20 Q. -- and that was it?

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

1 happened.

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

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

5 Here you're speaking about Elise's inquest.

6 **A.** Yeah.

7 **Q.** Who is "they"?

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

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

18 **A.** Yeah.

19 **Q.** -- at inquests.

20 **A.** Yeah.

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

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

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

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

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

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

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

1 into trouble.

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

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

6 **A.** Yeah.

7 **Q.** Three people?

8 **A.** Yeah.

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

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

16 **Q.** So each of these three individuals --

17 **A.** Yeah.

18 **Q.** -- will have been Deputy Ward Managers?

19 **A.** Yeah, yeah, they might well have been HCAs Band 5 and
20 6s. This a Management Development Programme for people
21 who are going to be 7s, so ...

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

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

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

5 Q. So three people within the same training?

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

9 Q. When was this?

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

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

14 A. Staffing. Yeah. All three were staffing.

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

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

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

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

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

3 **Q.** Can you be specific?

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

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

11 **A.** Yeah, yeah.

12 **Q.** -- those issues were still happening?

13 **A.** Yes, yeah.

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

17 **A.** Yeah -- no, no.

18 **Q.** I don't want to be unfair.

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

24 **Q.** Has it been resolved now?

25 **A.** There's still issues.

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

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

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

9 Q. Available publicly meaning --

10 A. I think so, yeah --

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

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

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

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

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

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

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

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

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

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

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

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

1 the time.

2 **Q.** So the Area Director --

3 **A.** Yeah.

4 **Q.** -- was telling you "No, it's fine", but had

5 miscalculated staff breaks?

6 **A.** Yeah, that's right, yeah. You know. If you've got five

7 staff on, they all need breaks, so five hours of the day

8 has gone. That wasn't factored in. It was very clear

9 that we were short of staff. I mean, we'd been raising

10 staffing for a very long time, but it was only after

11 Elise passed away and the CQC came in that anything was

12 done about staffing. Because I do feel like the Trust

13 only listen to the CQC.

14 **Q.** Okay. And this example that you gave was before Elise's

15 death -- with the Area Director?

16 **A.** It was actually -- yeah, and actually even before

17 a previous death on Larkwood in 2019, we'd raised

18 concerns about staffing.

19 **Q.** Was this in respect of Madison Naylor?

20 **A.** Yeah, that's correct, yeah.

21 **Q.** Are recommendations for follow-up investigations

22 tracked, so far as you're aware?

23 **A.** Well, clearly from what I've seen, they haven't been.

24 As I touched on earlier, I was asked to look at

25 investigations that had taken place and see if there was

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

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

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

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

23 **A.** Yeah.

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

1 What should happen within the information from those
2 audits?

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

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

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

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

5 **MS MALHOTRA:** Okay.

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

8 **THE CHAIR:** Fifteen minutes. Thank you.

9 **(11.02 am)**

10 **(A short break**

11 **(11.17 am)**

12 **THE CHAIR:** Ms Malhotra.

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

16 **A.** Yeah.

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

19 **A.** No.

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

21 **A.** No, I was still the -- I was on a secondment but I was
22 still in the Matron -- the Clinical Lead position.

23 I didn't move until I was -- yeah, until, yeah, quite
24 sometime later. So yeah, I'm sure it was as a direct
25 result of the coroner's ...

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

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

8 Q. We'll come on to that.

9 A. Yeah, yeah.

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

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

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

19 A. Yeah, sure. So there was a project lead. I believe he
20 was employed by the Trust. And he was like our liaison
21 between us, you know, and the Oxevision team. So we
22 first heard about it -- might have been at the end of
23 2020, maybe, I can't remember the exact dates, but we
24 were told about a system that helps you to monitor
25 patients. It's not instead of checks; it's in addition

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

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

5 A. *(The witness nodded)*.

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

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

10 Q. Who?

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

13 Q. A clinician?

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

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

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

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

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

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

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

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

19 Looking back --

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

21 **A.** Yes.

22 **Q.** Can you just explain specifically what was happening?

23 **A.** Yeah.

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

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

3 **Q.** I see.

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

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

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

21 **A.** Yeah.

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

1 **A.** No.

2 **Q.** About what their risk profile is? Whether that's

3 increased?

4 **A.** Yeah. No, no. I think I gave an example in my

5 statement where I was going down to check a patient and

6 I always checked patients visually, my whole career, it

7 was drummed into me. You go and look. And you go and

8 talk to them. I was on my way down and I checked on the

9 tablet to see where they were, they were in their room.

10 They were standing up, they're actually walking round.

11 I went to speak to them and they had a really tight

12 ligature on.

13 **Q.** And that wasn't visible --

14 **A.** No, you would never have done -- if you'd have just

15 checked, you'd have thought: oh, they're all right,

16 they're standing up, they're walking around. They were

17 far from all right. Luckily, I always checked.

18 **Q.** So you said that initially people could press a button

19 and they were checking the patient.

20 **A.** Yeah.

21 **Q.** Can you help us with what time period that was?

22 **A.** Oh, yeah, certainly 2021, '22. People were going and

23 doing checks, as well, but I know there were people

24 subsequently that we found just looking at Oxehealth.

25 Yeah. That's happened.

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

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

7 **Q.** Was there an escalation beyond speaking to them?

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

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

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

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

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

10 **Q.** Now, but at the time --

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

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

16 **A.** Yes, yeah.

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

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

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

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

1 been done.

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

3 **A.** Yeah. Yeah, well, people come into a ward where there's

4 a completely new system and they don't even know about

5 it. I don't think the information about Oxehealth was

6 put out there enough. And we had to do a quick -- show

7 people quickly. Because obviously, if we've got bank

8 staff coming on to the ward, it's generally because

9 we're very busy. Observations are high. You've done

10 your handover, then you need to take over from the next

11 shift, get people out on obs, and there's a quick

12 induction: "This is how you use it", and then off people

13 go. So that could have been better.

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

15 pilot.

16 **A.** Yeah.

17 **Q.** Was that the same for the Larkwood Ward, can you help us

18 at all?

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

20 **Q.** Okay.

21 **A.** Yeah, I'll have to double check. I don't know if they

22 did both wards at the same time or not, is my honest

23 answer. I can't remember.

24 **THE CHAIR:** Can I just ask you something.

25 **A.** Yeah.

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

3 **A.** Yeah.

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

7 **A.** Yeah, that's correct, yeah.

8 **THE CHAIR:** So they would have been trained?

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

14 **THE CHAIR:** I understand.

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

17 **THE CHAIR:** Thank you.

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

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

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

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

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

12 **Q.** Being watched --

13 **A.** Being watched --

14 **Q.** -- via a camera, Oxy --

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

18 **Q.** Could it exasperate somebody's --

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

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

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

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

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

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

18 **Q.** Why do you say not enough information?

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

1 could have been better.

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

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

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

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

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

23 **Q.** What the audit, the consent?

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

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

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

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

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

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

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

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

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

1 it's a difficult one.

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

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

10 **A.** Yeah, oh yeah. Yeah, definitely. Yeah.

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

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

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

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

1 mental health if they're on four checks an hour and
2 you're going in with a torch waking them up every
3 15 minutes all night. So that's a factor. Some of
4 these kids have experienced severe trauma as well, and
5 if you're a male going into a female's room at night
6 shining a torch at them, that's a problem.

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

8 **A.** Yeah.

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

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

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

15 **A.** Yeah.

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

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

20 **Q.** How do you know?

21 **A.** What? That they're asleep?

22 **Q.** Yeah.

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

1 experience, knowing the patient, knowing the ward.
2 I found it very good. The night vision was superb.
3 Hearing someone breathing, getting a -- knowing that
4 they've got a pulse and that they're breathing as well,
5 and recording that, so you know when you left. You can
6 get a very good -- I mean, I would still, if I couldn't
7 see their neck, though, I would still come and go and
8 get a female, if it was a female, and ask them to come
9 and check with me and ask the female to peel it back
10 just to check. That would be my practice. If I had
11 a clear view of them on the night vision, though, and I
12 could see everything and I could hear them breathing and
13 the obs are okay, I'd be all right with that.
14 Whether everyone did that, I --
15 **Q.** You couldn't say?
16 **A.** I couldn't say.
17 **Q.** Okay. You've mentioned about the breathing, the
18 respiratory rate --
19 **A.** Yes.
20 **Q.** -- and it tells you about when people have gone into the
21 bathroom, as well.
22 **A.** Yes.
23 **Q.** That's one of the matters you refer to in your
24 statement. Are there any limitations for taking those
25 measurements, in your experience?

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

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

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

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

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

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

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

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

10 A. That's okay.

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

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

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

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

1 **A.** No.

2 **Q.** Should that be happening?

3 **A.** No. No, absolutely not.

4 **Q.** You've talked about vital signs and measuring. Are you

5 aware that the Oxevision system, it doesn't detect

6 readings outside of limited ranges, say, for example,

7 a pulse rate 130 -- 150 to 130, and a breathing rate,

8 8 to 35 breaths per minute. It doesn't take those

9 readings. Are you aware of that?

10 **A.** No.

11 **Q.** Are you, given that -- I hope you can accept from me

12 that it doesn't alert to abnormal pulse or respiratory

13 readings.

14 **A.** Yeah.

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

16 **A.** Yeah. The benefits for me, I mean, the obs at nighttime

17 were a benefit. Patients being in their bathroom for a

18 long time, we did catch some self-harm and ligatures

19 because of that. That was certainly a benefit. And

20 then, with it later being linked up with the -- you

21 know, knowing if someone is in the room I thought was a

22 benefit, or if two people had gone in the room, or if

23 someone was at the door, I thought that was beneficial

24 as well. Yeah, so that's my view.

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

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

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

6 **Q.** Yes.

7 **A.** Yeah, a hundred per cent.

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

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

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

22 **A.** Mm-hm.

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

1 **A.** Yeah.

2 **Q.** -- I mean going into their room, checking them, and
3 there was that engagement that was happening throughout
4 the day, what benefit does Oxevision bring?

5 **A.** Yeah, it's again, how it was sold to us, it's something
6 additional. It should never replace observation and
7 engagement but it was just another -- that's how I saw
8 it. It's just another back-up that might save someone,
9 is how I saw it.

10 **Q.** It may be described to you as a back-up --

11 **A.** Yeah.

12 **Q.** -- could the issues that you were experiencing, that you
13 talk about in your witness statement and that you've
14 expanded upon today, could those issues equally have
15 been addressed by increasing staffing levels?

16 **A.** Yeah, yeah. You can't replace staffing and proper
17 observation and engagement, yeah. I think that's
18 a valid point.

19 **Q.** Do you accept that relying on the system or a system to
20 observe patients can present a serious risk to patient
21 safety?

22 **A.** It could be, if people aren't doing their job and
23 relying on a system, yeah.

24 **Q.** We've spoken about examples of muting an alarm.

25 **A.** Mm.

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

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

4 Q. And does that happen, in your experience?

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

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

9 A. Yeah.

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

11 A. Yeah, that happens a lot, yeah.

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

14 A. Exactly, yeah.

15 Q. Could that then impact on patient safety?

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

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

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

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

1 self-harming?

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

3 **THE CHAIR:** No, I'm so sorry, I meant a patient who you

4 considered had self-harmed but had done so in the

5 knowledge or in the expectation that somebody would come

6 as a result of the alarm system?

7 **A.** Yeah.

8 **THE CHAIR:** You said that self-harm in anticipation of being

9 checked happens a lot.

10 **A.** Oh yes, yeah.

11 **THE CHAIR:** Have patients ever said that they have done

12 that, been encouraged to self-harm because they know

13 that they've been in the bathroom and the alert will go

14 off?

15 **A.** Yeah, um, that's interesting. Not about that

16 specifically. But I do know someone might be on level 2

17 obs and they're okay when you see them. You go round

18 20 minutes later, they know you're coming and they've

19 just self-harmed. That does happen. I've spoken to

20 a patient subsequently after they've been discharged,

21 some have come back and done their nurse training and

22 things, and they're quite open. They used to talk about

23 some of the things that they used to do, and that was

24 one of them. They didn't want -- they wanted care and

25 support and help and wanted to express how bad they were

1 feeling and they wanted to be found. Yeah.

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

6 **A.** Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

7 **Q.** Were you ever given a reason?

8 **A.** No, no.

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

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

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

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

4 **Q.** To whom?

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

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

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

25 I was constantly reporting that, that was a big

1 issue, the wi-fi.

2 **Q.** And you mention the wi-fi in your statement as well.

3 Has anything, so far as you're aware in your experience,

4 changed with regards to the wi-fi?

5 **A.** Yeah, there's still blind spots that people tell me

6 about. And I still know a lot of people that work

7 there, and there's still blind spots especially when you

8 go to the education department, certain corridors where

9 it cuts out.

10 **Q.** So we've talked about observations. The Inquiry heard

11 from Abbigail Smith's mother Lisa Wolff, Abbigail Smith

12 died on 16 February 2022. She was first admitted to the

13 St Aubyn Centre in July 2012 and then on

14 13 February 2013 she was transferred to the Larkwood

15 Ward. Approximately, or less than six months before her

16 death, she wrote a letter dated 21 December 2021 where

17 she spoke -- wrote about her experiences at the

18 St Aubyn Centre. Are you aware of that letter that she

19 wrote?

20 **A.** I am aware that a letter was written. I don't know the

21 contents of it.

22 **Q.** One of the matters that Abbigail spoke about is staff

23 sleeping whilst carrying out overnight observations.

24 **A.** Mm.

25 **Q.** Were concerns raised amongst staff regarding the

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

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

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

15 **A.** Yeah, sure.

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

18 **A.** Yeah, no worries, yeah.

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

23 **Q.** You say it was always reported?

24 **A.** Yeah.

25 **Q.** How can you know that?

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

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

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

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

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

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

3 **Q.** Did anything happen?

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

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

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

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

1 long shifts that are done?

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

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

8 **A.** Mm.

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

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

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

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

2 Q. When was that changed?

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

4 Q. After Elise's death?

5 A. Yeah. Sadly, that practice is on CAMHS, you know, it

6 got changed, but other wards, adults, are still doing

7 the same thing.

8 Q. How do you know that?

9 A. I've been to them. Part of my job is going round to

10 adult wards. I've done bank shifts on adult wards, as

11 well, and their practice changed in CAMHS but not in

12 adults.

13 Q. Which adult wards?

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

15 Q. This is quite recently?

16 A. Oh yeah, yeah.

17 Q. How often were observations not filled in

18 contemporaneously?

19 A. Oh, when they were on paper, every day. There'd be

20 gaps. We would say at the start of shifts "You've got

21 to fill in your obs, make sure they're filled in." We

22 had nurses checking at the end of the day to see if

23 they'd been filled in or not. People had already gone

24 home. It got better once the system became electronic,

25 because you couldn't put them in retrospectively. You

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

5 But all over the Trust, that was a problem.

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

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

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

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

25 So I think more needs to be done about that and

1 people being held to account if the obs are missed.

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

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

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

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

20 A. Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 A. Yeah.

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

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

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

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

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

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

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

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

13 **A.** Yeah.

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

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

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

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

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

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

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

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

20 **A.** I don't remember that, no.

21 **Q.** I'd like to move on to ask you about strip searching.

22 Can you confirm whether staff were authorised to conduct
23 strip searches on the Longview Ward, either before,
24 during or after your tenure there?

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

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

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

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

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

8 **A.** Yeah.

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

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

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

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

4 **A.** Yeah.

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

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

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

9 **A.** I don't think so, no.

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

12 **A.** Yes. Yeah.

13 **Q.** How many?

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

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

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

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

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

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

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

14 **A.** Mm.

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

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

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

23 **A.** No.

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

1 **A.** No, no.

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

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

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

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

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

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

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

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

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

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

16 **A.** Mm.

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

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

1 **Q.** How did you put that into your practice?

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

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

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

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

25 **A.** Oh, okay.

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

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

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

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

21 **Q.** You say "now".

22 **A.** Yeah.

23 **Q.** Since when? Can you be specific?

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

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

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

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

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

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

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

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

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

21 **THE WITNESS:** Okay, thank you.

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

25 **THE WITNESS:** Thank you, I appreciate it.

1 **(12.52 pm)**

2 **(A short break)**

3 **(1.18 pm)**

4 **THE CHAIR:** Ms Malhotra.

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

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

15 So perhaps if I can summarise --

16 **A.** Yeah.

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

20 **A.** Yeah, yeah.

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

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

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

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

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

11 Q. Sorry, you said the Christopher Unit?

12 A. Yeah.

13 Q. I asked about the Longview Ward.

14 A. Oh yeah, sorry.

15 Q. Did you see an incident happen on --

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

21 Q. But what about the Longview Ward?

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

25 Q. How did you find that out?

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

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

6 **A.** Oh yeah.

7 **Q.** -- on the Longview Ward?

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

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

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

20 **Q.** Just on the subject of Datix, then. We talked about the
21 4,000 Datix that you were asked to review. Was this
22 a data hygiene issue or was it that they were open or
23 outstanding investigations?

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

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

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

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

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

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

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

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

10 **A.** Yes, I would say so, yeah.

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

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

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

19 **THE WITNESS:** Thank you.

20 **THE CHAIR:** Thank you very much indeed.

21 **THE WITNESS:** Okay.

22 **MS MALHOTRA:** Thank you, Chair. Tomorrow 10.00.

23 **THE CHAIR:** 10.00.

24 **(1.25 pm)**

25 **(The hearing adjourned until 10.00 am the following day)**

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I N D E X

BRIAN O'DONNELL (sworn)	2
Questioned by MS MALHOTRA	2

MS MALHOTRA: [17] 1/6 2/24 21/2 30/23 42/5 42/13 51/18 58/7 67/2 75/4 83/5 83/11 83/13 95/16 96/5 100/17 100/22 THE CHAIR: [24] 1/5 20/14 30/11 42/8 42/12 50/24 51/1 51/4 51/8 51/14 51/17 57/11 57/22 65/23 66/3 66/8 66/11 74/25 83/7 83/12 95/22 96/4 100/20 100/23 THE WITNESS: [4] 95/21 95/25 100/19 100/21	15 July 2026 [1] 1/1 15 minutes [1] 58/3 15-year-old [1] 82/18 150 [1] 62/7 155 [1] 81/13 157 [1] 78/11 16 February 2022 [1] 71/12 16 years [1] 28/25 18 [1] 4/20 181 [1] 32/2 182 [1] 29/7 183 [1] 29/6 185 [1] 67/10 18th [2] 3/25 4/18 19 [1] 28/25 1s [3] 67/23 68/6 68/11 2 20 [2] 8/8 8/12 20 minutes [1] 66/18 2003 [2] 4/2 5/5 2004 [2] 4/2 4/3 2006 [2] 4/6 5/5 2009 [3] 4/6 4/7 5/5 2012 [9] 4/11 5/1 5/5 5/10 5/24 6/4 6/11 71/13 73/14 2013 [2] 71/14 73/14 2014 [2] 6/9 91/11 2017 [1] 5/25 2019 [2] 39/17 90/10 2020 [4] 6/9 6/11 6/14 43/23 2021 [13] 3/18 6/14 6/19 6/25 15/11 17/19 19/24 28/25 40/7 43/12 47/22 49/21 71/16 2022 [3] 19/24 54/16 71/12 2024 [3] 17/20 21/11 40/7 2025 [2] 3/1 3/19 2026 [2] 1/1 3/2 21 December 2021 [1] 71/16 22 [1] 3/2 24 [1] 53/20 24 hours [2] 27/1 67/15 24/7 [2] 44/24 53/20 28 [1] 40/7 29 [1] 40/18 2s [2] 75/13 75/17 3 32 [3] 13/17 14/2 15/10 33 [2] 21/12 28/16	35 [1] 62/8 38 [1] 78/11 3s [1] 67/25 4 4,000 [13] 13/23 15/18 16/8 16/8 16/9 16/11 16/12 16/14 16/17 16/19 16/20 27/8 98/21 43 [2] 10/12 10/14 44 [1] 32/2 45 [2] 29/5 67/9 5 5.00 [1] 58/12 58 [1] 70/2 6 600 [4] 18/15 18/16 18/18 19/6 6s [1] 34/20 7 70 [1] 22/12 700 [3] 18/15 18/16 18/18 7s [1] 34/21 8 8 to [1] 62/8 80 [1] 22/12 82 [2] 8/8 8/12 8th [1] 32/11 9 90 [1] 22/12 A Abbigail [4] 71/11 71/11 71/22 91/2 Abbigail's [1] 91/4 able [10] 8/9 10/15 11/8 12/1 18/21 20/19 41/25 55/10 87/20 95/3 abnormal [1] 62/12 about [158] absconding [1] 5/23 absconsion [1] 20/9 absolute [2] 86/4 87/3 absolutely [5] 16/12 62/3 65/18 84/19 98/25 abuse [1] 92/7 accept [4] 22/20 55/8 62/11 64/19 access [12] 12/1 12/3 30/6 31/11 31/12 31/18 42/15 42/17 43/1 43/5 67/13 68/21	account [3] 9/19 78/1 78/2 accountability [1] 95/1 accurate [2] 55/20 94/20 accused [1] 73/20 acknowledge [1] 13/11 across [2] 61/23 94/12 act [4] 31/24 58/25 83/4 87/20 acted [3] 26/24 85/6 85/14 action [3] 17/6 17/15 26/1 actioned [3] 17/11 18/2 40/14 actioning [1] 27/14 actions [5] 17/11 17/16 17/23 17/25 20/16 activities [3] 99/8 99/20 100/3 actual [1] 58/17 actually [34] 9/12 12/24 14/18 21/21 22/16 24/24 33/8 36/8 38/8 38/10 38/20 39/16 39/16 41/8 47/10 48/6 52/23 53/2 53/6 55/11 57/16 57/24 58/25 63/13 68/11 75/17 75/21 75/24 75/25 83/19 84/20 86/24 91/20 95/5 acute [4] 4/15 5/21 16/1 22/10 add [1] 10/6 added [3] 53/6 53/7 54/17 adding [1] 53/3 addition [4] 43/25 44/16 48/4 48/6 additional [3] 64/6 79/4 88/2 addressed [1] 64/15 adequacy [1] 100/5 adequate [3] 63/21 90/25 100/6 adequately [2] 28/17 51/2 adjourned [1] 100/25 admin [2] 77/12 94/17 administered [1] 88/20 admission [7] 5/20 24/18 53/12 53/13	53/15 54/15 54/15 admissions [1] 53/11 admitted [1] 71/12 Adolescent [3] 1/11 3/17 3/21 adopted [1] 94/12 adult [5] 15/25 76/10 76/10 76/13 82/19 adults [2] 76/6 76/12 advance [1] 95/22 advice [1] 31/22 advocate [1] 92/23 affected [1] 72/2 afraid [1] 19/1 after [16] 1/16 30/4 30/11 30/13 39/10 66/20 67/13 70/16 73/8 76/3 76/4 85/24 87/9 87/18 87/18 90/13 again [15] 1/17 2/1 9/10 17/20 18/4 28/8 40/9 53/16 54/17 64/5 80/1 86/16 86/17 88/24 100/14 age [1] 28/25 aged [2] 3/24 4/18 agencies [1] 74/15 agency [9] 51/4 51/16 72/5 72/7 74/13 74/14 74/16 74/17 83/23 ago [4] 7/12 48/8 85/11 97/10 agree [4] 23/13 58/18 91/4 91/6 agreed [1] 5/11 aim [1] 13/23 alarm [7] 60/7 64/24 65/1 66/6 86/14 87/16 87/17 alarms [1] 60/24 alert [9] 60/14 60/14 61/7 61/8 61/12 61/17 62/12 65/1 66/13 alerts [2] 60/19 61/19 align [1] 55/23 all [74] 2/1 2/11 10/9 12/18 15/23 15/25 16/6 17/23 18/12 18/25 20/6 23/10 23/17 32/12 33/7 34/24 35/7 35/10 35/14 36/23 37/13 38/10 38/13 38/20 38/21 39/7 40/4 40/4 41/9 41/15 41/18
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