

Thursday, 16 July 2026

(10.00 am)

(Proceedings delayed)

(10.04 am)

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Good morning, Chair.

This morning, the Inquiry will hear from Ms Louise Borton, who was a staff nurse in October 2016 on the Cedar Ward at Rochford Hospital. She's worked as a Ward Manager and Matron at the Basildon Mental Health Unit since 2018. Ms Borton will give evidence of her experience of working within EPUT and its predecessor, SEPT.

It was anticipated that this afternoon the pre-recorded evidence of Stuart McGough would be played. However, due to technical issues with the visual and audio of that pre-recorded session under your direction as a special measure, instead, a transcript will be published in due course.

This afternoon we will return to the playing of Zoe Bunting's pre-recorded evidence and that will then conclude the Inquiry's business for this week, returning on Monday.

Before we hear any evidence this morning, and as with previous days, Chair, there may be aspects of

1 today's evidence that are difficult to listen to, and
2 for some, it may not be possible to sit through the
3 session. Anyone in the Inquiry room should feel free to
4 leave at any time.

5 May I take this opportunity to remind those engaging
6 with the Inquiry that emotional support is available to
7 anyone who requires it.

8 Present here again today, as with other days, are
9 emotional support staff from Hestia. They are
10 identifiable by their orange-coloured scarves. They are
11 currently in this room and there is a private room
12 downstairs where anyone who needs emotional support can
13 talk to the Hestia support staff in confidence.

14 If for any reason you prefer to speak to a member of
15 the Inquiry Team, we can put you in touch with the
16 emotional support staff who are available, and we should
17 all be wearing purple-coloured lanyards.

18 For those following the hearing online, emotional
19 support can be -- information about emotional support
20 can be found on the Lampard Inquiry website
21 @lampardinquiry.org.uk, and the "Support" tab is in the
22 top right corner.

23 As we have said on many occasions, we want everyone
24 engaging with this Inquiry, in whatever way, to feel
25 safe and supported.

1 Chair, we are ready to hear from our first witness
2 this morning. Could I ask that the witness be sworn,
3 please.

4 **LOUISE BORTON (sworn)**

5 **Questioned by MS MALHOTRA**

6 **MS MALHOTRA:** Thank you very much.

7 Now, you've provided a witness statement to the
8 Inquiry dated 28 May 2026. Have you had an opportunity
9 to read your statement recently?

10 **A.** I have.

11 **Q.** And do you have any corrections that you would like to
12 make to your statement?

13 **A.** Just regarding the period where I was the Deputy Ward
14 Manager on Cedar Ward in line with the time period
15 where -- sorry, SEPT merged and became EPUT.

16 **Q.** I see. We'll come to that, but aside from that --

17 **A.** No.

18 **Q.** -- clarification in terms of timings, is your
19 statement -- are the contents of your statement true?

20 **A.** Correct.

21 **Q.** So I'd like to start with your background. You're
22 currently employed by EPUT; is that right?

23 **A.** That's correct.

24 **Q.** And you're a nurse; is that correct?

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

1 Q. A Registered Mental Health Nurse?

2 A. Correct.

3 Q. You qualified as a nurse in 2016; is that right?

4 A. I did.

5 Q. And you started working with South Essex Partnership

6 University NHS Foundation Trust; is that right?

7 A. That's right, yes.

8 Q. And that was known as SEPT --

9 A. *(The witness nodded)*.

10 Q. -- pre-merger with EPUT?

11 A. *(The witness nodded)*.

12 Q. And that merger took place in 2017; is that right?

13 A. That's correct.

14 Q. You say -- and perhaps we could have this up to help,

15 page 1, paragraph 7, please -- you list here your

16 relevant employment history, starting with

17 September 2016 to October 2018, you were a Senior

18 Support Worker in the Cedar Ward; is that right?

19 A. The 2018 is incorrect. So it was the 2016, so it took

20 around a month for my nursing and midwifery pin to come

21 through.

22 Q. I see. It says here you worked at the Cedar Ward when

23 it was under SEPT.

24 A. *(The witness nodded)*.

25 Q. Can you just tell us what kind of ward the Cedar Ward

1 is?

2 **A.** Yes, of course. So at the time the Cedar Ward was
3 a 24-bedded mixed acute adult inpatient ward, so
4 accepted patients from the age of 18 up to 65,
5 experiencing acute mental illness. People would largely
6 be admitted, detained under the Mental Health Act but
7 had they undergone a period of assessment at our
8 assessment unit, they could be transferred for
9 a treatment bed on an informal basis.

10 **Q.** And then you then, at paragraph 8, we can see you became
11 a Staff Nurse on the Cedar Ward at Rochford Hospital?

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

13 **Q.** Then at paragraph 9 an Interim Deputy Ward Manager,
14 again at the Cedar Ward?

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

16 **Q.** And this is post-merger under EPUT. And then the Deputy
17 Ward Manager of Grangewaters Ward, Basildon Mental
18 Health Unit?

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

20 **Q.** Can you tell us, please, what type of ward Grangewaters
21 Ward was, please?

22 **A.** Yes, so Grangewaters at the time was a 28-bedded mixed
23 acute adult inpatient ward, similar to Cedar Ward but
24 for people in the Basildon area, so south-west Essex.

25 **Q.** Then you became Ward Manager at Grangewaters Ward?

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

2 **Q.** Then you went on to become, in 2021, the Matron of the
3 assessment unit?

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

5 **Q.** It's probably obvious, but tell us anyway, what was the
6 assessment unit? How was it different to the
7 Grangewaters Ward?

8 **A.** So the assessment unit at the time was a 20-bed unit and
9 it had two health-based place of safeties within that
10 ward environment, and they could be used at times as
11 escalation beds for the assessment unit if the demand
12 was such that people needed to be admitted. So the
13 assessment unit was again an acute adult working age
14 ward for people that had agreed -- sorry.

15 **Q.** I wonder if you could slow down slightly.

16 **A.** Apologies. So it was for people who had agreed to come
17 in to hospital voluntarily. They may have had a Mental
18 Health Act Assessment, and the outcome of that was for
19 informal admission. Or they may have been under the
20 Home Treatment Team or they could have been assessed in
21 an accident and emergency department. So it was for
22 informal admissions.

23 **Q.** For informal?

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

25 **Q.** Then we can see there was a health-based place of

1 safety. Tell us about that, please.

2 **A.** So the health-based place of safety was for people who
3 were admitted under Section 136 of the Mental Health
4 Act. So police would detain people who were detainable
5 under the 136 and bring them to the health-based place
6 of safety for further assessment. But as I described,
7 at times it was used for additional beds on the
8 assessment unit.

9 As a Trust, we had six health-based places of
10 safety, and we reduced down to one at one point and then
11 it was closed probably around 2020, perhaps, and then an
12 additional health-based place of safety was commissioned
13 at the Rochford site, so there was no loss of those as
14 an organisation.

15 **Q.** You also list here the Topaz Ward at the Crystal Centre.
16 Just to clarify, were you also Matron of the Topaz Ward?

17 **A.** That's correct, and that was an 18-bedded mixed acute
18 adult inpatient ward and at the time it was commissioned
19 for four detox beds managed by the Inpatient Detox Team.

20 **Q.** I see.

21 Then we can see you continued as Matron and this
22 time with the addition of the Christopher Unit at the
23 Linden Centre.

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

25 **Q.** Is that right?

1 **A.** Yeah, that's correct, I took over the responsibility of
2 the Christopher Unit for a period of time as I had
3 managed the Hadleigh Unit as a Matron and the request
4 was made to me by the Associate Director if I could
5 manage the Christopher Unit whilst at the Linden site or
6 the Crystal Centre for Topaz.

7 **Q.** Then from 2022 until this day, the Matron of the
8 assessment unit at Grangewaters and the Mental Health
9 Urgent Care Department?

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

11 **Q.** Can you tell us about the Mental Health Urgent Care
12 Department?

13 **A.** Yeah, so the Mental Health Urgent Care Department was
14 opened in March 2022, so it was designed in
15 collaboration with service users and --

16 **Q.** Can I ask you to slow down?

17 **A.** Sorry. I really apologise.

18 **Q.** It's not you, please don't apologise. It's just so we
19 can make sure a note is being taken of your evidence.

20 **A.** No problem.

21 Yeah, so it was co-designed, people with lived
22 experience and their relatives and carers. So it was
23 acknowledged that A&E departments were not the best
24 environment for people experiencing a mental health
25 crisis. So the Urgent Care Department was designed to

1 relieve pressures from A&Es and that was within the Mid
2 and South Essex locality, so Basildon, Broomfield, and
3 Chelmsford Hospital, and people would come there to have
4 a triage and a risk assessment and a decision made about
5 further care.

6 Sorry, I was going to say there's five assessment
7 rooms there. We see around 300 people per month, and
8 the sort of, the decision to admit is between two and 10
9 per cent of the people.

10 **Q.** Was this created as a result of the closure of the place
11 of safety?

12 **A.** So the Urgent Care Department is based where the
13 assessment unit used to be. So that moved into
14 Grangewaters Ward. And the assessment unit is now
15 a 15-bedded mixed assessment unit. And yes, the closure
16 of the place of safety and the move of the assessment
17 unit is where the Health based place -- sorry, where the
18 Mental Health Urgent Care Department is now located.

19 **Q.** And this Mental Health Urgent Care Department, is that
20 open 24 hours, seven days a week?

21 **A.** It is, yeah. So it's 24/7. Like I say, for people from
22 the Mid and South Essex locality. It's consultant led.
23 We have medical cover seven days a week. Consultant is
24 Monday to Friday. But outside of that, there's
25 speciality doctors that do sort of out-of-hour provision

1 in the evenings and at the weekends.

2 **Q.** And this sort of Mental Health Urgent Care Department,
3 can you help us with whether this is a new initiative?

4 **A.** It is a new initiative. There are other sort of
5 variations of the department across the country and
6 they're currently reviewing those. And I'm aware that
7 as an organisation, there will be two new Urgent Care
8 Departments that will operate slightly differently, one
9 in Colchester and one in Harlow, which are due to open
10 in the summer this year.

11 **Q.** So the primary purpose is to move mental health patients
12 away from accessing care via accident and emergency
13 departments; is that right?

14 **A.** That's correct. As a more suitable environment.

15 **Q.** And are you, given that you've been working there since
16 2022, for a number of years now, are you able to comment
17 on the sort of impact that it's having in terms of
18 patients being assessed promptly and then being moved to
19 an appropriate ward if required?

20 **A.** There are challenges, in terms of people being moved to
21 appropriate wards if required. So that's a national
22 issue, in terms of bed availability, so there's often
23 an issue of flow from the Mental Health Urgent Care
24 Department. So initially it was designed that it would
25 be for people to remain for up to 24 hours. However,

1 the reality is different.

2 **Q.** I'm so sorry to interrupt you. Could I just ask you to
3 slow down again, please?

4 **A.** Sorry. So the reality is not the 24 hours. People will
5 wait in the Mental Health Urgent Care Department for
6 much longer periods of time. Days. They do continue to
7 receive assessments whilst in the department and we have
8 got a psychologist as part of that team. So we do start
9 work, we begin medication, we have those regular reviews
10 and at times we can then safely discharge from the
11 department, but people are waiting there much longer
12 than it was designed for.

13 **Q.** I see. And does it follow, as a result people staying
14 there for longer, that the sort of therapeutic
15 activities that might be available, or
16 therapy-type-based treatments that might be available in
17 another ward wouldn't be available to those patients in
18 that urgent department?

19 **A.** So there's no wider Allied Health Professionals
20 offering. So on the wards we would have occupational
21 therapists, for example, or activity coordinators. We
22 do have a psychologist, and she has been a valuable
23 addition. However, it's not the same as a ward
24 environment. So it's just five rooms. There's sofas in
25 the rooms, but there's no beds, so it's not

1 a therapeutic space. But it's a least worst alternative
2 than somebody either being in an A&E department or at
3 home and family and carers perhaps not being able to
4 manage.

5 **Q.** I'd like to ask you about clinical risk assessments. In
6 your statement you make reference -- to help you, this
7 is page 3, paragraph 23 -- you refer here to a Mobius
8 risk stratification system. And you describe here the
9 system as a poor indicator of risk.

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

11 **Q.** In your experience, what impact does the risk
12 stratification system have on patient outcomes?

13 **A.** So the risk stratification like described, it assesses
14 people as low, medium or high risk, but as explained in
15 the statement, there was no sort of training or guidance
16 in relation to that, and --

17 **THE CHAIR:** Ms Borton --

18 **A.** I'm sorry. I'm really sorry.

19 **THE CHAIR:** Can I suggest you take your lead from the speed
20 at which Ms Malhotra speaks.

21 **A.** I will try. I am trying, I apologise.

22 **THE CHAIR:** We want to hear everything you say --

23 **A.** I hear you.

24 **THE CHAIR:** -- and we want to record it.

25 **A.** Yeah.

1 **THE CHAIR:** And just try and keep it at a slower tempo.

2 **A.** I will try, sorry, it's my usual pace, so I'm

3 struggling.

4 **THE CHAIR:** Don't worry.

5 **MS MALHOTRA:** Let's just take it a step back and take it in

6 stages.

7 **A.** Yeah, no problem.

8 **Q.** Just give us an overview, if you can, on what the Mobius

9 risk stratification system is?

10 **A.** So each risk, so for example, suicide, self-harm, is

11 listed, and then there's a space for you to incorporate

12 any free text that you want to in relation to that. And

13 then there's a section where the staff member would

14 select either low, medium, or high risk.

15 **Q.** So the low, medium or high is calculated or generated by

16 the system?

17 **A.** No, by the clinician.

18 **Q.** I see.

19 **A.** But there's no, as I've described, there was no clear

20 training or guidance in relation to that form, the

21 stratification.

22 **Q.** Just pausing there, then, this is part of the admission

23 process or the initial assessment?

24 **A.** Correct; the initial assessment of risk and need.

25 **Q.** So this would be undertaken by a nurse?

1 **A.** Yes.

2 **Q.** There was no training or guidance on how to make the
3 assessment of risk; is that fair?

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

5 **Q.** Or how to use the system that helped with identifying
6 the risk?

7 **A.** That's fair. So it was largely done by the clinical
8 judgement staff. People would often have discussions
9 with colleagues about what they considered that risk
10 stratification to be for that individual person's risk.

11 **Q.** And so why do you say here in your statement that it was
12 a poor indicator of risk?

13 **A.** In terms of the staff completing that form, I'm aware
14 that we had instances where people were recorded as high
15 risk on a risk assessment. Sorry, low risk on a risk
16 assessment. These forms were then not updated and then
17 it didn't reflect that current risk and we had instances
18 where, on discharge, somebody was rated a different
19 risk, like lower than what was actually happening. And
20 it did rely on the clinical judgement of the staff. And
21 risk is, you know, dynamic, quite often. So selecting
22 that risk, RAG rating doesn't determine the presentation
23 at that time.

24 **Q.** So you've mentioned RAG rating, red, amber green; is
25 that right?

1 **A.** Yes, high, medium, low.

2 **Q.** Just help us understand, then, what the impact of that
3 might be, the initial assessment here being a poor
4 indicator, and there being no training or guidance, and
5 the -- not being reviewed or updated regularly as you've
6 described.

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

8 **Q.** What impact did that have in practice, in your
9 experience?

10 **A.** People could sort of misunder -- misinterpret the level
11 of risk of the individual. If that risk assessment
12 hadn't been updated thoroughly, then you wouldn't have
13 that overview of that individual at that time when
14 making decisions, perhaps. And thinking about where we
15 end up as an organisation, when these documents are
16 reviewed at coroners, it often doesn't correlate with
17 the picture of that person during their journey.

18 **Q.** I see. How long has this gone on for, or is this
19 throughout your entire experience? Can you just help us
20 with the time frame.

21 **A.** That form has been used throughout the duration of my
22 time with EPUT and the predecessor, SEPT, but I am aware
23 that as part of the Nova programme, which is the review
24 of the electronic patient records used by the Trust,
25 that that form is being reviewed and there is the

1 consideration for a move away from the risk
2 stratification. As an organisation, when we -- when
3 staff go on STORM training, they're told to not really
4 use that risk stratification, is my understanding. And
5 staff have fed back that what they're taught on that
6 training differs from practice.

7 **Q.** So we'll come on to that. So you've mentioned Nova and
8 the STORM training.

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

10 **Q.** We'll come back to that, but just before we do, you say
11 here at paragraph 24 and paragraph 25 -- and I hope
12 I can summarise it fairly, you tell me if I haven't --
13 that the Mobius risk stratification tool that was used
14 by nursing staff was not in line with NHS England
15 guidance --

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

17 **Q.** -- nor the National Institute for Health and Care
18 Excellence -- NICE, for short -- NICE Guidelines; is
19 that right?

20 **A.** Yes.

21 **Q.** And if I was to ask you whether that was the NICE
22 guidance issued on 7 September of 2022, would you be
23 able to say whether that's right or wrong?

24 **A.** I wouldn't be able to confirm without checking.

25 **Q.** And NHS guidance Staying Safe from Suicide, dated

1 4 April 2025. Would you be able to recall if that's --

2 **A.** I can't recall but I imagine it would be, given those

3 dates, the most latest guidance.

4 **Q.** So you mention here at paragraph 26, that there is now

5 STORM Skills Training in Self-harm and Suicide

6 Prevention, which is consistent with NHS England and

7 NICE Guidelines. Is that a view which you have

8 independently formed, having reviewed those guidelines?

9 **A.** Yes, and from speaking to one of the STORM trainers.

10 Like I say, I haven't been on that training myself, but

11 that's my understanding, from speaking to one of the

12 trainers.

13 **Q.** And when did this STORM skills training start? Can you

14 help us?

15 **A.** Perhaps '20, '20, around '22, '23, perhaps. I remember

16 it specifically around the time of the Mental Health

17 Urgent Care Department but that's not to say that it

18 wasn't already happening and different services were

19 accessing that training.

20 **Q.** So possibly around '22, maybe '23?

21 **A.** Possibly.

22 **Q.** And this STORM skills training, you said that it

23 differed in the approach. Can you just expand on that

24 and explain that to us?

25 **A.** Yes, my understanding was that it was about the shared

1 formulation, the coproduction of the safety plans and it
2 didn't use the risk stratification. So it was more -- I
3 don't know how to describe it. Less about assigning
4 a risk and more about thoroughly understanding that
5 person, their history, and the risk, and formulating the
6 safety plan for them.

7 **Q.** So is it the case that staff are, on this STORM skills
8 training, they are not trained to use the risk
9 stratification -- the Mobius stratification tool --

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

11 **Q.** -- they are trained in a different way?

12 **A.** Yes, and that's where staff have fed back to the
13 organisation that there was a disparity in what they're
14 being taught and what's occurring in practice, and I do
15 remember that being taken to one of the Deputy Directors
16 of Quality and Safety, and that's where those
17 discussions surrounding the Nova programme came to
18 light.

19 **Q.** I see. And so is the Mobius risk stratification tool
20 still being used by the nursing staff?

21 **A.** It is, with no change to how STORM incorporates into
22 that, in terms of moving away from the stratification.

23 **Q.** Is that a concern for you?

24 **A.** It is, given that we're, as an organisation, training
25 people in STORM and our documents don't reflect what

1 we're teaching people to do in line with the guidance.

2 **Q.** Aside from that, in practice, have you seen, or can you

3 comment or give us an example, of what the impact of

4 that disconnect is?

5 **A.** I think for me, my understanding of that is it's more

6 the staff frustration that we're not working in a way

7 that is best practice.

8 **Q.** I see. And you mentioned speaking, I think it was to

9 the Deputy Director of Clinical --

10 **A.** Quality and Safety.

11 **Q.** Sorry, Quality and Safety, forgive me. What was the

12 outcome of that, do you know?

13 **A.** Only that there was the discussion surrounding Nova and

14 the change to the electronic patient records.

15 **Q.** So tell us about Nova, then, please.

16 **A.** So Nova is going to be the new clinical system that will

17 be used by the Trust and it will also be used by the

18 local acute Trusts and they'll have access to one shared

19 record system. So as a Trust, we'll no longer have two

20 clinical record systems. So it'll move away from Mobius

21 and Paris. So it should improve patient access to

22 services, both mental health and acute, at the time of

23 entry.

24 **Q.** I see in terms of practicality of having access to notes

25 and a more streamlined process; how does Nova address

1 the disconnect that you've described with the assessment
2 by nursing staff?

3 **A.** I'd be unable to comment at this stage, as I've not seen
4 the documentation that's been designed for use for the
5 initial assessments of risk.

6 **Q.** Okay. So you -- you're not able to say if Nova or the
7 implementation of it is going to resolve the concern
8 that you've got?

9 **A.** Not at this stage, but based on the discussion with the
10 Deputy Director of Quality and Safety, my understanding
11 is that when that is designed, it's going to move away
12 from the risk stratification. But I've not seen it so
13 I wouldn't be able to comment at this stage.

14 **Q.** So when is the implementation of Nova likely to happen,
15 do you know?

16 **A.** 2027, I believe.

17 **Q.** And you've touched upon records, and I want to ask you
18 a little bit about that. At paragraph 116 of your
19 statement, this is page 24, you say that:

20 "In response to recordkeeping issues identified on
21 the Assessment United [you] introduced one-to-one
22 engagement entries to better capture patient contact and
23 interaction."

24 And then:

25 "More recently [you've] worked with the Professional

1 Nurse Educator to improve the quality of nursing
2 documentation ..."

3 And you're not aware if any of the changes were
4 implemented or embedded in practice on the Hadleigh Unit
5 following the recordkeeping failings identified in the
6 Patient Safety Incident Investigation Report relating to
7 Jason Standing.

8 Do you know now if it has been implemented more
9 widely, at all?

10 **A.** Which has, sorry?

11 **Q.** The changes that you say -- improving quality to nursing
12 documentation, has that now been implemented?

13 **A.** So the Professional Nurse Educator who I'd spoken to, he
14 covers our Basildon site so although Hadleigh Unit isn't
15 my responsibility as a Matron, the work that I'd
16 requested be completed for the assessment unit has taken
17 place across the site.

18 **Q.** It has is taken place now?

19 **A.** Yeah. It's ongoing. There is still improvement
20 required, but the work is ongoing, yeah.

21 **Q.** You say improvement is required. Can you tell us
22 a little bit about that?

23 **A.** Yeah, so the Professional Nurse Educator will audit the
24 clinical records and not -- and on all wards there's not
25 always evidence of the one-to-one engagement. The

1 frequency for the one-to-one nursing entry was set as
2 once a week, but it needs to ideally be increased to
3 daily one-to-one engagement evidence in the notes.

4 **Q.** So as far as you're aware, that hasn't happened?

5 **A.** Daily, it doesn't happen consistently. Staff are
6 engaging, but it's not always captured in the records on
7 the Clinical Continuation Sheet.

8 **Q.** You summarise the many challenges that affected
9 contemporaneous recordkeeping. What impact did or does
10 incomplete records and generic care plans have on risk
11 assessment and discharge planning?

12 **A.** It could give a false sense of security to the team,
13 including the consultant psychiatrist who will review
14 the records, as well as discussing with the clinical
15 team on duty. So it could create that gap which could
16 lead to risk to patient safety.

17 **Q.** And how do these issues affect staff understanding of
18 patient progress, recovery, or their risk of self-harm
19 when making decisions about leave or discharge?

20 **A.** If it's not captured within those documents, it's
21 difficult to evidence. So the staff would need to look
22 through perhaps the form which is a 4.1, a continuation
23 sheet. They'd perhaps need to look through the
24 Therapeutic Engagement and Supportive Observations. So
25 it's quite a laborious task to do that and it would rely

1 on the clinical handover from one shift to another, and
2 information could be lost when doing that, it could be
3 diluted.

4 **Q.** Can you help us with what impact, if any, positive risk
5 taking had on decisions to leave?

6 **A.** I'd say that positive risk is important within the
7 mental health services. But in order to do that, you
8 need the thorough understanding of that individual.

9 **Q.** So if you're making clinical decisions based on
10 incomplete -- an incomplete picture, what sort of
11 decision is that going to lead to? Can you help us?

12 **A.** It could lead to an unsafe decision.

13 **Q.** You mentioned the Professional Nurse Educator conducting
14 an audit. When did that audit process start, in your
15 experience?

16 **A.** Within the last six to 12 months.

17 **Q.** Okay, and before that, there wasn't one?

18 **A.** There's audits on Tendable, but they're completed by
19 nursing staff. And the staff understanding of those
20 audits, I would say, isn't always clear. So, for
21 example, at times, audits might show high compliance and
22 then when you check the clinical records yourself, so
23 myself, if I were to check, I wouldn't have scored that
24 a hundred per cent. So there was a difference in how
25 people were sort of agreeing whether something had been

1 completed or not.

2 Q. I see. So this -- the audit on Tendable, when did that
3 happen or when did that start? Can you help us?

4 A. Tendable has been around since I've been at Basildon but
5 I couldn't remember when we started using that system.
6 Within the last five years, perhaps. But it could be
7 longer or shorter.

8 Q. Okay. I think, if I've understood your evidence
9 correctly, there was difficulties or barriers to
10 understanding the outcome of an audit; is that fair?

11 A. Yes. I would question whether they were accurate
12 reflections of practice.

13 Q. Okay. And so as a result of that, help us with what the
14 impact might be.

15 A. False assurance that things were taking place, which
16 subsequently could be discovered to not be taking place,
17 for example during CQC inspection or internal compliance
18 visits. If there were a patient safety incident on
19 review of clinical records. Yeah, a very --
20 a variation.

21 Q. So another example of a potential safety -- a patient
22 safety concerns arising?

23 A. Yes.

24 Q. Would you agree with that?

25 A. Yes.

1 Q. Just going back, then, to the clinical risk assessment.
2 You mention -- I'm sorry, we are skipping around your
3 witness statement, but page 3, paragraph 21 -- you talk
4 here about key performance indicators.

5 A. Mm-hm.

6 Q. Can you help us with what the key performance indicators
7 are?

8 A. So for risk assessment, it was that that was completed
9 within four hours of admission. So it was determining
10 whether those performance objectives have been met.

11 Q. And so the aspiration and the guidance is that it's done
12 within four hours?

13 A. Yes, and it would be reported if there were any
14 breaches.

15 Q. Okay. You wouldn't be able to say if that happens in
16 every case because, presumably, you're not involved in
17 every case?

18 A. No.

19 Q. Okay. You talk about patient and carer involvement, and
20 you refer to dashboards as well, which I think is how
21 any breaches, for example, you've just described, it
22 would come up. That's on the dashboard, is it?

23 A. So it would show on the dashboard and then emails would
24 be sent to Ward Managers, Matrons, highlighting that
25 there'd been a breach, and asking for any narratives

1 surrounding that. But the dashboard has got a paperwork
2 gap report which will show where paperwork hadn't been
3 completed. However, if someone were to open a risk
4 assessment and save that without any information being
5 added, it wouldn't show as a breach, as it has been
6 saved. But nothing may have been added to that risk
7 assessment.

8 Q. So slightly different question, but in respect of the
9 KPIs, they're focused on a time, an assessment being
10 completed within a time?

11 A. *(The witness nodded)*.

12 Q. It's not assessing the quality of an assessment?

13 A. No, and like I say, if you open that 2.1, save it with
14 no information, it won't show as a breach. So you could
15 sort of override the system that way.

16 Q. I see. You talk in your statement -- this is at
17 paragraph 30, page 5 -- about a KPI -- there isn't a KPI
18 for updating assessments on discharge; is that right?

19 A. Yeah, that's correct, and I had made suggestion in the
20 past for that to be considered. So we had a patient
21 safety incident when I was on the Grangewaters Ward of
22 a patient that had died following discharge, and the
23 risk assessment hadn't been updated. And I have asked
24 for that KPI to be considered and included on the
25 dashboard, but it hasn't. So in terms of mitigating

1 that, as a site, we've got a discharge checklist and the
2 Professional Nurse Educator also audits those on
3 discharge.

4 **Q.** So you've given us a specific example there.

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

6 **Q.** Can you tell us when this arose?

7 **A.** Prior to becoming a Matron, while I was Ward Manager on
8 Grangewaters, so I'd say between 2019 and 2021.

9 **Q.** So you raised this concern?

10 **A.** Yes.

11 **Q.** Who did you raise the concern with?

12 **A.** I think it was as part of the investigation process,
13 from what I can recall. And I believe management. I
14 couldn't say who, specifically.

15 **Q.** And that still hasn't been addressed?

16 **A.** We don't have it on discharge, no, as a KPI.

17 **Q.** At paragraph 284 of your statement, this is page 56, you
18 say that:

19 "Ward culture was not always conducive to the
20 delivery of good quality inpatient care and treatment."

21 And you refer to staff often being focused on risk
22 management rather than therapeutic engagement. How did
23 emphasis on KPIs relating to risk assessments impact
24 patient care and safety?

25 **A.** Sorry, could you repeat it in a different way?

1 Q. Yes, of course.

2 A. Sorry, my brain can't ...

3 Q. Let me break it down. It's a long question. You talk

4 about ward culture --

5 A. Yeah.

6 Q. -- and that it wasn't always focused, and I'm

7 paraphrasing here, it wasn't always focused on delivery

8 of good quality inpatient care --

9 A. *(The witness nodded)*.

10 Q. -- and treatment.

11 A. *(The witness nodded)*.

12 Q. And that staff are often focused on risk management

13 rather than therapeutic engagement.

14 A. *(The witness nodded)*.

15 Q. And so what I'm trying to understand is, was it the KPIs

16 that were causing that imbalance that you've described?

17 A. No, I wouldn't say so. I would say the focus on the

18 risk management was to do largely with the numbers of

19 patients that we had on the wards, staffing, and

20 managing that immediate risk. We've had a lot of

21 change, in terms of our staffing establishments. So

22 previously it would be quite common for one nurse to be

23 on duty, responsible for up to 28 patients when it was

24 Grangewaters, with three support workers. So it was

25 challenging and it did mean that, yeah, it was more

1 focused on that risk management. People were put on
2 observations more frequently. I'd say there was less
3 understanding of restrictive practice and the drive to
4 reduce that.

5 We didn't really have psychology provision until
6 around 2023, so staff understanding of trauma-informed
7 care was really poor. Our observation policy, now
8 Therapeutic Engagement and Supportive Observations, used
9 to be called Engagement and Supportive Observations,
10 there was no focus on the therapeutic engagement with
11 people. And it was about keeping that person alive.

12 And I would say, as an organisation -- as
13 a clinician working through inquests that we became
14 aware of as an organisation, and also more recently
15 through the Lampard Inquiry, staff anxiety was higher,
16 and some of those decisions were about managing that
17 risk in the context of what was going on for the
18 organisation.

19 **Q.** You talk about, in your statement -- this is at
20 paragraph 21 and 22 -- about staffing pressures meant
21 that it was not always routine practice to involve
22 patients and carers in risk assessments, and that staff
23 often relied on previous assessments rather than
24 conducting full reassessment of clinical risks.

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

1 **Q.** How often did that occur in practice?

2 **A.** I would say that was common practice. I think that
3 there's been a move away from that, but that was common
4 practice. It was, and still is, a trending document.
5 So you could go back. We had high levels of admissions,
6 especially on the assessment unit and the Grangewaters
7 Ward. So those are the wards that I can directly speak
8 to.

9 And with those number of admissions, often within
10 a short space of time, that focus on that KPI being met
11 meant that people weren't always spoken to in that
12 immediate time.

13 In terms of patients and families being involved,
14 I would say that's less so in that 2.1 risk assessment
15 but they were involved in ward rounds with the medical
16 team, and more recently, we've had the Family and Carer
17 Ambassadors. So we've got two of those at Basildon site
18 and they cover the four wards. And they are focused on
19 engaging with families and carers and ensuring that
20 their voices are captured within our records but also,
21 you know, by virtue in the admission process.

22 **Q.** So you've talked about family and carer advocates being
23 part of the process. Can you help us with how widely
24 that's been used?

25 **A.** I would say the rollout of the Family and Carer

1 Ambassadors hasn't been the strongest. I understand
2 that we were one of the first Trusts that have used
3 Family and Carer Ambassadors in Adult Mental Health
4 services. I'm aware that they'd been used in CAMHS
5 services previously.

6 **Q.** Can I just ask you to slow down, so sorry.

7 **A.** Yeah, sorry.

8 Repeat that for me, then, sorry.

9 **Q.** You said the rollout has not been the strongest --

10 **A.** Yes.

11 **Q.** -- and that the Trust was the first?

12 **A.** That's my understanding.

13 **Q.** When did the rollout start?

14 **A.** Our Family and Carer Ambassador, we had one that started
15 last year. However, they didn't remain in post. So
16 more recently ours is within the last six months,
17 I would say, for the assessment unit and Hadleigh Unit.
18 But as an organisation, I believe they were trialled at
19 Rochford and the Linden Centre.

20 **THE CHAIR:** In 2025 was that?

21 **A.** Ours, in Basildon?

22 **THE CHAIR:** Across the Trust?

23 **A.** Basildon, I know that's when ours started. I wouldn't
24 like to say when exactly they started at the other
25 sites, but I believe it was in response to the, you

1 know, Time to Care, but also the CQC section 29s.

2 But there's variation in the Family and Carer
3 Ambassadors, I would say. So myself and the two Ward
4 Managers, one for Hadleigh and one for the assessment
5 unit, met and have determined what we think that that
6 Family and Carer Ambassador should be doing on
7 a day-by-day basis, and I did share that with the other
8 wards that I'm not the Matron for, to try and have some
9 consistency across the site.

10 **THE CHAIR:** Can I just ask you, they are representing the
11 family, and are they providing sources of information
12 about a particular patient, their history, background?
13 Can you describe what --

14 **A.** As in the Family and Carer Ambassador?

15 **THE CHAIR:** Yes.

16 **A.** So they'll be the link with the patient and the family
17 and carer of that person. So they'll speak to them at
18 a determined frequency. They'll introduce themselves,
19 determine how that person wants the communication to be
20 maintained. They'll gather information from them and
21 they'll share information following MDT or ward rounds.
22 They'll also share information about other services and
23 link them up to support discharge.

24 **THE CHAIR:** And will they advocate for the families if they
25 have a particular concern?

1 **A.** If they have a concern they would, yes. Our Family and
2 Carer Ambassador attends our MDT on the assessment unit
3 and that's held Monday to Friday, and she'll bring to
4 that MDT any concerns that a family have raised and then
5 she'll feed back following. And they document that in
6 the records, as well, for the patient.

7 **THE CHAIR:** Thank you. Very helpful.

8 **MS MALHOTRA:** I'd like to -- we will come back to family
9 engagement in a moment but I'd like to ask you about
10 EUPD and the pathway, emotionally unstable personality
11 disorder, and the pathway.

12 You describe in your statement -- this is, for those
13 who are following, page 13, paragraph 65 to 68 -- you
14 describe longstanding issues in the application of the
15 Trust's EUPD pathway in inpatient services. You say
16 that the 2023 Standard Operating Procedure, the SOP,
17 was:

18 "... not fully approved, implemented or reviewed and
19 therefore did not provide a robust or consistently
20 applied structure for clinical practice."

21 How long has that been an issue?

22 **A.** I think the Trust has discussed EUPD pathway for a very
23 long time, but the reality is that there doesn't appear
24 to be an EUPD pathway.

25 **Q.** You say for a very long time. How long?

1 **A.** Prior to 2023, and around that period, I would say, but
2 yeah, there is discussion about the EUPD pathway. But
3 in practice, I don't think that we have one that
4 operates and meets the needs of patients in terms of if
5 they're admitted to the wards, but also to the staff
6 working on the wards where patients with emotionally
7 unstable personality disorder are admitted.

8 **Q.** Why do you say that?

9 **A.** I don't think that we support people in line with the
10 guidance for admission to be short, sort of, crisis
11 admission. So quite often our patients with EUPD will
12 be admitted, and it's not for a crisis admission, and we
13 know that people with EUPD do -- it's not therapeutic to
14 remain in hospital for a very long period of time. But
15 as it stands, people are admitted for longer than crisis
16 admissions.

17 I know other Trusts, for example, have different
18 ways of operating their pathways. I think it's -- I
19 can't remember which Trusts, but they've got like, it
20 seems a very robust team that will offer sort of 12-week
21 intensive support to avoid people going in to hospital
22 and if they're admitted, bring them out, and almost like
23 a Crisis Resolution Home Treatment but for EUPD, but as
24 it stands, our patients don't seem to have that support.

25 **Q.** And you mentioned staff as well, dealing with patients

1 diagnosed with EUPD, what do you mean by reference to
2 the staff? Is it that they aren't trained to deal with
3 them or they don't have the skills or there's a lack of
4 understanding? Can you just help us understand that.

5 **A.** I think it's more that people with EUPD remain on
6 inpatient wards for very long periods of time where
7 there's no clear purpose for that continued admission.

8 **Q.** I see.

9 **A.** And again, I think that probably relates to the
10 community provision, and also the landscape, like
11 I described that we're working in, and the fear of
12 discharge of people who could potentially, due to the
13 nature of their illness, die. Even if that wasn't the
14 intended consequence -- suicide.

15 **Q.** And so the impact, as you've just described, can be
16 catastrophic?

17 **A.** It can. Yeah. We do have better provision, like
18 I said, in terms of patients with EUPD. On the wards
19 we've got a psychology team that over the years is
20 established. There's only one vacancy at Basildon that
21 I'm aware of. And the clinical psychologist is working
22 to resolve that. They've attempted to recruit in the
23 past. People have been recruited but then they don't
24 start. So we have trainee psychologists and the hope is
25 that eventually they could recruit people that they'd

1 developed through that route, if unable to recruit
2 externally before.

3 **Q.** Would you agree that the Trust practice doesn't align
4 with National Best Practice Guidance; would you agree
5 with that?

6 **A.** I would.

7 **Q.** How has practice changed since 2023, if at all?

8 **A.** I don't think it has really changed. Like I say, we do
9 have better provision on the ward in terms of
10 psychology. But I wouldn't say that there is an
11 effective EUPD pathway.

12 **Q.** You say at page 13, paragraph 68, that staff awareness
13 of inquests and this Inquiry is contributing to
14 defensive practice.

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

16 **Q.** Can you provide some examples of this defensive
17 practice?

18 **A.** For me, it's about people remaining on the ward when
19 they're clinically ready for discharge. But perhaps
20 people may inform that they're not ready, that they will
21 harm themselves, and that people will be responsible --
22 almost threatening that staff will be responsible if
23 they harm themselves. And that's not only patients. At
24 times, relatives have said similar things. And that's
25 as part of a wider clinical assessment where we might

1 have people utilising leave, engaging well on the ward
2 with staff and patients, to all intents and purposes
3 objectively appear ready for discharge, and are deemed
4 clinically ready but then are not discharged due to
5 statements made.

6 **Q.** So you say here if we look at paragraph 68, second
7 sentence:

8 "Staff were acutely aware of scrutiny arising from
9 coroners' inquests and the ongoing Lampard Inquiry,
10 which heightened concerns about risk, accountability,
11 and decision-making. This environment could contribute
12 to defensive practice ..."

13 **A.** People have had really poor experiences of coroners'
14 inquests. I'm thinking of the consultant psychiatrist
15 that I work with, and it does have an impact on decision
16 making, when you've had such difficult inquests, and the
17 approach that's taken during those.

18 **Q.** And so, when you go on here to say that it can
19 contribute to defensive practice, can I just press you
20 a bit. What do you mean by that?

21 **A.** I think people -- for me, it's about people remaining on
22 wards longer than necessary, rather than -- I don't want
23 to say sticking to, but rather than using the clinical
24 judgement that's already been formed and the
25 observations during usually quite a sustained period of

1 time.

2 Q. So it's impacting on clinical decision making?

3 A. Yes.

4 Q. And have I understood it correctly, if I've got this
5 wrong, that can lead to people not being discharged --

6 A. *(The witness nodded)*.

7 Q. -- when perhaps they should be?

8 A. Correct.

9 Q. And I think, when we discussed before in the context of
10 EUPD patients, the impact of longer admissions, putting
11 to one side patients with EUPD, and speaking about
12 general inpatient population, mental health patients, is
13 there an impact on delayed discharge on them?

14 A. There may be a reliance. People may then struggle to be
15 discharged. They may start to feel more contained on
16 the ward. It is important, I think, to consider that
17 whilst we have people clinically ready for discharge on
18 the wards, we've got people in the community that need
19 to be admitted. And it's about that balance, so keeping
20 that in mind, so that we're maintaining the safety of
21 people in the community. But I do think that perhaps
22 because that's sort out of sight, out of mind, you're
23 not the clinician responsible for those people; you're
24 responsible for the people on your ward, that that might
25 contribute to the decision making too.

1 **THE CHAIR:** Can I ask you about your comments about
2 impacting decision making and defensive practice,
3 keeping people on wards. Is that sometimes to the
4 detriment of what some have referred to as positive risk
5 taking --

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

7 **THE CHAIR:** -- with someone's treatment, in other words
8 offering opportunities to integrate back into the
9 community even when it may not be evident that that's
10 going to work, but it might offer a better outcome?

11 So I think my question is: do you sometimes feel
12 that it is detrimental to the patient not to have the
13 opportunity to --

14 **A.** Yeah.

15 **THE CHAIR:** -- take the next step?

16 **A.** I do. It's detrimental, like in terms of that next
17 step, but quite often it'll impact the wider patient
18 population, and then people will observe that people
19 aren't being discharged. They'll then say similar
20 things when they're reviewed. They'll then stay longer
21 on the ward, and it can have quite a knock-on effect.

22 **MS MALHOTRA:** Chair, I wonder if that's a convenient moment
23 to take our morning break. Fifteen minutes.

24 **THE CHAIR:** Fifteen minutes.

25 **(11.05 am)**

1 (A short break)

2 (11.22 am)

3 THE CHAIR: Ms Malhotra.

4 MS MALHOTRA: Thank you.

5 Before we took our morning break, we were talking
6 about EUPD patients, discharge pathways, and
7 a defensive -- defensive practices. And one of the
8 things you mentioned in your evidence was that when
9 a patient's ready for discharge, they're clinically
10 ready, but not discharged to statements made. And
11 I just wondered whether you could expand on what do you
12 mean by "statements made"?

13 A. So at times patients may say, "I'm going to kill
14 myself," and that "You will be responsible, you will,
15 you know, be responsible for this" to the team that's
16 assessing at that point, so the Consultant Psychiatrist,
17 the nurse that's in the review and any other members of
18 the MDT, but usually directed at the Consultant
19 Psychiatrist but that decision would be made by the MDT.

20 Q. You've mentioned the Consultant Psychiatrist. At
21 paragraph 291, this is page 58 of your statement, you
22 make reference to the Consultant Psychiatrist working on
23 a female ward who placed all patients diagnosed with
24 emotionally unstable personality disorder on level 3
25 Therapeutic Engagement and Supportive Observations.

1 You go on to say:

2 "I believe this practice was harmful, as such

3 diagnoses do not automatically indicate a need for

4 constant observation."

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

6 **Q.** And you go on to explain:

7 "For some patients, this level of monitoring was

8 intrusive, distressing and counter therapeutic. Despite

9 this, the practice continued, seemingly because it had

10 become embedded as accepted practice."

11 Can you help us, please, with when did this happen?

12 Or does it still happen?

13 **A.** My understanding is that it does still happen. I know

14 you heard evidence from -- in relation to Dispatches and

15 the practice on Willow Ward, and I'm aware -- not more

16 so recently, but I am aware, that the Matron for that

17 ward had raised concern about the practice.

18 **Q.** And so this practice of a Consultant Psychiatrist

19 putting a patient on level 3 observations, I'll say for

20 now, inappropriately, in your view?

21 **A.** In my view, yes.

22 **Q.** In your view, when did you first become aware of that or

23 when did you first become concerned about that?

24 **A.** Yeah, I think I was aware of it for quite a period of

25 time, whilst the consultant had been on that ward. And

1 it did concern me in the sense of the reason that I've
2 included in that paragraph: it is an intrusive level of
3 observations, level 3. It's a restriction on that
4 person's privacy, it impacts on dignity, and it's not
5 always a required level for somebody with a diagnosis of
6 emotionally unstable personality disorder.

7 **Q.** And so this is restricted to one Consultant Psychiatrist
8 or is this more widespread?

9 **A.** That's my understanding. That's my experience.

10 **Q.** And you said you're not sure about timescales. Is it
11 within a year, two years, five years, a decade?

12 **A.** So Willow Ward opened less than a decade ago, probably
13 around five years, perhaps. And it's been happening up
14 to the last year. That's when I recall the
15 conversations about the concerns being raised by the
16 management on that site. And I believe the Deputy
17 Director of Quality and Safety was aware and was
18 attempting to support, in terms of the reducing
19 restrictive practice and the Therapeutic Engagement and
20 Supportive Observations.

21 **Q.** So I just want to explore that a bit with you. Did you
22 challenge this practice with the consultant?

23 **A.** So it's not my ward so I wouldn't challenge that
24 directly with the consultant but I had raised the
25 concern about the practice.

1 **Q.** And raised the concern with who?

2 **A.** With the Deputy Director of Quality and Safety, as well
3 as had the discussion with the management of that site,
4 so the Matron for the area.

5 **THE CHAIR:** Can I just be clear with you, it's not just, in
6 your view, that it is an affront to privacy and is
7 restricted, do you think it's actually harmful,
8 sometimes, for such a patient to be on level 3
9 observations the whole time?

10 **A.** Yeah, if it's not required, I would say that's harmful.
11 And it has a significant impact on that individual, but
12 also other individuals on the ward, if there are any
13 issues with staffing, for example. And at times, it can
14 increase the reliance on staff and make that reduction
15 in observation and discharge more challenging.

16 **MS MALHOTRA:** So if I was to summarise it, could it set
17 a patient back?

18 **A.** Personally, I believe that that could, that practice.

19 **Q.** So you say that you raised this with the Matron, you
20 raised it with the Deputy Director for Quality and
21 Assurance --

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

23 **Q.** -- and what were you told, and what was done?

24 **A.** I don't know what was done, but I'm aware that it was
25 a sort of known issue, but I don't know what support was

1 put in place in order to address.

2 Q. And are you aware whether similar restrictive practices
3 were imposed on male patients?

4 A. I'm not aware of that, and the consultant, it's an
5 all-female ward, but I'm not aware of male patients on
6 wards automatically being on level 3 if they've got such
7 diagnosis, across the Trust.

8 Q. Would you accept that a consultant who will be making
9 those decisions, will have a clinical reason for doing
10 it? Or is it that your concern is you don't consider
11 that there was a clinical reason for it?

12 A. I wouldn't say it was just myself. If the Matron for
13 that site also had a similar concern. Yes, the
14 Consultant Psychiatrist will have their clinical
15 judgement, but I do feel that the clinical judgements of
16 others within that multidisciplinary team, not just
17 nursing, should also be considered.

18 Q. I'd like to ask you about The Haven. Is that -- are you
19 aware of The Haven? Do you have any experience or
20 knowledge of it?

21 A. I've not heard of The Haven.

22 Q. I'd like to ask you next about comorbidities and -- not
23 the same category, but patients, inpatients with
24 substance misuse. Firstly, you say, or you rather
25 observe, that there was a lack of appropriate services

1 for individuals with comorbid mental health and
2 substance misuse needs, particularly in relation to
3 dedicated integrated dual diagnosis services.

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

5 **Q.** This is at paragraph 32 of your statement. And later,
6 at paragraph 46, let me give you some page references
7 for this. So paragraph 32 is page 5.

8 **A.** Page 8.

9 **Q.** Yes, it's on the screen in front of you.

10 "In addition, there was evident fragmentation
11 between mental health services with the Trust and
12 external substance misuse services."

13 And then you go on to explain the joint working
14 arrangements which did not always provide a consistently
15 coordinated or integrated approach to care.

16 Then if we go to paragraph 46, page 8, you say here:

17 "Patients with substance misuse difficulties,
18 including drug and alcohol dependence, were frequently
19 managed on inpatient wards, despite the therapeutic
20 benefit of admission not always being clear and despite
21 the impact such presentations could have on behaviour,
22 risk and ward dynamics."

23 Why do you think those struggling with substance
24 misuse did not receive therapeutic benefit from being on
25 the ward?

1 **A.** I would say that, as described within Essex there's a
2 number of drug and alcohol services. So on -- in the
3 assessment unit in Basildon more recently, the discharge
4 coordinator has set up weekly forums with local drug and
5 alcohol services, but prior to that, I wasn't aware of
6 any sort of in-reach work that was going on. And more
7 recently I've reached out to the forensic service, who
8 have set up Alcoholics Anonymous meetings within their
9 services to see whether that's something that we can try
10 within the assessment unit at Basildon, but would be
11 offered more broadly to patients on the other wards
12 there.

13 But prior to the discharge coordinator setting it
14 up, it was very sort of fragmented. There was no
15 in-person support and we know that that first contact
16 with drug and alcohol services can be quite challenging
17 and people don't always make that contact. It is
18 a self-referral route to those agencies. So if we have
19 somebody that is on site and is familiar to that person
20 and can build those relationships, that has supported
21 the engagement with those services, in my experience,
22 over the last maybe six to 12 months.

23 **Q.** So just so I've understood this correctly, the discharge
24 coordinator has set about bringing an in-reach --

25 **A.** Yes.

1 Q. -- and that was six months ago, sorry?

2 A. I'd say six to 12 months. It might be slightly longer

3 but it is relatively recently.

4 Q. And so prior to that, would you say that those patients

5 with substance misuse and mental health issues often

6 fell through the cracks?

7 A. I would. Like I say, it relied heavily on the

8 self-referral. So that was a challenge for people with

9 such illnesses.

10 Q. And here, at paragraph 33, so if we go back to page 5,

11 dealing with co-occurring -- or comorbidities and

12 co-occurring issues, here:

13 "Physical health needs such as mobility were

14 assessed by the Physiotherapy and Occupational Therapy

15 teams following referral. There were delays in

16 accessing Speech and Language Therapy [the SALT teams]

17 and Tissue Viability services."

18 And you say:

19 "At Basildon Mental Health Unit physical health

20 needs were poorly managed due to a lack of manual

21 handling equipment."

22 A. *(The witness nodded)*.

23 Q. Do you mean equipment to move patients?

24 A. Yeah, that's correct. So until this year, and it's not

25 currently operational, there was no hoist at Basildon

1 Mental Health Unit.

2 **Q.** Sorry, there was no? Hoist?

3 **A.** Hoist. Manual handling. And the availability of beds
4 for patients requiring additional physical health needs,
5 so DDA rooms. On the assessment unit we've got two and
6 then on our treatment wards and the Psychiatric
7 Intensive Care Unit there's one of those beds. But the
8 number of patients having such needs has increased over
9 time. So sometimes there are delays of people accessing
10 services, and they may at times remain in the acute
11 hospital if one of those beds that could accommodate
12 them isn't available, and then there's a process where
13 we need to hire equipment for those rooms, so bariatric
14 beds, pressure-relieving mattresses, and so on.

15 **Q.** I see. So you said that the hoist wasn't available, and
16 then it was, and then I think you --

17 **A.** So. It's in place --

18 **Q.** It's in place?

19 **A.** So it's been ordered and it's a trial. But room
20 availability at Basildon Mental Health Unit is very
21 limited so they struggled to find a suitable room for it
22 to be located that was accessible by staff that also had
23 charging facilities.

24 **Q.** I see. And in terms of speech and language therapy,
25 access to the SALT team, how has that worked, in your

1 experience?

2 **A.** It's been very challenging, the referral process. It's
3 not very clear, I would say. We don't often have people
4 that require SALT. On occasions where we had, I've
5 spoken to the Matron for the older adult services who
6 had been able to signpost when we struggled as
7 a service.

8 **Q.** And then at paragraph 34 here, you talk about "Nursing
9 staff completing falls risk assessments," and that VTE,
10 so venous thromboembolism, risk assessments were
11 undertaken by the medical team, and that the Trust uses
12 a dashboard to monitor compliance, although variation in
13 compliance across wards remains.

14 Can you just explain what the variation is?

15 **A.** In terms of the compliance of those VTE --

16 **Q.** Assessments being undertaken, right?

17 **A.** So largely, falls risk assessments were completed but
18 often the VTE is completed by the medical team, and
19 there'd be delays in the completion due to competing
20 demands, they are discussed in the MDTs on a daily basis
21 and the need for completion is raised. But in periods
22 where there are large numbers, for example on the
23 assessment unit, having medical reviews daily, if the
24 on-call doctor hasn't completed that out of hours, the
25 medical team are already on a back foot --

1 **THE CHAIR:** Remember your speed.

2 **A.** Sorry, sorry. They're already on the back foot before
3 they've started because they'll need to be in the ward
4 reviews for those patients.

5 **MS MALHOTRA:** I'd like --

6 **A.** But they are reported to the Trust on the dashboard and
7 then there's emails sent for monthly performance rating.

8 **Q.** Monthly?

9 **A.** But as clinicians, the dashboard can be viewed daily,
10 multiple times throughout the day.

11 **Q.** And in your experience, how often are they viewed daily?

12 **A.** The dashboards? On the assessment unit, one of the
13 nurses generally checks it daily. I couldn't say how
14 regularly the medical team review that but, like I say,
15 we do discuss it in the MDT, and the need.

16 **Q.** I'd like to move on to another topic, please:
17 post-incident investigations. Bethany Lilley died on
18 16 January 2019 on the Thorpe Ward. Can you help us
19 with whether you attended a hot debrief immediately
20 after Bethany died?

21 **A.** I did. We had a debrief on the date of her death.

22 I remember it being challenging to attend due to
23 what was going on on the ward in terms of supporting
24 other patients at the time, but there was a hot debrief,
25 and there was -- I think psychology led a separate

1 debrief, up to a week later, perhaps. And it was more
2 about staff wellbeing, I would say.

3 **Q.** Okay. You were the Deputy Ward Manager on Grangewaters
4 Ward, is that right, at the time?

5 **A.** Yeah.

6 **Q.** And the site officer on shift when Bethany died; is that
7 right?

8 **A.** Yes, I was the site officer on the night shift when
9 Bethany died.

10 **Q.** And I want to ask you about whether you were involved in
11 the investigation that happened -- firstly, whether you
12 were interviewed into the investigation?

13 **A.** No.

14 **Q.** Would you have expected to be?

15 **A.** I would have expected to have been interviewed, as the
16 site officer on duty, so responsible for overseeing the
17 incident. And I had raised concern regarding the
18 completion of the level 1 Therapeutic Engagement and
19 Supportive Observation hourly check --

20 **Q.** Can I ask you to slow down slightly.

21 **A.** On the night --

22 **Q.** Pausing there, let's take it in stages.

23 You say that you reported concerns about the level 1
24 observations?

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

1 **Q.** When did you report concerns about the level 1
2 observations?

3 **A.** On the night of the incident. So we had an on-call
4 manager, and on-call director attend. I can't remember,
5 I think it was the director that I raised it to. So my
6 observation when I was on the ward, having supported
7 calling services, was that the level 1 check had not
8 been completed. At the time with everything going on,
9 I didn't have the opportunity to photocopy that form.
10 However, subsequently, it had been completed as a check
11 being carried out.

12 **Q.** I see. So you raised it with the director?

13 **A.** Yes.

14 **Q.** Did you complete a Datix?

15 **A.** I completed the Datix for the incident covering the
16 death, yeah.

17 **Q.** You describe in your statement and perhaps I can
18 describe it this way, and you tell me if I've got it
19 wrong, but robust. You were robust in escalating
20 concerns in relation to patient care, would you agree
21 with that?

22 **A.** I would say that I do escalate concerns relating to
23 patient care.

24 **Q.** And do you consider that the failure to seek your
25 contribution to the root cause analysis was impacted by

1 the fact that you had raised concerns?

2 **A.** So are you asking that because I raised concerns, I
3 wasn't involved?

4 **Q.** Yeah.

5 **A.** No. I don't consider that. I don't know why I wasn't
6 involved. But I had raised those concerns, I completed
7 the Datix, so the information is there, I attended the
8 Coroner's Court, although not asked specifically about
9 those concerns, I would have been able to speak to them
10 at that space.

11 **Q.** Have you ever been provided with an explanation about
12 why you weren't involved with the investigation?

13 **A.** No.

14 **Q.** Did you tell anyone that you had relevant information
15 before the reviews were completed?

16 **A.** I don't recall being aware that the reviews were being
17 completed, if I'm honest with you. I don't think, at
18 that time, I was aware of what takes place once there
19 has been a patient safety incident on a ward. So my
20 understanding of the process at that time, I don't think
21 I was really conscious of that.

22 **Q.** Are you able to say in what way the lack of your input
23 impacted on the findings, the recommendations, or the
24 action plans that arose as a result of Bethany Lilley's
25 death?

1 **A.** No, I think my concerns that I included in the Datix
2 about the -- sorry -- about the two clinical record
3 systems, that was picked up in the report, and about the
4 transfer of information when somebody is admitted from
5 the North of the Trust. I'm aware that in the inquest
6 outcome, it includes the query about the level 1
7 observation. But other than that, I wouldn't really be
8 able to comment, I don't think.

9 I think they're captured.

10 **Q.** You say that the subsequent death of Jason Standing
11 demonstrated that transfer issues persisted after
12 Bethany Lilley's death --

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

14 **Q.** -- and that learning was not embedded?

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

16 **Q.** Can you tell us about that?

17 **A.** Yes, so the learning from Bethany Lilley focused on the
18 transfer -- safe transfer -- and also included about the
19 two clinical systems. So when Jason Standing was
20 transferred, it wasn't a safe transfer. Clinical
21 information -- I know in the report it says that
22 Christopher Unit said that they'd sent it, Hadleigh Unit
23 said that they hadn't received, but I'm aware that the
24 duty doctor who clerked in Mr Standing had made
25 a comprehensive entry where there was only a H4, so the

1 transfer from one hospital site to another, was
2 included.

3 And there was unknowns about him and his physical
4 health in terms of sleep apnoea.

5 In prior meetings on Microsoft Teams, physical
6 health had been discussed, in terms of Mr Standing was
7 clinically obese. I believe he had diabetes, and he had
8 wounds, and Tissue Viability had supported with that and
9 that was discussed in that meeting. But that aside,
10 sleep apnoea hadn't been referred to.

11 **Q.** And so how are issues with transfer post Bethany
12 Lilley's death, both Jason Standing's death, dealt with
13 now?

14 **A.** I would say as a site, there is the awareness of the
15 need for MDT clinical handover. That's been reviewed.
16 So when somebody is transferred from one ward to
17 another, MDT clinical handover should be sent. There
18 should be the discussions. Often these occur
19 consultant-to-consultant, not only between the nursing
20 staff. I think that largely covered him. But I'm
21 aware, from the records that I reviewed in relation to
22 the Rule 9, I know I cover it in my statement, that
23 certain aspects weren't embedded in practice and still
24 aren't, for example how information about a patient
25 being transferred should be headed in and email, for

1 example.

2 **Q.** Okay. So accessibility of information about a patient
3 being clear to the receiving ward?

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

5 **Q.** Is that a fair summary?

6 **A.** Yeah.

7 **Q.** And that still hasn't been embedded?

8 **A.** I would say it hasn't. I think, until we're on one
9 clinical system, there remains issue. I know for the
10 Mental Health Urgent Care Department and some staff on
11 the assessment unit have got access to both clinical
12 record systems but not all staff do. So it is
13 challenging. You would rely on the transferring ward,
14 making contact with them, and asking them to send you
15 information. But when they do so, they'll be under
16 their own competing demands, so they're not going to
17 send you the entirety of that patient records, and
18 whether what's required is captured in that, I would
19 question.

20 **Q.** And are there any other learnings that you think are
21 still not embedded?

22 **A.** From Bethany and Jason? I think our documentation still
23 needs to improve, and that's picked up when doing
24 audits. I think there's been a renewed focus as a site
25 on Therapeutic Engagement and Supportive Observations.

1 In terms of Mr Standing and the failure to observe, I'd
2 say that's improved but other than that, I can't think
3 of anything right now.

4 Q. Were you ever given a copy of the root cause analysis
5 report?

6 A. No. For Bethany? No.

7 Q. And what about action plans?

8 A. No.

9 Q. So it's not something that was shared with you, that you
10 were invited to comment upon?

11 A. No.

12 Q. Are you able to comment on consultant-to-consultant
13 discussions prior to transfer? Is that something that
14 you would be privy to?

15 A. I think it would be best placed to ask the individual
16 consultants but I am aware from -- I've not more
17 recently been on the Bed Management course, but they
18 have been asked on those to have
19 consultant-to-consultant discussions prior to any
20 transfers.

21 Q. I'd like you to look at paragraph 94 of your statement
22 so this is page 18. You say here that:

23 "Following Bethany Lilley's death a Peter Bruff
24 Unit-Thorpe Ward Interface Meeting was established."

25 When was that established?

1 **A.** I can't recall the exact date of that starting, I'm
2 afraid.

3 **Q.** Was it weeks after her death? Months? Years?

4 **A.** I can't recall; I'm really sorry.

5 **Q.** Can you tell us with how effective those meetings were?

6 **A.** I didn't find them effective. As in my statement,
7 I felt that the focus of those meetings was too narrow.
8 So it only focused on the Peter Bruff Unit and Thorpe
9 Ward and I felt there was a risk in doing so, that
10 there -- the learning might not be more widely
11 understood. I know that when Thorpe Ward closed it was
12 extended, I believe, to Cherrydown Ward which is the
13 female acute inpatient ward on the site, and I believe
14 that Kelveden Ward may have also attended, but we can
15 have patients transferred from wards across the
16 organisation and I was really concerned about the risk
17 not being understood and applied in practice. I did
18 raise those concerns, but there was no change.
19 I don't --

20 **Q.** Sorry to interrupt you. You said you raised those
21 concerns. With whom you raise them?

22 **A.** So with people that were in those meetings.

23 **Q.** So just tell me the roles.

24 **A.** I think it was, like, Matrons. Possibly -- I believe
25 Service Manager. And then more recently, it was taken

1 to the Inpatient Quality and Safety Meeting, because it
2 didn't feel valuable, in terms of the meetings from what
3 I could observe, because I no longer attended them, but
4 I would still receive the notifications on Microsoft
5 Teams. People didn't appear to still be attending. And
6 those that were invited, I believe it was the Matron
7 for -- covering the Peter Bruff Unit, was also
8 questioning the purpose of those meetings.

9 So it was taken -- the ask was -- and I can't
10 remember who that was from -- that it be taken to the
11 Inpatient Quality and Safety Meeting, but I don't think
12 there was a decision made as to: should they continue?
13 Did they need to be reviewed? Did they need to include
14 more widely wards in the organisation? Or a different
15 way to share learning?

16 **Q.** You say at --

17 **A.** Sorry, just going back to that point.

18 **Q.** Yes.

19 **A.** So our wards are now operating locality models. So at
20 the time of the transfer, Thorpe Ward was commissioned
21 for ten North patients. So that was the reason that
22 Bethany was identified to transfer to Thorpe Ward. But
23 now, with the locality meetings, people should remain in
24 their locality. So the likelihood of somebody being
25 transferred from the Peter Bruff Unit to the South of

1 the Trust is significantly lower than it was in practice
2 at the time and even more recently, before the
3 introduction of the locality model.

4 **Q.** So when has the locality model started?

5 **A.** I would say within the last year to 18 months, I really
6 wouldn't want to put a time on that. Yeah, possibly
7 around 18 months, maybe two years maximum.

8 **Q.** In your statement, I can take you to it if you would
9 like, but you talk about not receiving training and
10 using Paris and Mobius.

11 **A.** Yeah.

12 **Q.** Do you consider that you should be trained on using
13 those systems?

14 **A.** I think it would be helpful, definitely. So lots of
15 student nurses or qualified nurses aren't always aware
16 of where they can find relevant information, and that
17 can impact day-to-day functioning on wards, but also if
18 completing tribunal reports, for example, it's good to
19 know where you can locate information within that system
20 to support you as the clinician writing that report.

21 But more generally, it's really helpful to know
22 where you would find a recent Discharge Summary, for
23 example, or anything else that's contained within those
24 documents.

25 **Q.** Presumably if you're a member of the nursing team

1 required to make a decision about a patient, you need to
2 have access to as much information as possible about
3 that patient in order to inform the clinical decisions
4 that you make; would you agree with that?

5 **A.** I would.

6 **Q.** And so not having access to Paris and Mobius could
7 impact patient safety?

8 **A.** Yes, so are you referring to if -- of the alternative
9 system, or the thorough understanding of the system in
10 which you work?

11 **Q.** Well --

12 **A.** Does that make sense?

13 **Q.** Both.

14 **A.** Both, yeah.

15 **Q.** Firstly, to have access to the system?

16 **A.** Yeah.

17 **Q.** And then to actually understand how to use if it --

18 **A.** Yeah.

19 **Q.** -- and where to find the relevant information?

20 **A.** Yes.

21 **Q.** Is that your understanding -- you haven't received the
22 training on those systems. What about -- is there
23 a programme in place for staff to receive it? Were you
24 an exception, for example?

25 **A.** No. I think there isn't a programme -- I can speak to

1 Mobius, I wouldn't like to comment further on Paris --
2 but for Mobius there isn't a system that I'm aware of.
3 It appears to be more that staff are supporting, as in
4 the staff on the ward, are supporting one another with
5 that system.

6 I remember when it was first introduced there was
7 talk about training but I don't remember receiving any
8 training for Mobius.

9 I think it probably depended on whether you were on
10 duty at the time, perhaps.

11 **Q.** But you certainly speak to other staff members for
12 support?

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

14 **Q.** And so --

15 **A.** I feel comfortable and confident with the use of Mobius,
16 and that's through me being able to use technology. But
17 other people perhaps wouldn't know how to navigate the
18 system. And I've used that system for 10 years, and
19 have, I guess, at stages, been directed where I could
20 find things myself.

21 **Q.** So this issue has persisted for over a decade?

22 **A.** Yes.

23 **Q.** And continues to persist?

24 **A.** And I would hope that with the Nova programme that there
25 will be intense support in the staff being able to use

1 that system.

2 **Q.** And so, if it were the case that the Trust were
3 confirming that training had been undertaken and that
4 all relevant staff had received training, would you
5 disagree with that?

6 **A.** From my experience, yes.

7 **Q.** Are you familiar with the HIE system? I think it's
8 Health and Information Exchange?

9 **A.** I am, yeah. That's the system that was enabling -- I
10 believe it's changed recently but I've not had to use
11 that system, because I've got access to Paris and
12 Mobius, but it enables clinicians to review, or it did,
13 information from both systems. But it was limited, in
14 my experience, when I did use it, prior to having Paris
15 access. You wouldn't see the documents as you did if
16 you were accessing the system directly.

17 It was helpful to an extent but it wasn't the same
18 as having the system, I would say.

19 **Q.** And so was there any training for the HIE system?

20 **A.** Not that I recall.

21 **Q.** And I wonder, if there had been any training, for
22 example, would you have expected to know about it?

23 **A.** I would, yes. And I would expect there to be a register
24 and that I would hold a register of the people that
25 I was responsible for as the Ward Manager at the time,

1 or as a Matron for services.

2 **Q.** I appreciate you didn't see a copy of the root cause
3 analysis report in respect of Bethany Lilley's death and
4 the investigation that subsequently followed. Was
5 anything ever said about observations being downgraded
6 without appropriate assessment or the involvement of all
7 members of the clinical team? Can you ever remember any
8 discussions about that?

9 **A.** I remember that I believe the policy may have changed at
10 one point, which enabled a Band 6 or above to downgrade.
11 And then there was a change to the policy, that it had
12 to be a multidisciplinary team decision. My experience,
13 in practice, on the assessment unit when I was there,
14 and on Cedar Ward, was that we wouldn't reduce
15 a patient's levels of Therapeutic Engagement and
16 Supportive Observations as nurses alone, that we would
17 consult a wider MDT.

18 **Q.** So you say that there was a change and that it should be
19 discussed within the MDT?

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

21 **Q.** Can you help us with when that change might have come
22 about?

23 **A.** I am not sure whether it was around 2022, I'm not sure,
24 to be honest with you. And then there was a focus on
25 a Mobius form being completed. I think it's a 5.3,

1 which is a Therapeutic Engagement and Supportive
2 Observations care plan, and that includes the rationale
3 for any change to observation, increase or decrease; any
4 special instructions, and it includes the names of the
5 members of the MDT that were involved in that change.

6 **Q.** So possibly around 2022?

7 **A.** Possibly.

8 **Q.** Has that changed again?

9 **A.** Not that I'm aware. If it has, in practice, it's still
10 an MDT on the assessment unit where I work, or
11 responsible for.

12 **Q.** Are you familiar with the Safe Wards programme?

13 **A.** Safe Wards, yeah. My understanding of Safe Wards was
14 that it was in place in some wards across the
15 organisation. But around, in line with one of the
16 Deputy Directors of Quality and Safety starting, there
17 was a renewed focus on Safe Wards, and its
18 implementation across the Trust. There were programmes
19 delivered, training sessions, where staff would
20 attend -- I believe they were held solely at The Lodge,
21 and staff from the wards would attend those.

22 **Q.** And so was this relevant to any of the wards that you
23 oversaw?

24 **A.** Yes, Safe Wards was implemented on the assessment unit
25 at Basildon. It is not applicable to the Mental Health

1 Urgent Care Department.

2 **Q.** And would you say that observation practice was

3 influenced by the Safe Wards programme?

4 **A.** It had the potential to support, in terms of some of the

5 interventions, Getting to Know Me, Soft Words, that

6 could support it. I would say largely the change to the

7 Therapeutic Engagement and Supportive Observation policy

8 probably drove a reduction, and more widely reducing

9 restrictive practice understanding across the Trust, as

10 well as trauma-informed care.

11 **Q.** You said it drove a reduction. Reduction in

12 observations?

13 **A.** In reducing observations, if they were safe, I would

14 say.

15 **Q.** Okay.

16 **A.** Not just reducing observations for the sake of it.

17 That's not been my experience on the wards I've worked.

18 **Q.** Just going back to Bethany Lilley's death and the

19 circumstances that arose, the concerns that you raised

20 about the observations. That's one example, isn't it,

21 of where there was concerns about observations; would

22 you agree with that?

23 **A.** About the recordkeeping of the observations was my

24 concern. I wasn't aware at the time that she'd been on

25 level 3 observations at the Peter Bruff Unit and

1 downgraded.

2 **Q.** Are you aware that -- that concern you had about the
3 recording of the observations, then, are you aware of
4 whether that was more of a widespread issue or was that
5 an isolated incident?

6 **A.** I'm aware that there were concerns about recording of
7 observations within the Trust, about observations being
8 recorded after the time that had been sort of time
9 stamped, I guess, when you were writing them. I know
10 that with the introduction of the e-obs, that we were
11 told that that would stop that. I know now you can
12 retrospectively enter for an observation period on
13 e-obs, but that it does identify that it was added
14 later.

15 **Q.** For how long were these retrospective entries of
16 observations a known issue?

17 **A.** I can't remember the first sort of incident, as such.
18 I think it was related to learning, or incidents that
19 have occurred within the organisation, but I can't
20 recall. I imagine that had been going on for a long
21 period of time, that people had written they might have
22 got engaged in other activities and hadn't had the
23 opportunity to write down what had happened at that
24 moment in time. And then, if there were other demands
25 going on, so perhaps patient incidents, that that might

1 not have been recorded.

2 Q. Were you aware about safeguarding concerns?

3 A. Generally?

4 Q. In respect of Bethany Lilley. Were you aware

5 safeguarding concerns?

6 A. Having read the reports that came with the Rule 9.

7 I wasn't -- I didn't work on Thorpe Ward. It was only

8 that I was the site officer for that night that I had

9 any interaction with Bethany.

10 Q. Do you have any experience of dealing with safeguarding

11 concerns within the Trust at the time?

12 A. Yes.

13 Q. Tell us about what your concerns were?

14 A. Oh sorry, I thought you said did I have any dealings

15 with?

16 Q. Did you have any concerns about --

17 A. Oh sorry, my apologies.

18 Q. -- about how safeguarding issues were raised?

19 A. Not that I recall. If there were safeguarding concerns,

20 we would raise them. At the time it was a paper form,

21 SETSAF1. We had safeguarding leads for the unit that we

22 could contact, Datix Incident Reports would be

23 completed. I don't recall concerns with safeguarding at

24 the time.

25 Q. Were you made aware of the Thurrock Clinical

1 Commissioning Group report in respect of Bethany
2 Lilley's death?

3 **A.** Subsequently.

4 **Q.** Subsequently. I'm just wondering whether you weren't
5 given the root cause analysis report, you weren't aware
6 of the action plan, or the subsequent Clinical
7 Commissioning Group investigation. Does that say
8 anything to you about learning from Bethany Lilley's
9 death?

10 **A.** For me, it raises that if we are not sharing more
11 widely, then there's a risk that that may happen to
12 a different ward even within the same site, let alone
13 within the organisation, as large as it is
14 geographically.

15 **Q.** In respect of Jason Standing, who we've touched upon, we
16 touched upon his death on 5 January 2022 at the Hadleigh
17 Unit. Were you involved in the investigation into Jason
18 Standing's death?

19 **A.** What paragraph does that relate to? Just so I can
20 remind myself.

21 **Q.** I believe it's 311, page 62.

22 **A.** So the involvement with Jason Standing's death, I was
23 informed of his death, attended the site prior to me
24 coming on to duty. Not early hours but, you know,
25 before 8.00 am, I would say. Supported with gathering

1 initial witness statements. I requested the salient
2 video data for Oxevision and completed other relevant
3 sort of notifications such as that to the CQC of his
4 death. And then there was a long period without any
5 real further discussion, and a report was shared.
6 I felt quite uncomfortable with his death having known
7 that I'd requested the CCTV -- sorry, not CCTV -- it
8 wasn't a Freudian slip, either -- the Oxevision data,
9 and whether that had been reviewed. I was just really
10 mindful that Jason had died, and did we do everything,
11 and what could we learn?

12 And then, when the report was sent, I had concerns
13 because I wasn't involved, wasn't interviewed. I'd sent
14 information to the author on multiple occasions. Often
15 the same information requested more than once. When
16 I met with the Trust's legal team, I think it must have
17 been approaching, or near approaching the inquest, that
18 I'd raised about the CC -- for God's sake, sorry -- I'd
19 raised about the Oxevision then, and it was only then
20 that that was reviewed and the report was co-authored.
21 And the Consultant Psychiatrist, I think it was the
22 Deputy Medical Director at the time, also raised
23 concerns about the initial report into his death.

24 Q. So you had concerns. Would you have expected to have
25 been involved in the investigation into Jason Standing's

1 death?

2 **A.** Having been there at the time of the incident developing
3 post-death and steps that I had taken, I would have
4 expected to.

5 **Q.** And you say that you sent an email about it.

6 **A.** Yes.

7 **Q.** Several times?

8 **A.** So I've sent emails regarding the -- several times, the
9 requests. So information was requested. I think it was
10 statements from staff, and other information such as the
11 records of the Therapeutic Engagement and Supportive
12 Observations. Those were sent on multiple occasions.
13 I emailed with the concerns about the report on one
14 occasion.

15 **Q.** Okay. And I think, if we look at paragraph 141 of your
16 statement --

17 **A.** Did you say 141?

18 **Q.** So that's page 29. You say here:

19 "In response, Paul Scott, Chief Executive and Alex
20 Green, Chief Operations Officer attended the site ..."

21 Can you help us with the context for that?

22 **A.** Yes, that was prior to Jason's death. So it was
23 a challenging time, in terms of the Covid-19 pandemic,
24 but also the management of the Hadleigh Unit in
25 particular. The Ward Manager had high sickness or other

1 leave from the ward. There was high use of the
2 temporary staff, and it didn't feel safe. And, yeah,
3 Paul and Alex attended. They spoke to staff in the MDT
4 room on a one-to-one basis, but I didn't receive any
5 clear feedback about the outcomes of those discussions,
6 and we continued with the same challenges, in terms of,
7 yeah, staffing. And oversight.

8 **THE CHAIR:** Sorry, were you directly involved in those
9 discussions with them about the --

10 **A.** About how it felt on the ward? Yes, yeah.

11 **THE CHAIR:** You saw them on that occasion and talked to
12 them?

13 **A.** I had spoken to them and said my concerns and
14 encouraged, I think it was Paul, to then speak to staff
15 that were around.

16 **THE CHAIR:** Thank you.

17 **MS MALHOTRA:** I just wonder if we can unpack that a little
18 bit. So you had concerns about working conditions,
19 staffing --

20 **A.** Yeah --

21 **Q.** -- safety?

22 **A.** -- it was a challenging time. At the time, the Hadleigh
23 Unit was a mixed ward. We had patients on there with
24 the diagnosis of emotionally unstable personality
25 disorder, and there were continued incidents of

1 self-harm. It was a very challenging environment to
2 work in. As other wards on the site, there was a high
3 use of bank and agency. From my recollection they had
4 a number of unfilled posts and it was just a very
5 challenging place to work. And it didn't feel safe.

6 Q. So you were concerned about the safety and you escalated
7 your concerns?

8 A. Yeah.

9 Q. Did you escalate your concerns directly to Paul Scott
10 and Alex Green? How did they become involved?

11 A. I think they'd planned a visit. I can't recall, to be
12 honest, but I think it was part of a visit where I'd
13 explained how I was feeling about the safety. I think
14 it might have been a different reason for them initially
15 coming.

16 Q. I see. And you spoke to them, was it on the day of the
17 visit, or before?

18 A. On the day, from what I recall. I think they'd been
19 shown around by the Service Manager at the time and it
20 was -- yeah, very challenging.

21 Q. And as a result of that visit, did anything change?

22 A. I don't recall any changes, no.

23 Q. Can you recall what you precisely said to them? Is it
24 the concerns you've told us about?

25 A. Yeah. To that effect.

1 Q. Would you say that your concerns were adequately
2 responded to?

3 A. It didn't feel that they were. I think it's quite
4 challenging, like, the executive team, sort of
5 visibility and understanding of the services. I would
6 say it's quite limited, the visibility of the executive
7 team. So perhaps that understanding of what is really
8 going on, and the impact, isn't well understood.

9 Q. And just going back to the investigation concerning
10 Jason Standing's death, you had requested the Oxevision
11 footage, if I've understood your evidence correctly?

12 A. Yes.

13 Q. And had the reviewers viewed it?

14 A. Not -- no. When the co-author report happened, the
15 co-author had to locate the footage, which gets sent to
16 the Trust and was then viewed in a detailed timeline of
17 what was observed was reported, as part of that
18 co-authored report.

19 Q. Just taking a step back for a moment, what does that
20 tell you about the quality of an investigation?

21 A. I don't think it was there. It wasn't a thorough
22 investigation undertook. There were gaps in what
23 information was viewed or sought, had missed
24 opportunities for potential learning. Yeah.

25 Q. And there was an addendum report, as well?

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

2 **Q.** Were you concerned about that?

3 **A.** I don't recall -- is that the report that went to the

4 coroner's, the one that was done following the emails

5 with the concerns raised?

6 **Q.** So if we have a look at 314, page 63. You say here,

7 this is following on from the chronology, you raised

8 concerns -- sorry, 313, page 62. Just to give you the

9 context.

10 **A.** Yeah.

11 **Q.** You raised concerns about not being interviewed by the

12 original investigator -- we can see there at the bottom.

13 Then you say at the top of page 63 about the

14 Oxevision footage.

15 **A.** Yeah.

16 **Q.** And then at 314 you say:

17 "When the addendum report was produced, I questioned

18 whether the Trust had considered a wider review of the

19 investigation considering the concerns raised. I also

20 queried whether interview records had been reviewed in

21 full to determine whether a more comprehensive

22 re-investigation was required. I expressed that it

23 remained unclear to me as to why other key individuals

24 were not consulted before further iterations of the

25 report were produced."

1 Then you go on to express your views.

2 At 316 you say:

3 "I believe that cultural and leadership factors
4 within EPUT adversely affected the quality of
5 investigations during this period."

6 What do you mean by that?

7 **A.** It didn't feel that there was a culture of learning, and
8 involving key people. I mentioned in my report that
9 I think the Patient Safety Team does appear to have
10 improved over time. But it didn't feel that there was
11 a focus on ensuring that the right people were spoken
12 to, that they had access to all the required
13 information.

14 I'm not sure about the training that was undertaken
15 by individuals before reports were completed, and
16 whether people identified were best suited for that
17 task.

18 And having completed a patient safety -- I can't
19 think of the word -- not a full investigation, review --
20 it is in addition to your own workload. So it is
21 challenging to do that alongside your own role. I'm
22 aware that some people do that in their own time and I'm
23 unsure whether or not perhaps that could lead to less
24 thorough investigations.

25 **Q.** Perhaps it's obvious, but if there isn't a robust

1 investigation identifying learnings, making
2 recommendations, then are there missed opportunities for
3 that learning to be identified even?

4 **A.** Definitely.

5 **Q.** You say there was a culture. The investigation into
6 Jason Standing's death is one example, but can I infer
7 from what you said that there were many others, then?

8 **A.** My experience has -- in relation to that is about
9 Bethany Lilley and Jason Standing. But Jason Standing
10 definitely stood out for me, more so, I would say, than
11 Bethany Lilley's. And perhaps, like I said earlier,
12 that's because of my experience over time and my
13 understanding of what should be happening.

14 **Q.** You describe in your statement your subsequent
15 involvement in investigations in 2022 and that you
16 completed the root cause analysis training.

17 **A.** Yeah.

18 **Q.** Was that training sufficient, in your view?

19 **A.** I only did one root cause analysis following that
20 training. I felt equipped to undertake that, and I felt
21 supported by the consultant who was also involved in
22 that RCA. If I hadn't have been, I would have raised
23 that at the time rather than continue.

24 **Q.** Given that your practice was exclusively within
25 inpatient mental health settings, did you feel that you

1 were the right person to undertake any investigation
2 into incidents that occurred in the community?

3 **A.** I think it's about having an understanding of how the
4 services were working. Like I say, there was
5 a consultant also involved in that RCA, and then the
6 more wider understanding of services available, how we
7 should be operating through policy and procedure, and
8 then also understanding of practice.

9 I wouldn't like to say, to be honest, definitively.

10 **Q.** You explain in your statement, just going back for a
11 moment to culture, that -- this is at page 64,
12 paragraph 321 -- that:

13 "... the sharing, implementation, and monitoring of
14 recommendations arising from investigations were not
15 undertaken as robustly as they are currently. There was
16 limited visibility regarding how actions were tracked."

17 The investigation into Jason's death was only
18 completed, I believe, two years ago. What's materially
19 changed since then?

20 **A.** As in in terms of how -- (overspeaking) -- described?

21 **Q.** Yes.

22 **A.** So that action plan is not being overseen by myself;
23 that's by the Matron for the Hadleigh Unit. But my
24 understanding, more generally, is that the Trust is
25 moving towards electronic oversight with actions-tracked

1 individuals and that these are overseen by a team within
2 the Trust. I think it might be under the Patient Safety
3 Team but I wouldn't like to say for certain.

4 **Q.** So there are moves to change it?

5 **A.** Correct.

6 **Q.** But your understanding is that those changes aren't
7 currently in place?

8 **A.** My understanding is that those moves are taking place.
9 I'm not sure the extent of where older action plans are,
10 for example.

11 **Q.** So would you say that recommendations are now tracked
12 within the Trust?

13 **A.** I would say that they are, from my experience, because
14 when I've done a Safety Action Plan I've been asked for
15 updates about information within that Safety Action
16 Plan.

17 **MS MALHOTRA:** Thank you, Chair. I wonder if now is a good
18 time to take a 10-minute break.

19 **THE CHAIR:** Ten minutes.

20 **(12.27 pm)**

21 **(A short break)**

22 **(12.40 pm)**

23 **MS MALHOTRA:** Thank you, Chair.

24 Just one further question on investigations, and
25 then I'd like to ask you about a different topic.

1 Perhaps you could have a look at page 20, paragraph 99
2 of your witness statement. I'll ask that that be put on
3 the screen.

4 At the last sentence, you say:

5 "In my view, these issues persisted because learning
6 from previous incidents was not fully embedded across
7 the Trust."

8 I want to ask, does that -- is that still a view
9 that you hold, that learning is not being embedded?

10 **A.** So that was my view about the time that was covering the
11 transfer of Bethany, and then subsequently Jason. Those
12 issues hadn't been persisted -- they hadn't been
13 embedded, those learnings.

14 I feel that we're probably not there as an
15 organisation, in terms of embedding learning.

16 **Q.** Generally, or --

17 **A.** Generally, yeah, yeah.

18 **Q.** Why do you feel that is?

19 **A.** I think it's such a huge organisation. There are so
20 many staff that need information to be cascaded to.
21 I don't think there's effective means to share that
22 learning. Yeah. I think it's a huge organisation. I
23 don't know whether we've got the oversight to ensure
24 that learning is embedded consistently across the
25 organisation.

1 Q. And so I just want to pick up on the --

2 A. I think we move -- sorry, I should say I think we move
3 from one thing to another without always ensuring that
4 things are always embedded in practice. It's quite
5 reactive.

6 Q. So let me just ask, you've talked about the size of the
7 organisation --

8 A. *(The witness nodded)*.

9 Q. -- and in fact it's one of your recommendations, if you
10 look at page 67, paragraph 336. You say:
11 "My primary recommendation is that [EPUT] should be
12 divided into more than one Trust."
13 Can you explain why you invite the Chair to make
14 that recommendation?

15 A. I think that when the two Trusts merged, that that, from
16 my perception, is where we lost control as an
17 organisation. And I don't know whether that's naivety,
18 in the sense that I was a student nurse at the time, but
19 I'd worked in different organisations, large
20 organisations, public sector. So I do think I had some
21 awareness of how things should operate. But I do think
22 that it is too big in its current guise. Whether that
23 is that if it's not going to be divided into more than
24 one Trust, that there's more effective oversight in how
25 areas, maybe care units, I'm not sure, are managed.

1 And I feel like we took on more and more physical
2 health within the Trust and it, to me, has just become
3 unmanageable. That's how it feels as a member of staff
4 working in the service.

5 **Q.** I want to ask you next about medication. Could I ask
6 you to look at page 10, paragraph 56 of your witness
7 statement. You describe here the predominance of the
8 medical model combined with limited psychology provision
9 contributed to a reliance on restrictive practices.

10 Can you explain what restrictive practices you're
11 referring to there?

12 **A.** I would say largely the levels of Therapeutic Engagement
13 and Supportive Observations above level 1, the use of
14 medication, including PRN medication. Seclusion --

15 **Q.** Was there an over-use -- an over-use of PRN medication?

16 **A.** PRN, I would say, yes, so lorazepam and promethazine
17 were routinely prescribed for admissions and they were
18 routinely used. And where we didn't have the wider sort
19 of offering from psychology, and where we had the skills
20 mix and the staffing mix that we had, it was often the
21 first line response to a crisis situation to offer PRN.
22 There has been a move away from that, I would say, but
23 it does still persist. Quite often medication isn't
24 reviewed or stopped and there've been occasions where
25 people are still working towards discharge and still

1 have those medications on their chart are routinely
2 using them. So it's then about thinking how we
3 prescribe those on discharge for a short period of time
4 to support that discharge, that person during their
5 discharge period so as to not go without that
6 medication.

7 **Q.** You've mentioned a few times in your evidence earlier
8 about psychologists and you mention it obviously in your
9 statement, as well, about psychologists being
10 available --

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

12 **Q.** -- I think from 2023?

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

14 **Q.** What changed to facilitate that?

15 **A.** I think we had a new Clinical Lead Psychologist, and she
16 seems to have been instrumental in -- I'm talking about
17 Basildon site -- in ensuring that we have the right
18 provision and then the organisation would have
19 considered the need as well, so we've got more Clinical
20 Associate Psychologists, we now take trainees, I think
21 that was led by the Lead. So it's been a gradual
22 increase over -- since 2023, and there is one position
23 that remains unfilled, to my knowledge.

24 **Q.** You mentioned earlier.

25 I'd like to ask you next about Oxevision.

1 **A.** Yeah.

2 **Q.** You make certain observations in your statement. Could
3 I ask you to have a look at page 46, paragraph 230. You
4 say here:

5 "The introduction of technology, particularly
6 Oxevision and electronic observations, had a significant
7 impact on ward practice. While alerts could be helpful
8 the time required to complete electronic recording often
9 resulted in less comprehensive documentation."

10 And you go on to say that:

11 "In my view, the use of this technology negatively
12 impacted inpatient mental health care."

13 Do you consider that there are any benefits to the
14 use of Oxevision?

15 **A.** Not personally, no. Unless it was an individual care
16 plan and perhaps for older adult services, but for adult
17 inpatient services, unless you have a specific need no.

18 **Q.** So do you think there's a clinical justification for
19 using it?

20 **A.** Personally, I don't. And I think that's been picked up
21 in external audits and I think that the Parliamentary
22 Ombudsman investigation and outcome identified concerns
23 around Oxevision, consent, et cetera. And I think it's
24 since then that the organisation has really re-focused
25 on Oxevision, its use, the understanding of the consent,

1 and reviewing how staff are using that in practice, but
2 I think there's still a way to go in terms of that whole
3 consent process to ensure that all patients on admission
4 understand the intended use, and to make the informed
5 decision whether or not they want that technology in
6 their bedroom.

7 **Q.** So you explain, this is at 205 to 206 of your witness
8 statement, page 42, you explain that patients who
9 refused Oxevision could still that have the system
10 remain pending MDT review.

11 **A.** That was at the time, my understanding of it when it was
12 introduced. There have been changing -- changes more
13 recently for six-hour window where a decision needs to
14 be made, whether that technology remains on or off.

15 **Q.** So my question was going to be that if a patient had not
16 consented, and that patient had refused, and then they
17 had to wait until the MDT, was Oxevision still in
18 process until the MDT had reviewed it?

19 **A.** Yes.

20 **Q.** Do you know how long that could be?

21 **A.** So the meeting needed to take place within the 72 hours.

22 **Q.** Within 72.

23 **A.** But now, like I say, it's changed to the six hours.

24 **Q.** And who had final decision-making authority in those
25 cases?

1 **A.** From recollection, it was the MDT decision, and the
2 current SOP, my understanding is that it's the
3 Consultant Psychiatrist with the nurse in charge. Out
4 of hours it would be the duty doctor and the nurse in
5 charge.

6 **Q.** Can you help us with whether there were any safeguards
7 in place to prevent misuse of recorded or live
8 monitoring relating to body-worn cameras, CCTV, or
9 Oxevision?

10 **A.** No, not that I'm aware of. I know in relation to the
11 Oxevision I had concerns about the vision into the room
12 and that people could be in a state of undress, that
13 that could be opened up in the ward office.
14 Potentially, if staff were that way inclined, they could
15 take a photograph of that person in their room. And
16 I had concerns about that. So I discussed that, and
17 reminded staff of its intended use.

18 In terms of body-worn cameras and CCTV, I'm not
19 aware of any.

20 **Q.** You talk in your statement about concern with staff
21 turning down alert volumes. Do you consider that your
22 concerns about that were dealt with appropriately?

23 **A.** So we make sure, like I had a sign laminated for the
24 office, we made sure it was discussed in huddles, in
25 handovers. The tablets now, if they're turned down,

1 they revert back to an audio -- audible, sorry -- alert
2 sound. I'm not sure whether the television, the screen
3 in the office, whether that was resolved. Yeah. I
4 don't know if that answers ...

5 **Q.** And so it sounds to me that the viewing within the
6 nurses' office hasn't been resolved?

7 **A.** So it's only if you're taking the physical health
8 observations that you'll now have the 15 seconds where
9 you have a live video stream into that room. And like
10 I say, following that Parliamentary Ombudsman there's
11 been a focus on the use of technology and reports have
12 been circulated regarding the use of the non-vital
13 contact observations, which allow you to have that
14 function of seeing a clear video image. And they were
15 in the high thousands, for a site over a month. So
16 staff have been reminded about the use.

17 **Q.** What about the alert volumes?

18 **A.** I know that one of the directors came round and looked
19 at the alert volumes, and was shown about the tablets,
20 how they go back to an audible alert sound. And there
21 are always tablets in the office charging, and I often
22 hear the alert sounds when I'm on the wards.

23 **Q.** Now, you make a number of recommendations in your
24 statement, page 67. We've looked at one of those. Is
25 there anything that you would like to invite the Chair

1 to consider in addition to what's in your witness
2 statement about the recommendations?

3 **A.** Not in addition to what I've included.

4 **MS MALHOTRA:** Thank you very much. Those are all the
5 questions I have for you. We'll now take a ten-minute
6 break so that if there are any questions from any Core
7 Participants, we'll come back and I will ask those. If
8 not, that will conclude your evidence.

9 So ten minutes, please.

10 **THE CHAIR:** Ten minutes.

11 **THE WITNESS:** Thank you.

12 **(12.54 pm)**

13 **(A short break)**

14 **(1.11 pm)**

15 **MS MALHOTRA:** Chair, there are some questions.

16 Firstly, we discussed your role on the night of
17 Bethany Lilley's death. You explained that you raised
18 concerns about the level 1 observation record not having
19 been completed. To be clear, did you raise those
20 concerns before or after Bethany died?

21 **A.** I wouldn't have been aware before because I believe it
22 was the 17 -- 1900 check. I was in the health-based
23 place of safety receiving handover from 7.00 pm, so it
24 was post death.

25 **Q.** So it was after?

1 You have discussed your concerns about the death of
2 Jason Standing.

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

4 **Q.** And -- but in particular, you have told us that there
5 has been renewed attention as a site on therapeutic and
6 supportive observations, given the identified failure to
7 carry out observations for him overnight.

8 Are you aware, can you help us at all, with whether
9 sedated mental health patients with physical conditions
10 such as sleep apnoea, whether those patients are at
11 greater risk of mortality, for example, rapid
12 tranquilisation can lead to respiratory depression,
13 cardiovascular complications, and unconsciousness?

14 **A.** Yes.

15 **Q.** Were you or other staff specifically trained on the
16 potential effect of sedation on patients, including the
17 importance of understanding the particular clinical
18 notes in full?

19 **A.** Repeat the part, please?

20 **Q.** Yes. Were you and other staff trained on the potential
21 effects on patients, the side effects --

22 **A.** Yes, medicine management --

23 **Q.** -- of sedation?

24 **A.** -- and also post-rapid tranquilisation policy.

25 **Q.** And the sort of follow-up question to that is the

1 importance of understanding clinical notes, I think
2 completing clinical notes in full.

3 **A.** Yes.

4 **Q.** Is that something that staff are trained --

5 **A.** Is aware --

6 **Q.** Nurses are trained on?

7 **A.** I don't know if there's any specific training in
8 completing clinical notes in full. There's clinical
9 guidelines that outline what should be included, and
10 that has prompts, but I don't know if there's any
11 specific training on the completion of those.

12 **Q.** What about --

13 **A.** I don't believe there are.

14 **Q.** What about nursing standards?

15 **A.** So nurses would be held in line with the nursing -- the
16 Code, et cetera. But in terms of specific training that
17 would be for all staff because our support workers would
18 also complete some documentation.

19 **Q.** Is there an EPUT policy on sedation and observations in
20 mental health settings other than the Acute Disturbed
21 Behaviour Policy?

22 **A.** I wouldn't like to say. When I think of it, I think of
23 the rapid tranquilisation policy, so I wouldn't want to
24 comment further.

25 **Q.** In respect of Jason Standing, the Patient Safety

1 Investigation recommended that there was a need to
2 ensure that staff completing enhanced observations fully
3 understood the task assigned to them.

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

5 **Q.** Do you agree that this and the other failings identified
6 in the Patient Safety Investigation were both basic and
7 avoidable?

8 **A.** Yes.

9 **Q.** You said that sometimes someone appears objectively
10 ready for discharge, and is deemed clinically ready, but
11 is not then discharged because of statements made by the
12 patient or relatives about their risk. Do you accept,
13 however, that someone may appear ready for discharge
14 clinically, but if there is no proper community mental
15 health team plan or community support in place, families
16 may reasonably be concerned that the person will be left
17 without support in the community?

18 **A.** Yes, of course. My statements were in the context of
19 clinically ready and appropriate discharge provision in
20 place.

21 **Q.** And that readiness for discharge is dependent on this,
22 I think, you agree with that?

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

24 **Q.** Are there times where families are raising legitimate
25 concerns about how that discharge will safely take

1 place?

2 **A.** In the sense of somebody returning home, or in what
3 context? Are you able to clarify?

4 **Q.** So in the context of somebody being discharged, are
5 there times when families can be raising legitimate
6 concerns about how discharge will be -- will safely take
7 place?

8 **A.** They might question follow-up provision.

9 **Q.** You've identified a flaw in the KPI, key performance
10 indicator, review system, whereby if a blank risk
11 assessment is opened and saved, it doesn't show it as
12 a breach. Is there any system or audit process to check
13 how often that is happening? And do you have any sense
14 of how frequently this happened?

15 **A.** I'm not aware of any audit that checks post-admission
16 whether a full assessment was updated of all -- thorough
17 risk assessment.

18 **Q.** What impact can delays in completing risk assessments
19 have on patient safety and management of patients in the
20 ward?

21 **A.** Significant. Worst case would be death. I would say
22 that generally when people are admitted to a ward, even
23 if the initial risk assessment wasn't completed, that
24 there would be a risk assessment undertaken, but that
25 might not be formally documented at that point.

1 **Q.** In your statement, I won't take you to the particular
2 passage unless you wish me to, about you talk about
3 training for managerial roles and clinical supervision.

4 **A.** Mm-hm.

5 **Q.** How common is it for individuals promoted to managerial
6 roles not to have training for them?

7 **A.** I would say that the Management Development Programme
8 isn't mandatory. People are encouraged to complete
9 that. So it could be common that people hadn't complete
10 that but that would be reviewed in line with one-to-one
11 support and appraisal processes, and I'm aware of people
12 that are in managerial roles that I'm responsible for,
13 that we discuss those in supervision, and ensure that
14 they're enrolled on to those. I can only speak for
15 myself about how that is managed.

16 **Q.** So there is training available but not mandatory?

17 **A.** Correct. The Management Development Programme.

18 **THE CHAIR:** If somebody wanted to take a Management
19 Development Programme or you encouraged them to do so,
20 will they have protected time to do that?

21 **A.** It's challenging. I know that on the Mental Health
22 Urgent Care Department those staff have management days
23 and so quite often they've started to arrange them on
24 their management day so that they're not disrupted.
25 Other people have chosen to complete them whilst off

1 duty, but reflected on the health roster. I know --

2 **THE CHAIR:** What does that mean, off duty --

3 **A.** So they're not at work but they've got Microsoft Teams,
4 for example, they can complete the training because it's
5 online, and then it will be reflected that they've
6 completed that training.

7 **THE CHAIR:** But they have to do it in their own time.

8 **A.** Yeah, some people would choose that. Quite often people
9 would be enrolled on a course but if there was a demand
10 on the ward that ensured patient safety at the time,
11 they would prioritise that rather than the completion of
12 the mandatory training element.

13 **THE CHAIR:** And I think what you're telling me, therefore,
14 is there is no protected time for Management
15 Development --

16 **A.** Programme.

17 **THE CHAIR:** -- Programmes.

18 **A.** No.

19 **THE CHAIR:** Thank you.

20 **MS MALHOTRA:** Forgive me if you've already answered this,
21 but was the NHS Management Development Programme
22 available to you?

23 **A.** It wasn't spoken about, I would say, the EPUT Management
24 Development Programme. I didn't complete it. I would
25 say a lot of what I experienced, I sought advice from

1 HR, for example, and was then supported to do that at
2 that time, or through line management.

3 Q. I see, so --

4 A. We also discussed, sorry, the wider NHS programmes for
5 senior leaders and things like that, that's not
6 EPUT-led, the NHS programmes. They're part of the
7 one-to-one and appraisal discussions.

8 Q. So had you done the NHS -- no?

9 A. No.

10 Q. And you hadn't done the EPUT one?

11 A. No.

12 Q. Was that quite a common occurrence amongst your peers?

13 A. Yeah.

14 Q. In your experience, did the combination of training not
15 being made available and the limited or irregular
16 availability of clinical supervision for nurses
17 contribute to variations in practice?

18 A. Yeah, I would say so.

19 Q. I'd like to ask you about family engagement next.

20 The Family and Carer Ambassador acting as a link, we
21 spoke about that role, and I think you said the rollout
22 was slow.

23 A. Mm.

24 Q. And then there was one in place now, I believe --

25 A. Yes.

1 Q. -- in your experience?

2 A. Two in Basildon, but one covers the assessment unit for
3 which I'm responsible, and the Hadleigh Unit PICU and
4 then the other one at Basildon covers the female and
5 male acute ward.

6 Q. And so to what extent does it remain the case that risk
7 assessments and care plans are often completed without
8 family or carer input?

9 A. It's reduced, as in it's improved. There was an audit
10 that was completed recently where I think it was two of
11 the five records had no evidence of the engagement --

12 Q. So two out of five?

13 A. -- out of five, whereas previously I would say that it
14 would be like much lower than that. And that's
15 something that's ongoing and gets discussed with the
16 Family and Carer Ambassador.

17 Q. Next topic, Oxevision --

18 A. Sorry, just to go back into that. Whilst the Family and
19 Carer Ambassador will ensure that they're communicating,
20 it might not always be that it's captured in the 2.1 or
21 the care plan but it will be within the clinical
22 records, and then in the ward rounds there will be the
23 evidence of engagement with families completed by the
24 medical team.

25 Q. Next topic, Oxevision.

1 **A.** Mm-hm.

2 **Q.** Did you come across specific examples of patients being
3 observed or photographs being taken inappropriately?

4 **A.** Not photographed, no. Observed, people use the
5 non-contact observation functionality, and I don't think
6 it was well known that that should not be happening in
7 practice at the frequency that it was happening.

8 **Q.** I see. So to give you the context, you made a comment
9 about reminding staff about not --

10 **A.** Yeah.

11 **Q.** -- about the purpose of it.

12 **A.** Yeah.

13 **Q.** I just wanted to explore whether that arose from
14 a specific example?

15 **A.** No specific instance. It was more being mindful of that
16 risk.

17 **Q.** Okay. And so I think you've answered this, but were you
18 aware of Oxevision being used inappropriately in place
19 of direct observations?

20 **A.** So I became aware that that had been occurring within
21 the organisation, and I shared with the team about the
22 importance of in-person checks. I know that the SOP at
23 one point referred to reducing sleep disturbance, which
24 may have caused confusion with staff.

25 **Q.** And sorry, I just want to pick up on the point about

1 family engagement. You said two out of five would have
2 no engagement?

3 **A.** Yes, at the last audit. I don't recall the previous
4 from that.

5 **Q.** And so I think you said before that, it would have been
6 lower.

7 **A.** Yeah.

8 **Q.** So would that have been one out of five?

9 **A.** It would have been significantly lower, I would say.
10 That it wasn't consistently captured with clear evidence
11 of the patient's relative and carer's voice within the
12 care plans.

13 **Q.** Okay, all right.

14 Thank you very much. Those are all the questions.
15 That concludes your evidence to the Inquiry.

16 And Chair, we will return at 2.15, please.

17 **THE CHAIR:** Can I thank you very much indeed for your
18 evidence. It's been extremely clear and very, very
19 helpful, thank you.

20 **THE WITNESS:** Thank you.

21 **(1.25 pm)**

22 **(The Short Adjournment)**

23 **(2.15 pm)**

24 **(Proceedings delayed)**

25 **(2.24 pm)**

1 **MS DRAPER:** Good afternoon, Chair. We are now ready to
2 continue playing the pre-recorded session of Zoe
3 Bunting, which is approximately 30 minutes.

4 **THE CHAIR:** Thank you.

5 **(Pre-recorded evidence of Zoe Bunting continues)**

6 **THE CHAIR:** Ms Draper?

7 **MS DRAPER:** Chair, that concludes the evidence for today.
8 We will resume on Monday at 10.00 am, when we will turn
9 to the topic of resuscitation.

10 **THE CHAIR:** Thank you very much indeed. 10.00 am Monday.

11 **(2.49 pm)**

12 **(The Public hearing adjourned until Monday,**
13 **20 July 2026 at 10.00 am)**

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LOUISE BORTON (sworn)3
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