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

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

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

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

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

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

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

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

LOUISE BORTON (sworn)

Questioned by MS MALHOTRA

MS MALHOTRA: Thank you very much.

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

A. I have.

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

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

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

A. No.

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

A. Correct.

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

A. That's correct.

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

A. *(The witness nodded).*

Q. A Registered Mental Health Nurse?

A. Correct.

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

A. I did.

Q. And you started working with South Essex Partnership University NHS Foundation Trust; is that right?

A. That's right, yes.

Q. And that was known as SEPT --

A. *(The witness nodded)*.

Q. -- pre-merger with EPUT?

A. *(The witness nodded)*.

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

A. That's correct.

Q. You say -- and perhaps we could have this up to help, page 1, paragraph 7, please -- you list here your relevant employment history, starting with September 2016 to October 2018, you were a Senior Support Worker in the Cedar Ward; is that right?

A. The 2018 is incorrect. So it was the 2016, so it took around a month for my nursing and midwifery pin to come through.

Q. I see. It says here you worked at the Cedar Ward when it was under SEPT.

A. *(The witness nodded)*.

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

is?

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

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

A. *(The witness nodded)*.

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

A. *(The witness nodded)*.

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

A. *(The witness nodded)*.

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

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

Q. Then you became Ward Manager at Grangewaters Ward?

A. *(The witness nodded)*.

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

A. *(The witness nodded)*.

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

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

Q. I wonder if you could slow down slightly.

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

Q. For informal?

A. *(The witness nodded)*.

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

safety. Tell us about that, please.

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

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

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

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

Q. I see.

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

A. *(The witness nodded).*

Q. Is that right?

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

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

A. *(The witness nodded)*.

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

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

Q. Can I ask you to slow down?

A. Sorry. I really apologise.

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

A. No problem.

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

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

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

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

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

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

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

in the evenings and at the weekends.

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

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

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

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

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

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

the reality is different.

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

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

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

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

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

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

A. *(The witness nodded)*.

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

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

THE CHAIR: Ms Borton --

A. I'm sorry. I'm really sorry.

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

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

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

A. I hear you.

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

A. Yeah.

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

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

THE CHAIR: Don't worry.

MS MALHOTRA: Let's just take it a step back and take it in stages.

A. Yeah, no problem.

Q. Just give us an overview, if you can, on what the Mobius risk stratification system is?

A. So each risk, so for example, suicide, self-harm, is listed, and then there's a space for you to incorporate any free text that you want to in relation to that. And then there's a section where the staff member would select either low, medium, or high risk.

Q. So the low, medium or high is calculated or generated by the system?

A. No, by the clinician.

Q. I see.

A. But there's no, as I've described, there was no clear training or guidance in relation to that form, the stratification.

Q. Just pausing there, then, this is part of the admission process or the initial assessment?

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

Q. So this would be undertaken by a nurse?

A. Yes.

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

A. *(The witness nodded)*.

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

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

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

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

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

A. Yes, high, medium, low.

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

A. *(The witness nodded)*.

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

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

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

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

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

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

A. *(The witness nodded)*.

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

A. *(The witness nodded)*.

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

A. Yes.

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

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

Q. And NHS guidance Staying Safe from Suicide, dated

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

A. I can't recall but I imagine it would be, given those dates, the most latest guidance.

Q. So you mention here at paragraph 26, that there is now STORM Skills Training in Self-harm and Suicide Prevention, which is consistent with NHS England and NICE Guidelines. Is that a view which you have independently formed, having reviewed those guidelines?

A. Yes, and from speaking to one of the STORM trainers. Like I say, I haven't been on that training myself, but that's my understanding, from speaking to one of the trainers.

Q. And when did this STORM skills training start? Can you help us?

A. Perhaps '20, '20, around '22, '23, perhaps. I remember it specifically around the time of the Mental Health Urgent Care Department but that's not to say that it wasn't already happening and different services were accessing that training.

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

A. Possibly.

Q. And this STORM skills training, you said that it differed in the approach. Can you just expand on that and explain that to us?

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

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

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

A. *(The witness nodded)*.

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

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

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

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

Q. Is that a concern for you?

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

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

Q. Aside from that, in practice, have you seen, or can you comment or give us an example, of what the impact of that disconnect is?

A. I think for me, my understanding of that is it's more the staff frustration that we're not working in a way that is best practice.

Q. I see. And you mentioned speaking, I think it was to the Deputy Director of Clinical --

A. Quality and Safety.

Q. Sorry, Quality and Safety, forgive me. What was the outcome of that, do you know?

A. Only that there was the discussion surrounding Nova and the change to the electronic patient records.

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

A. So Nova is going to be the new clinical system that will be used by the Trust and it will also be used by the local acute Trusts and they'll have access to one shared record system. So as a Trust, we'll no longer have two clinical record systems. So it'll move away from Mobius and Paris. So it should improve patient access to services, both mental health and acute, at the time of entry.

Q. I see in terms of practicality of having access to notes and a more streamlined process; how does Nova address

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

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

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

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

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

A. 2027, I believe.

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

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

And then:

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

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

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

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

A. Which has, sorry?

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

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

Q. It has is taken place now?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. It could lead to an unsafe decision.

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

A. Within the last six to 12 months.

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

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

completed or not.

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

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

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

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

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

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

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

A. Yes.

Q. Would you agree with that?

A. Yes.

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

A. Mm-hm.

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

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

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

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

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

A. No.

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

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

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

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

A. *(The witness nodded).*

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

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

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

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

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

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

A. *(The witness nodded)*.

Q. Can you tell us when this arose?

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

Q. So you raised this concern?

A. Yes.

Q. Who did you raise the concern with?

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

Q. And that still hasn't been addressed?

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

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

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

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

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

Q. Yes, of course.

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

Q. Let me break it down. It's a long question. You talk about ward culture --

A. Yeah.

Q. -- and that it wasn't always focused, and I'm paraphrasing here, it wasn't always focused on delivery of good quality inpatient care --

A. *(The witness nodded)*.

Q. -- and treatment.

A. *(The witness nodded)*.

Q. And that staff are often focused on risk management rather than therapeutic engagement.

A. *(The witness nodded)*.

Q. And so what I'm trying to understand is, was it the KPIs that were causing that imbalance that you've described?

A. No, I wouldn't say so. I would say the focus on the risk management was to do largely with the numbers of patients that we had on the wards, staffing, and managing that immediate risk. We've had a lot of change, in terms of our staffing establishments. So previously it would be quite common for one nurse to be on duty, responsible for up to 28 patients when it was Grangewaters, with three support workers. So it was challenging and it did mean that, yeah, it was more

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

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

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

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

A. *(The witness nodded).*

Q. How often did that occur in practice?

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

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

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

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

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

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

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

A. Yeah, sorry.

Repeat that for me, then, sorry.

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

A. Yes.

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

A. That's my understanding.

Q. When did the rollout start?

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

THE CHAIR: In 2025 was that?

A. Ours, in Basildon?

THE CHAIR: Across the Trust?

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

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

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

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

A. As in the Family and Carer Ambassador?

THE CHAIR: Yes.

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

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

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

THE CHAIR: Thank you. Very helpful.

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

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

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

How long has that been an issue?

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

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

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

Q. Why do you say that?

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

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

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

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

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

Q. I see.

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

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

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

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

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

A. I would.

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

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

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

A. *(The witness nodded)*.

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

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

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

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

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

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

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

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

time.

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

A. Yes.

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

A. *(The witness nodded)*.

Q. -- when perhaps they should be?

A. Correct.

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

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

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

A. *(The witness nodded).*

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

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

A. Yeah.

THE CHAIR: -- take the next step?

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

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

THE CHAIR: Fifteen minutes.

(11.05 am)

(A short break)

(11.22 am)

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Thank you.

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

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

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

You go on to say:

"I believe this practice was harmful, as such diagnoses do not automatically indicate a need for constant observation."

A. *(The witness nodded).*

Q. And you go on to explain:

"For some patients, this level of monitoring was intrusive, distressing and counter therapeutic. Despite this, the practice continued, seemingly because it had become embedded as accepted practice."

Can you help us, please, with when did this happen? Or does it still happen?

A. My understanding is that it does still happen. I know you heard evidence from -- in relation to Dispatches and the practice on Willow Ward, and I'm aware -- not more so recently, but I am aware, that the Matron for that ward had raised concern about the practice.

Q. And so this practice of a Consultant Psychiatrist putting a patient on level 3 observations, I'll say for now, inappropriately, in your view?

A. In my view, yes.

Q. In your view, when did you first become aware of that or when did you first become concerned about that?

A. Yeah, I think I was aware of it for quite a period of time, whilst the consultant had been on that ward. And

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

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

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

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

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

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

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

Q. And raised the concern with who?
A. With the Deputy Director of Quality and Safety, as well as had the discussion with the management of that site, so the Matron for the area.
THE CHAIR: Can I just be clear with you, it's not just, in your view, that it is an affront to privacy and is restricted, do you think it's actually harmful, sometimes, for such a patient to be on level 3 observations the whole time?
A. Yeah, if it's not required, I would say that's harmful. And it has a significant impact on that individual, but also other individuals on the ward, if there are any issues with staffing, for example. And at times, it can increase the reliance on staff and make that reduction in observation and discharge more challenging.
MS MALHOTRA: So if I was to summarise it, could it set a patient back?
A. Personally, I believe that that could, that practice.
Q. So you say that you raised this with the Matron, you raised it with the Deputy Director for Quality and Assurance --
A. *(The witness nodded)*.
Q. -- and what were you told, and what was done?
A. I don't know what was done, but I'm aware that it was a sort of known issue, but I don't know what support was

put in place in order to address.

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

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

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

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

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

A. I've not heard of The Haven.

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

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

A. *(The witness nodded).*

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

A. Page 8.

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

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

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

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

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

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

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

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

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

A. Yes.

Q. -- and that was six months ago, sorry?
A. I'd say six to 12 months. It might be slightly longer but it is relatively recently.
Q. And so prior to that, would you say that those patients with substance misuse and mental health issues often fell through the cracks?
A. I would. Like I say, it relied heavily on the self-referral. So that was a challenge for people with such illnesses.
Q. And here, at paragraph 33, so if we go back to page 5, dealing with co-occurring -- or comorbidities and co-occurring issues, here:

"Physical health needs such as mobility were assessed by the Physiotherapy and Occupational Therapy teams following referral. There were delays in accessing Speech and Language Therapy [the SALT teams] and Tissue Viability services."

And you say:

"At Basildon Mental Health Unit physical health needs were poorly managed due to a lack of manual handling equipment."

A. *(The witness nodded)*.
Q. Do you mean equipment to move patients?
A. Yeah, that's correct. So until this year, and it's not currently operational, there was no hoist at Basildon

Mental Health Unit.

Q. Sorry, there was no? Hoist?

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

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

A. So. It's in place --

Q. It's in place?

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

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

experience?

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

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

Can you just explain what the variation is?

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

Q. Assessments being undertaken, right?

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

THE CHAIR: Remember your speed.

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

MS MALHOTRA: I'd like --

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

Q. Monthly?

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

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

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

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

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

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

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

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

A. Yeah.

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

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

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

A. No.

Q. Would you have expected to be?

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

Q. Can I ask you to slow down slightly.

A. On the night --

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

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

A. *(The witness nodded)*.

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

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

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

A. Yes.

Q. Did you complete a Datix?

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

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

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

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

the fact that you had raised concerns?

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

Q. Yeah.

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

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

A. No.

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

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

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

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

I think they're captured.

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

A. *(The witness nodded)*.

Q. -- and that learning was not embedded?

A. *(The witness nodded)*.

Q. Can you tell us about that?

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

transfer from one hospital site to another, was included.

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

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

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

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

example.

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

A. *(The witness nodded)*.

Q. Is that a fair summary?

A. Yeah.

Q. And that still hasn't been embedded?

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

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

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

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

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

A. No. For Bethany? No.

Q. And what about action plans?

A. No.

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

A. No.

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

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

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

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

When was that established?

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

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

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

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

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

I don't --

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

A. So with people that were in those meetings.

Q. So just tell me the roles.

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

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

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

Q. You say at --

A. Sorry, just going back to that point.

Q. Yes.

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

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

Q. So when has the locality model started?

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

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

A. Yeah.

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

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

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

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

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

A. I would.

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

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

Q. Well --

A. Does that make sense?

Q. Both.

A. Both, yeah.

Q. Firstly, to have access to the system?

A. Yeah.

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

A. Yeah.

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

A. Yes.

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

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

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

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

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

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

A. *(The witness nodded)*.

Q. And so --

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

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

A. Yes.

Q. And continues to persist?

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

that system.

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

A. From my experience, yes.

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

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

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

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

A. Not that I recall.

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

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

or as a Matron for services.

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

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

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

A. *(The witness nodded)*.

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

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

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

Q. So possibly around 2022?

A. Possibly.

Q. Has that changed again?

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

Q. Are you familiar with the Safe Wards programme?

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

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

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

Urgent Care Department.

Q. And would you say that observation practice was influenced by the Safe Wards programme?

A. It had the potential to support, in terms of some of the interventions, Getting to Know Me, Soft Words, that could support it. I would say largely the change to the Therapeutic Engagement and Supportive Observation policy probably drove a reduction, and more widely reducing restrictive practice understanding across the Trust, as well as trauma-informed care.

Q. You said it drove a reduction. Reduction in observations?

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

Q. Okay.

A. Not just reducing observations for the sake of it. That's not been my experience on the wards I've worked.

Q. Just going back to Bethany Lilley's death and the circumstances that arose, the concerns that you raised about the observations. That's one example, isn't it, of where there was concerns about observations; would you agree with that?

A. About the recordkeeping of the observations was my concern. I wasn't aware at the time that she'd been on level 3 observations at the Peter Bruff Unit and

downgraded.

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

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

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

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

not have been recorded.

Q. Were you aware about safeguarding concerns?

A. Generally?

Q. In respect of Bethany Lilley. Were you aware safeguarding concerns?

A. Having read the reports that came with the Rule 9. I wasn't -- I didn't work on Thorpe Ward. It was only that I was the site officer for that night that I had any interaction with Bethany.

Q. Do you have any experience of dealing with safeguarding concerns within the Trust at the time?

A. Yes.

Q. Tell us about what your concerns were?

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

Q. Did you have any concerns about --

A. Oh sorry, my apologies.

Q. -- about how safeguarding issues were raised?

A. Not that I recall. If there were safeguarding concerns, we would raise them. At the time it was a paper form, SETSAF1. We had safeguarding leads for the unit that we could contact, Datix Incident Reports would be completed. I don't recall concerns with safeguarding at the time.

Q. Were you made aware of the Thurrock Clinical

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

A. Subsequently.

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

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

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

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

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

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

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

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

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

death?

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

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

A. Yes.

Q. Several times?

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

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

A. Did you say 141?

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

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

Can you help us with the context for that?

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

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

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

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

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

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

THE CHAIR: Thank you.

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

A. Yeah --

Q. -- safety?

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

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

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

A. Yeah.

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

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

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

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

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

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

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

A. Yeah. To that effect.

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

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

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

A. Yes.

Q. And had the reviewers viewed it?

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

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

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

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

A. *(The witness nodded)*.

Q. Were you concerned about that?

A. I don't recall -- is that the report that went to the coroner's, the one that was done following the emails with the concerns raised?

Q. So if we have a look at 314, page 63. You say here, this is following on from the chronology, you raised concerns -- sorry, 313, page 62. Just to give you the context.

A. Yeah.

Q. You raised concerns about not being interviewed by the original investigator -- we can see there at the bottom.

Then you say at the top of page 63 about the Oxevision footage.

A. Yeah.

Q. And then at 314 you say:

"When the addendum report was produced, I questioned whether the Trust had considered a wider review of the investigation considering the concerns raised. I also queried whether interview records had been reviewed in full to determine whether a more comprehensive re-investigation was required. I expressed that it remained unclear to me as to why other key individuals were not consulted before further iterations of the report were produced."

Then you go on to express your views.

At 316 you say:

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

What do you mean by that?

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

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

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

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

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

A. Definitely.

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

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

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

A. Yeah.

Q. Was that training sufficient, in your view?

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

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

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

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

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

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

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

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

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

Q. Yes.

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

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

Q. So there are moves to change it?

A. Correct.

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

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

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

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

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

THE CHAIR: Ten minutes.

(12.27 pm)

(A short break)

(12.40 pm)

MS MALHOTRA: Thank you, Chair.

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

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

At the last sentence, you say:

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

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

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

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

Q. Generally, or --

A. Generally, yeah, yeah.

Q. Why do you feel that is?

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

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

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

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

A. *(The witness nodded)*.

Q. -- and in fact it's one of your recommendations, if you look at page 67, paragraph 336. You say:

"My primary recommendation is that [EPUT] should be divided into more than one Trust."

Can you explain why you invite the Chair to make that recommendation?

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

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

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

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

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

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

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

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

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

A. *(The witness nodded)*.

Q. -- I think from 2023?

A. *(The witness nodded)*.

Q. What changed to facilitate that?

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

Q. You mentioned earlier.

I'd like to ask you next about Oxevision.

A. Yeah.

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

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

And you go on to say that:

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

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

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

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

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

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

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

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

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

A. Yes.

Q. Do you know how long that could be?

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

Q. Within 72.

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

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

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

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

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

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

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

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

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

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

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

Q. What about the alert volumes?

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

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

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

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

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

So ten minutes, please.

THE CHAIR: Ten minutes.

THE WITNESS: Thank you.

(12.54 pm)

(A short break)

(1.11 pm)

MS MALHOTRA: Chair, there are some questions.

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

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

Q. So it was after?

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

A. *(The witness nodded)*.

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

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

A. Yes.

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

A. Repeat the part, please?

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

A. Yes, medicine management --

Q. -- of sedation?

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

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

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

A. Yes.

Q. Is that something that staff are trained --

A. Is aware --

Q. Nurses are trained on?

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

Q. What about --

A. I don't believe there are.

Q. What about nursing standards?

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

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

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

Q. In respect of Jason Standing, the Patient Safety

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

A. *(The witness nodded)*.

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

A. Yes.

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

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

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

A. *(The witness nodded)*.

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

place?

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

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

A. They might question follow-up provision.

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

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

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

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

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

A. Mm-hm.

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

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

Q. So there is training available but not mandatory?

A. Correct. The Management Development Programme.

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

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

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

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

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

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

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

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

A. Programme.

THE CHAIR: -- Programmes.

A. No.

THE CHAIR: Thank you.

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

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

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

Q. I see, so --

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

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

A. No.

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

A. No.

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

A. Yeah.

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

A. Yeah, I would say so.

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

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

A. Mm.

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

A. Yes.

Q. -- in your experience?

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

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

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

Q. So two out of five?

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

Q. Next topic, Oxevision --

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

Q. Next topic, Oxevision.

A. Mm-hm.

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

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

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

A. Yeah.

Q. -- about the purpose of it.

A. Yeah.

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

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

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

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

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

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

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

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

A. Yeah.

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

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

Q. Okay, all right.

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

And Chair, we will return at 2.15, please.

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

THE WITNESS: Thank you.

(1.25 pm)

(The Short Adjournment)

(2.15 pm)

(Proceedings delayed)

(2.24 pm)

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

THE CHAIR: Thank you.

(Pre-recorded evidence of Zoe Bunting continues)

THE CHAIR: Ms Draper?

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

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

(2.49 pm)

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

I N D E X

(14) records... - see