Monday, 20 July 2026

(10.00 am)

(Proceedings delayed)

(10.02 am)

THE CHAIR: Ms Harris, good morning.

MS HARRIS: Good morning, Chair.

Chair, this morning we turn to the Inquiry's examination of potential systemic issues in relation to emergency response and resuscitation.

We will begin with an update on the Inquiry's investigation of this topic, and then we will hear from Mr Adam Benson Clarke, who will be giving evidence on behalf of Resuscitation Council UK.

Mr Benson Clarke will be giving evidence of the standards to be expected in relation to emergency response and resuscitation on mental health inpatient units. He will also be giving evidence about cardiac arrest and about the clinical issues relating to medical emergencies on mental health inpatient wards.

This afternoon we will hear the recorded evidence of Beverly Switzer who is a member of staff at EPUT. She provided her evidence during a recorded evidence session last Friday, having been granted special measures by you, and we will play that evidence this afternoon.

As with previous days, Chair, there may be aspects

of today's evidence that are difficult to listen to, and for some people it may not be possible to sit through the two sessions. As with other days, anyone in the Inquiry room should feel free to leave at any time.

May I take this opportunity, please, to remind those engaging with the Inquiry that emotional support is available for all who require it. Present here again today are emotional support staff from Hestia, an experienced provider of emotional support at these types of hearing and they're currently in this room, I believe, and are wearing orange scarves.

There is a private room downstairs where anyone who needs emotional support can talk to Hestia support staff. If you prefer, you can speak to a member of the Inquiry Team and we will put you in touch with emotional support staff and we're all wearing purple-coloured lanyards.

For those following the hearing online, information about the emotional support that is available can be found on the Lampard Inquiry website @lampardinquiry.org.uk.

I will then move, Chair, if I may, to an update on the Lampard Inquiry's emergency response and resuscitation investigations.

Update statement by MS HARRIS KC

MS HARRIS: Chair, over the course of the last year, you have heard many accounts from bereaved families which have included details of patients being discovered by staff on mental health inpatient units in circumstances of serious medical emergency. A number of those accounts have revealed apparent systemic issues in mental health inpatient care relating to emergency response and attempts to resuscitate.

Furthermore, in December last year, Chair, you invited some submissions from Core Participants in relation to the Inquiry's work more generally. And these submissions included concerns raised by Core Participants about the evidence the Inquiry has heard in relation to emergency response and attempts to resuscitate.

In March this year, having heard the accounts given by the bereaved families, and having considered the Core Participant submissions, you directed your team to look closely at issues relating to emergency response and resuscitation of deteriorating patients on mental health inpatient units, and you asked us to do so without delay.

Put shortly, you considered that some of the evidence this Inquiry has heard gives rise to serious

questions, amongst other matters, about the recognition of emergency situations, clinical response, emergency decision making, the availability and accessibility of vital equipment, and the adequacy of resuscitation practices and procedures, past and present, within mental health inpatient settings. You have determined that this is an emerging area requiring investigation because it holds potential implications for the safety of current patients and may also be of national impact.

Questions relating to the adequacy of emergency response and resuscitation efforts arise in at least 21 of the Inquiry's illustrative cases. Many illustrative case summaries were disclosed to Core Participants in advance of this hearing.

The evidence the Inquiry has heard from bereaved families has revealed a number of potential systemic issues that appear to extend across almost all aspects of resuscitation and the processes of emergency response on mental health inpatient units.

And those potential systemic issues can be summarised broadly at this stage as, firstly, failures to identify and to understand the true nature of the emergency and to act accordingly; clear issues with sufficiency of knowledge, familiarity with appropriate procedures and equipment, and adequacy of training for

staff; problems with availability and accessibility on wards of vital equipment; and delay at every stage.

And with those broad headings or issues in mind, examples of the types of perceived failings that bereaved families have told us about, or that have emerged from our illustrative cases, include some of the following: failures by staff to understand the urgency and the nature of self-harm attempts and injuries, delays in responding, and failures in senior clinical leadership.

Staff training records showing non-compliance, gaps, and absences in mandatory training. In one case, seven out of the ten staff involved in the emergency response were found to have been non-compliant with their mandatory training.

An insufficient level or absence of knowledge amongst staff about their roles and remit during any emergency, the equipment that should be available, where to locate it how to use it competently.

A lack of clarity about whether pinpoint alarms used by staff signified medical or mental health emergencies, and a lack of clarity about who should respond to that alarm.

Failures to remove ligatures before attempting resuscitation; failures to bring appropriate ventilation

equipment to the scene, even where such equipment was readily available.

Failures, where that equipment was brought, to be able to locate it within the grab bag, and to apply it correctly and without delay.

Life-saving equipment being misused, incorrect placement of defibrillator paddles, use of the wrong masks, problems administering oxygen, including failing to appreciate that pull tabs on oxygen cylinders would need to be removed to start the flow of oxygen, or persevering with broken equipment.

In other cases, life-saving equipment was missing or broken.

There have been delays in staff raising the alarm, with vital minutes lost before emergencies were identified, before appropriate steps were taken, and before emergency calls went out from the ward.

Issues with the basic practicalities of making those emergency calls.

The basic fact that the situation was an emergency not being explained by those on the ward to the staff who they were calling out, with one case where an on-call doctor was told he had time to get his coat. In one case, that call being delayed because the staff member making the call was unaware that an additional 9

was needed for an outside line.

In another, the emergency number for the general hospital resuscitation team had changed without staff on the unit being informed meaning that the team simply couldn't be reached and alternatives had to be tried, with vital seconds and minutes passing.

999 calls being made by staff on non-portable phones, which were sometimes not available, and who therefore could neither see the patient nor provide proper, up-to-date information to emergency service operators.

Failures to give clear, accurate information about timings and crucial events to 999 call operators and to attending paramedics, delaying or hampering appropriate intervention further.

In one case, a failure to inform paramedics who were attempting resuscitation that the patient had swallowed an item.

Paramedics being misdirected in terms of the site of or access to the ward, being given conflicting addresses and directions to different entrances.

Paramedics being unable to gain access to wards despite having been called out to an emergency, and when that access was gained, further delay while emergency responders were slowed by having to be escorted or

allowed through a series of locked doors.

In one case, family members who were present in the reception area of the unit having to intervene themselves to assist attending paramedics to gain access to the ward.

Attending emergency responders in numerous cases described chaotic scenes on arrival, with ward staff in states of panic, confusion and disorganisation.

Apparent failures in terms of investigations after the event and the Trust's ability to assess failures and to learn lessons from them, including failures to complete "resuscitation event" forms.

And in terms of potential systemic issues the real risk that opportunities to identify learning have been lost.

Furthermore, Chair, over the past two weeks the Inquiry has heard evidence from staff who currently work on mental health inpatient units in Essex, and this included, for example, the evidence of Brian O'Donnell who, on Wednesday last week, shared his concerns as to whether those who were first on the scene of an emergency situation have always received adequate training.

Whilst the evidence we have heard, and the illustrative cases the Inquiry has looked at, appear to

reveal systemic issues dating back to the early 2000s, your motivation in considering this topic now is your concern about current patient safety and you have therefore directed your team to focus on recent policies and procedures and practices and recent training provision, and to ascertain the current position.

Before I go any further, I'd like to say a little, if I may, about cardiac arrest and secondary cardiac arrest. And we'll hear evidence about this shortly.

Cardiac arrest is the ultimate medical emergency. It is defined by the absence of a person's normal breathing and/or signs of life. When a person is in cardiac arrest, their heart stops pumping blood around their body and they lose consciousness. And we will hear that without cardiopulmonary resuscitation, also known as CPR, and, where indicated, defibrillation, a person will not survive a cardiac arrest.

CPR is the combination of administering chest compressions and delivering rescue breaths. In acute clinical settings, like general hospital wards, CPR is supplemented by additional key skills which are provided by a specific expert team (often called the cardiac arrest or resuscitation team), or crash team. This team will be mobilised to attend a patient when a cardiac arrest call is made, but this is unlikely to be the

position or the provision in many mental health inpatient units, however.

A significant proportion of cardiac arrests that take place in healthcare settings, and in particular in mental health inpatient settings, are what are known as secondary cardiac arrests. Secondary cardiac arrests are a patient's response to a preceding clinical event or trigger. And examples of trigger events include many of those common to mental health inpatient settings, such as low oxygen levels (hypoxia), airway obstruction, overdose, severe physical deterioration and ligature-related asphyxia.

And in circumstances where there has been a trigger event such as those I've just described, a patient goes into cardiac arrest at the end of a process, and that process includes deterioration of the patient, the patient's loss of consciousness, and the patient stopping breathing. And secondary cardiac arrests usually result in non-shockable heart rhythms. And this means that the use of a defibrillator, which works for shockable rhythms, is not usually indicated for secondary cardiac arrests, and survival rates of secondary cardiac arrests are therefore poor.

Secondary cardiac arrests therefore need to be managed differently, depending on the trigger event.

For example, if a patient goes into cardiac arrest secondary to low oxygen levels, hypoxia, a key treatment is to manage the patient's airway and provide high-concentration and high-flow oxygen, by providing artificial ventilation along with the CPR.

In mental health inpatient settings, those who are first on the scene of a medical emergency should provide treatment to the level they have been trained, at the same time as urgently summoning expert help. In circumstances where secondary cardiac arrest has not yet occurred, there may be an opportunity to identify deterioration, and intervene before that secondary cardiac arrest takes place. And we'll hear evidence about that from Resuscitation Council UK, or RCUK, this morning.

On a mental health inpatient unit, preventative measures might include removal of the ligature, recognition and prompt management of an airway or breathing compromise, monitoring and escalation of deteriorating vital signs, management of overdose or intoxication, and an early transfer or escalation to acute medical services. Any delay could be fatal.

And given the massive impact that certain skills and intervention may have on the outcome for a patient, one of the issues this Inquiry intends to investigate is the

level and type of training that could, or should, be provided to those who might find themselves as first responders on mental health inpatient units, and which elements of training specific to mental inpatient units should be included.

With regards to the expert help to be summoned, in a mental health inpatient setting, this might be a cardiac arrest team depending on the location of the unit, but more commonly, it will be the ambulance services, or, in the interim, ward staff who are trained in more advanced resuscitation skills while they wait for the larger team to attend.

The Inquiry also intends to look at what sorts of arrangements could or should be in place on mental health inpatient wards to ensure that the expert help can be called quickly, and most importantly, to ensure that the help can get on to the ward and to the patient without confusion and delay.

We will hear some evidence today, Chair, that the window of opportunity to influence the outcome for these sorts of emergencies is small. It would appear, therefore, to be of paramount importance that those who are first on the scene can identify the emergency and the signs of deterioration, that they know what to do, that they have access to the equipment and the drugs

they need to treat the patient, that there are suitably trained staff available to lead the emergency response and resuscitation attempt, that there are systems and resources in place to summons expert help, that there are processes by which that expert help can gain access without delay, and so on. And these are all matters that you have directed your team to look at, Chair.

To this end, then, may I say a brief word, please, about life support training.

Basic life support or BLS, as it's sometimes known, training; teaches the basic set of first aid procedures needed to keep someone alive during a life-threatening emergency before advanced medical help arrives. Anyone can undertake basic life support training and many do, in the workplace, for example, or at sports clubs, or as volunteers in the community. BLS training often includes the use of automated external defibrillator, AED, which provides prompts.

Immediate life support, ILS, training, is more comprehensive and it is aimed at healthcare professionals who may have to act as first responders in emergency situations and it provides those healthcare professionals with additional skills required to manage patients in cardiac arrest before expert help arrives. And ILS training may also be suitable for other types of

first responders such as police officers or air stewards. ILS training can teach a variety of skills, including managing a deteriorating patient, identifying causes, and treating cardiac arrest.

You do not have to be clinically trained to undertake ILS training.

Advanced life support, ALS, training, is as the same suggests, advanced. And ALS training is designed to ensure that healthcare professionals are equipped to recognise and manage cardiac arrest situations, and can lead or work effectively within a resuscitation team. A healthcare professional requires certain relevant clinical qualifications before they can undertake ALS training.

When I have finished this update, Chair, we will hear evidence from Adam Benson Clarke, the Director of Clinical and Service Development of Resuscitation Council UK. Mr Benson Clarke is also a registered nurse. RCUK is a non-statutory, charitable incorporated organisation which describes itself as "dedicated to saving lives by developing guidelines, influencing policy, delivering courses, and supporting innovative research concerning resuscitation practice."

RCUK are the organisation responsible for issuing resuscitation practice guidelines and standards for the

healthcare sector throughout the UK. RCUK develop and publish the Quality Standards for Cardiopulmonary Resuscitation Practice and Training, and they're known as the Quality Standards, for healthcare organisations to follow. These standards are based on the most recent RCUK Resuscitation Guidelines, and we will look at some of the relevant parts of the Quality Standards with Mr Benson Clarke this morning.

The Quality Standards reflect a number of different types of settings where clinical care is provided and where resuscitation may be required, and one of those settings is mental health inpatient care, which is sometimes known as MHIC for the purpose of the standards.

Chair, there has been a wealth of relevant policy, review and guidance issued or published on this topic over the course of the period the Inquiry is investigating, which I will not rehearse for the purpose of this update. They have included but are not limited to NICE Guidelines, guidance issued by the Royal College of Psychiatrists, DHSC guidance on the use of force, for example, Health Service Circulars, and previous guidelines published by RCUK.

The current introduction and Overview to the RCUK Quality Standards was first published in November 2013

and was last updated in May 2020. The sections on mental health inpatient care and equipment and drug lists for mental health inpatient care were first published in May 2014. And that was the first time that formalised national standards had been published by RCUK in respect of mental health inpatient care, and they too were last updated in May 2020.

The Royal College of Psychiatrists was one of the organisations that contributed to the Quality Standards and were on the working group, but there does not appear to have been any input from a mental health nurse, for example, and it is unclear the extent to which the standards reflect the experience of those with 'on ward' experience in mental health inpatient units.

The RCUK Quality Standards Introduction and Overview set out nine core standards, which we will look at shortly.

Number 1 is that the deteriorating patient is recognised early and that there is an effective system to summon help in order to prevent cardiorespiratory arrest.

Number 2 is that cardiorespiratory arrest is recognised early and that cardiopulmonary resuscitation, CPR, is started immediately.

Number 3 is that emergency assistance is summoned

immediately, as soon as cardiorespiratory arrest is recognised, if help has not been summoned already.

Number 4 is that defibrillation, if appropriate, is attempted within three minutes of identifying cardiorespiratory arrest.

Number 5, appropriate post-cardiorespiratory arrest care is received by those who are resuscitated successfully, and this includes safe transfer.

Number 6, implementation of standards is measured continually, and processes are in place to deal with any problems identified.

Number 7, staff receive at least annual training and updates in CPR, based on their expected roles.

Number 8, staff have an understanding of decisions relating to CPR.

And number 9, appropriate equipment is available for resuscitation.

The Quality Standards for Mental Health Inpatient Care provides a framework and it outlines RCUK's expectations for CPR practice, governance, training, equipment and medication provision and emergency response arrangements within mental health providers organisations. The equipment and drug lists set out RCUK's position on the minimum resources required to support effective resuscitation.

As for the status of the Quality Standards, RCUK state that their Quality Standards are intended to support organisations in developing local systems, policies and training arrangements appropriate to their clinical environment, patient population and available resources. RCUK does not mandate implementation of their standards, and RCUK does not operate any formal compliance, accreditation, or assurance process in relation to the adoption of their standards within mental health inpatient providers.

And furthermore, as the Inquiry understands the position, no separate organisation undertakes accreditation processes nor inspects, nor regulates specifically the implementation or operation of RCUK's Standards in any setting. Formal regulatory oversight of inpatient mental health care providers in England, including provision relating to emergency response, sits principally with the Care Quality Commission, the CQC, of course. And RCUK does not direct the CQC's inspection methodology and does not receive routine provider-level assurance information about the implementation of RCUK Quality Standards.

And when Mr Benson Clarke gives his evidence this morning, we will look at the relevant parts of the RCUK's Quality Standards that relate to mental health

inpatient care, and at those which indicate that certain units should have in place particular processes for resuscitation in special circumstances. Those circumstances include suffocation, application of ligature, self-harm, seclusion, and rapid tranquilisation. We will also hear that the Quality Standards are due for review later this year.

In respect of restrictive interventions, Chair, there has long been guidance in relation to restrictive interventions. The CQC has separately issued a "Brief guide: Immediate Life Support training for services that may use restrictive interventions", which in turn refers to NICE Guideline NG10. NG10 recommends that in any setting where restrictive interventions (rapid tranquilisation, restraint or seclusion) are used, there should be immediate access to staff trained in ILS and to appropriate ILS medication and equipment. The CQC guide also refers to the recommendations within RCUK's Quality Standards. EPUT have already informed the Inquiry that for a period of time, at least from November 2019 to March 2023, they interpreted NICE guideline NG10 for a setting where restrictive interventions may be used as requiring access to BLS-trained staff rather than ILS-trained staff.

As previous outlined, Chair, one of the issues this

Inquiry intents to look at in relation to this topic, particularly given the need for staff to be able to identify immediately signs of deterioration in a patient to prevent a secondary cardiac arrest if possible, and the importance of the role of those who are first at the scene, is what level of training could, or should, be given to which staff working on mental health inpatient units.

We will hear, for example, that whilst RCUK does not expect all healthcare assistants working on mental health wards to have ILS training "as a blanket requirement", their Quality Standards do set out what RCUK consider to be the minimum skills required for "staff who respond immediately". Staff who respond immediately are the ward staff or other locally designated staff who are expected to provide the initial resuscitation response to a patient who has collapsed or who is in cardiorespiratory arrest, before the arrival of the cardiac arrest team, or ambulance clinicians or other staff trained in advanced resuscitation skills. RCUK recognise that these first responding staff may well include healthcare assistants, for example. And the Inquiry is aware, through evidence from bereaved families, through staff witness accounts such as that of Brian O'Donnell, and through its illustrative cases,

that healthcare assistants will often be the first on the scene.

RCUK provides education and training through its own resuscitation courses and associated guidance issued to RCUK-registered course centres. These course centres include NHS Trusts, private healthcare organisations and providers of mental health inpatient care. RCUK are not, however, the only providers of life support training.

According to RCUK, their ILS training was developed for healthcare professionals who may have to act as the first responder in an emergency. Its purpose is to give individuals the skills to recognise the deterioration, to identify the cardiac arrest, and start immediate resuscitation, use defibrillation where appropriate, summon expert help, and manage the patient until a cardiac arrest team, ambulance clinicians, or other advanced responders arrive.

It is not designed, that is the ILS training, is not designed to provide comprehensive training in the definitive management of every special circumstance listed.

Within its ILS training, RCUK has developed mental health-specific ILS course materials and simulation scenarios for healthcare professionals working in mental

health inpatient settings. And we will hear that these include scenario-based training content, assessment materials, and instructor resources intended for mental health environments. And we will hear evidence as to RCUK's view of the importance of simulated and scenario-based training for all of those working on an inpatient mental health unit, and for the importance that that training should take place as a team, if at all possible.

But as previously stated, Chair, RCUK is a non-statutory professional body. It's not a regulatory or inspection organisation. It does not mandate, oversee, nor monitor implementation of its Quality Standards within individual providers. RCUK does not routinely liaise directly with NHS Trusts or private providers of mental health inpatient care regarding the implementation of its standards.

Implementation and organisational responsibility sits with providers. Health Service circular series number HSC 2000/028, which was published as far back as September 2000, stipulates that chief executives of all NHS Trusts should give a Non-Executive Director designated responsibility on behalf of the Trust Board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical

governance framework.

Chair, the Inquiry has requested and received evidence on this topic from each of the Core Participant Trusts and providers. Our aim, as directed by you, is to ascertain and examine, where possible, the reasons behind apparent systemic failures in emergency response and attempts to resuscitate. And those focused evidential requests therefore included: requests for relevant policies and procedures in place at each of the Core Participant Trusts or Providers, with a focus, as directed by you, on recent years and current provision.

Requests for each Trust or Provider to identify where those policies and procedures departed from, and or modified, the RCUK standards, or national policy or NHS England Guidance, and to include any departure from guidance or quality standards produced by NICE.

They included requests for evidence in relation to any local variation included in Trust/Provider policies and procedures, in respect of individual mental health inpatient units or specific wards, and any local agreements that were in place between such units and wards and acute services or with nearby accident and emergency departments.

They included requests for evidence relating to the training of staff on mental health inpatient wards in

respect of emergency response and resuscitation. We have asked questions about all staff, clinical and non-clinical, nurses, doctors and healthcare assistants, bank staff and agency staff, and we've requested information on the courses that were available, whether they were mandatory, when staff were required to complete them and how regularly they were required to repeat them. We've asked about practical elements and scenario training, assessment of trainees and monitoring of training completion. We have also asked about any adaptions -- adaptations that were made to training to make it ward, unit or patient specific, and, where applicable, any differences in the policies, procedures and training provided in respect of adult patients and child patients.

And we've requested -- made requests for evidence about any modifications to Trust/Provider policies and procedures made during the Covid-19 pandemic and whether those modifications are still in place.

This is also an area, Chair, where you considered it important to identify how arrangements in Essex compare with the provision in other Trusts across the UK, and to explore whether any challenges identified in Trusts and providers in Essex are, in fact, national challenges. The Inquiry therefore asked the same questions of four

other UK Trusts -- NHS Trusts: North Staffordshire Combined NHS Trust, Northamptonshire Healthcare NHS Foundation Trust, Hertfordshire Partnership University NHS Foundation Trust, and East London NHS Foundation Trust. You consider that evidence from comparator Trusts will assist you in assessing the evidence you receive about practice and procedure in Essex into its proper national context.

And furthermore, given that the Inquiry has identified cases illustrating apparent systemic issues at EPUT, the Priory Group, and St Andrew's, the Inquiry has asked those providers to set out details of where and how learning from any failings were identified, disseminated, what action was taken, including how those actions were implemented, reviewed and monitored to ensure that learning was effectively embedded and sustained and applied in practice.

In respect of EPUT more specifically, where a systemic issue had been identified in one case but apparently repeated in later cases, we asked for an expansion of why that systemic had reoccurred and whether any action had been taken now to prevent the future reoccurrence.

Those witness statements, Chair, recently received from both Essex providers and the comparator Trusts

I have referred to, have already been disclosed to Core Participants with a significant number of exhibits to follow. And the Inquiry intends now to undertake appropriate analysis of whether and how the policies, procedures, practices for emergency response and resuscitation in place at the Trust and providers in Essex reflect proper standards and guidance. We also intend to explore whether the provision now in place is sufficient for the safety of current patients, taking into account, where necessary, appropriate local operational needs, and the reality of day-to-day working on a mental health inpatient ward.

And we intend to review carefully whether lessons have been learned from previously identified systemic failures in relation to emergency response and resuscitation, or whether history has been allowed to repeat itself.

The Inquiry will not hear the evidence from the individual Trusts and providers during this hearing. The Inquiry intends to explore these matters, and consider any analysis more broadly, as part of the reframed interim recommendations hearing in October. The Inquiry is also in the process of currently engaging with others including those with relevant expertise, who we consider may be able to assist you, and we're

actively exploring what data is available.

Finally, Chair the Inquiry is grateful to the Core Participants for their input and engagement into this topic thus far.

THE CHAIR: Thank you.

MS HARRIS: Chair, that update having been completed, can I invite you to take a ten-minute break and come back at 10.50 to allow, I think, Mr Benson Clarke to come back and for arrangements to be made.

THE CHAIR: Yes, until 10.50.

MS HARRIS: Thank you.

(10.39 am)

(A short break)

(10.51 am)

THE CHAIR: Ms Harris.

MS HARRIS: Thank you, Chair. Could the witness be sworn, please.

ADAM BENSON CLARKE (affirmed)

Questioned by MS HARRIS KC

MS HARRIS: Good morning.

A. Good morning.

Q. Thank you very much. I know you've just referred to it in your affirmation but can you state your full name for the record, please?

A. Adam Benson Clarke.

Q. Mr Benson Clarke, you have provided two witness statements to the Inquiry. The first is dated 15 May 2026, and the second is dated 22 June 2026. And you should have a copy of both of those statements in front of you.

A. Mm-hm.

Q. I see you're nodding. Would you be kind enough to say, "Yes"?

A. Sorry, yes.

Q. -- because your evidence is being transcribed, so if you could confirm, that would be very helpful.

You have signed the final page of each of those statements?

A. Yes.

Q. Which contained a statement of truth?

A. Correct.

Q. And can you confirm, in fact, that your second witness statement is an updated and revised version of the first statement?

A. That is correct.

Q. You having been asked some follow-up questions by the Inquiry.

A. Correct.

Q. Have you had an opportunity to read those statements recently?

A. Yes.

Q. Is there anything you would wish to change in those statements?

A. Nothing to update.

Q. And do you stand by those statements?

A. I do.

Q. Well, those statements, and in particular the second updated statement, form the basis of your evidence to the Inquiry along with the answers that you give today. I will refer to paragraphs predominantly in your second witness statement when asking you questions, but there's no need to read the statement out in full, and in fact I've already referred to quite a lot of your evidence during an update I just provided to the Chair, so we may be able to move through some parts of it quite quickly.

You've also provided, I think, 26 exhibits?

A. Correct.

Q. By way of background, you are the Director of Clinical and Service Development of Resuscitation Council UK?

A. Correct.

Q. It's a registered charity?

A. It is.

Q. And you were appointed to the role in April 2026?

A. Correct.

Q. I think you held the position of Interim Director before

that since last November?

A. Correct.

Q. And prior to that you were the Deputy Director?

A. Correct.

Q. From about June 2023?

A. Yes.

Q. And before that, you were Courses Manager/Clinical Lead from 2017 to 2023?

A. That's correct.

Q. And you are giving evidence here on behalf of Resuscitation Council UK.

A. I am.

Q. Which I think is sometimes known as RCUK for short; is that right?

A. That's correct, yes.

Q. Well, we might do that to stop me stumbling over it. And we know from paragraph 3 of your witness statement, and I'm not going to ask you about it in detail, that you're giving evidence on behalf of Resuscitation Council UK, but some of the information within the statement was provided by others?

A. Correct.

Q. You are also a registered nurse, we see?

A. I am.

Q. When did you qualify as a nurse?

A. In 2006.

Q. Are you still in clinical practice or are you now working full time for RCUK?

A. I work full time for RCUK but maintain the requirements for my professional registration.

Q. As a nurse, did you work in hospital, on hospital wards, or in the community?

A. So my role was very much in acute hospital settings.

Q. And as a nurse, were you ever involved in a resuscitation event?

A. Many times. I specialise in resuscitation in a hospital setting.

Q. When was RCUK first formed?

A. So it was formed in 1982 or '83, it's over 40 years old, by a group of clinicians who recognised there was a gap, and lacking within UK healthcare systems for resuscitation training and governance and practice. So this group of clinicians then formed the Resuscitation Council to sort of embed clinical practice and training throughout the UK.

Q. And does that remain its purpose?

A. Yes. We've extended slightly, so our core remit at the moment is we write the National Guidelines for Resuscitation for the UK, which are based on the European Resuscitation Council Guidelines, and consensus

statements from the International Liaison Committee on Resuscitation. So that information creates the guidelines for the UK.

We write the Quality Standards for healthcare organisations, which enable them to provide robust quality resuscitation services within their organisation.

We also fund resuscitation research throughout the UK. We also have a strong campaigns and policy arm where we will look at where there's discrepancies or opportunities to enforce resuscitation over education -- so one of our big campaigns was resuscitation in schools, to get it on the National Curriculum. We're also looking at survivorship post-cardiac arrest and looking at how there's disparities within healthcare within the UK about what level of care you might receive once you get discharged from hospital. So we're looking at how we can influence on a national scale policy, it comes from Government. So we've got quite a few different arms. And obviously the educational components which relate to our courses.

Q. So you also deliver courses?

A. We do.

Q. You describe, in your witness statement, the core membership of RCUK and you say, this is paragraph 5 for

those who are following it, and I don't necessarily ask you to turn to it, Mr Benson Clarke but you say:

"The core membership comprises clinical and academic experts recognised as international leaders in resuscitation."

But it does not currently and has not previously, included any qualified psychiatrists, psychologists, or mental health nurses or anyone else whose principal role was within the inpatient mental health services; is that right?

A. That's correct, yes.

Q. So what do the core membership do?

A. So the way that we work, as a charity, we have a board of trustees which has four clinicians and the role of president, vice president, treasurer and honorary secretary, but our constitution is written so that there will always be a greater element of clinicians and then we have three appointed trustee members who are lay members of the public who people from the industry. They govern the organisation, and below that, it feeds into what we call our executive committee.

These are the chairs of our course and clinical subcommittees as well as people who are elected in via our membership.

So these individuals very much make up people who've

got a high level of academic interest in research in resuscitation science or recognised clinical experts in resuscitation science as well.

Q. You also explain at your paragraph 6, that you have a much wider membership?

A. *(The witness nodded)*.

Q. A much, much wider membership, in fact, over 15,000 specialist healthcare volunteers who you say provide training to over 150,000 member of the UK healthcare sector every year, to your recognised standards?

A. That's correct.

Q. You've been asked about the make-up of that wider membership, that much wider membership, but I think you've explained -- and this is again at your paragraph 6 -- that you don't collect demographic or professional qualification data in a way that allows you to identify, for example, how many are volunteers, who are qualified psychiatrists, psychologists, or mental health nurses?

A. That's correct. We collect baseline demographic data. We're expanding that remit currently but we can identify who are nurses, who are doctors, paramedics, if they work in acute or community, but not down to the level of if they are sort of a mental health registered nurse.

Q. At paragraph 7 of your statement, you describe RCUK as

the organisation responsible for issuing practice guidelines and standards.

A. *(The witness nodded).*

Q. You've already explained how that works and you've said that your practice guidelines and standards development process is conducted to the highest standards?

A. *(The witness nodded).*

Q. And sorry to ask what might seem an obvious question: why is it that you are confident that your guidelines and standards are developed or processes are developed to the highest standards?

A. So it starts very much from the International Liaison Committee on Resuscitation so they look at a group of questions and the recent guidelines cycle, I believe there's about 250 questions that they asked looking at resuscitation science, which goes through an international peer review process and public consultation. That information is, those recommendations then distills into a Continental Resuscitation Council, so in our case that's the European Resuscitation Council. Again, that's distilled and has a public consultation looking at that and it then comes to the UK and we use that information.

As part of that process we also follow what was the NICE recommendations, so the National Institute for

Clinical Excellence. They had a process of validating and recognising specialist organisations, guidelines and recommendations that we'd written, so they recognise that we are the experts in resuscitation, we would follow their guideline process manual, which goes through very stringent remit of what it takes to get that NICE accreditation.

They withdrew that in 2024, but we still maintain and follow what were those recommendations to provide ourselves rigour and accountability for what we produce.

Q. Just in terms of withdrawing accreditation in 2024, what is the background to that?

A. It was a decision that NICE made -- I can't recall off the top of my head. It did cause concern with some of the other charitable bodies and organisations because it looks, on face value, that we've had the accreditation taken away but NICE are very clear that we can add a statement to our regulations and guidelines to say that they are still of a standing, it's just that NICE are no longer accrediting external guideline processes.

Q. Do others provide such accreditation?

A. No other organisation that I'm aware of.

THE CHAIR: And will that have happened to other organisations?

A. Yes, yes.

THE CHAIR: Can you give me an example?

A. Not off the top of my head, sorry.

THE CHAIR: Perhaps you could let us know.

A. Certainly.

MS HARRIS: Before I go on to ask you about your guidelines and your standards, can I ask you to help us a little bit about cardiac arrest and secondary cardiac arrest, which you deal with in your statement. And to go straight to it, at paragraph 9 of your second witness statement, you describe cardiac arrest as the ultimate medical emergency.

You're nodding, can you --

A. Yes, sorry. Yes. It very much is the ultimate medical emergency. It's time-critical where seconds count.

Q. Sorry, time critical?

A. It's time critical.

Q. And in terms of from what happens from a clinical perspective, is this right: when a person is in cardiac arrest, their heart stops pumping blood around their body?

A. Correct.

Q. And that's different, although it seems like an obvious thing to say, from a heart attack, say, where the heart continues to pump?

A. That's correct and a lot of people get the two terms

very much interchanged and confused. So a heart attack is where you have a blockage within the main blood vessels which supply the heart with oxygenated blood for the coronary arteries. When that happens the muscle of the heart starts to die very quickly. A severe heart attack can lead to a cardiac arrest --

Q. That was my next question.

A. -- and that is where we have -- the heart stops pumping oxygenated blood around the body and we need to try and restart that heart.

Q. Going back to cardiac arrest, then, without cardiopulmonary resuscitation, can we call it "CPR" for the purposes of the questions, please?

A. Yes.

Q. And defibrillation, and we'll come back to defibrillation in a moment, a person will not survive a cardiac arrest?

A. You can't survive a cardiac arrest without medical intervention, so you need good quality CPR, so chest compressions and ventilation to buy yourself time. If a heart has gone into an abnormal rhythm where a defibrillator will work, we need to shock it to get it back into a normal rhythm, but CPR and good management of the airway and providing ventilation buy you time for advanced resuscitation to hopefully reverse what's

caused the cardiac arrest.

Q. There may be people that are not fully familiar with CPR so can I just ask you to explain what CPR is, please.

A. So CPR is the act of rhythmically putting pressure on -- chest compressions on the chest, so you're compressing the heart, so you're physically pumping blood around the body with -- including with that we do ventilation, so we're providing oxygenated -- we provide oxygen, we inflate the lungs ourselves to try and get oxygenated blood circulating around the body to preserve those vital organs, so predominantly the heart and the brain.

Q. In terms of the ventilator providing oxygen, that can begin with rescue breaths?

A. Yes, that is, yeah, correct.

Q. Although I think it's -- in adults, we will come back to this in a moment, just the -- the chest compressions to start off with, are the key point; is that right?

A. So within the guidelines outlined, we always start with chest compressions, predominantly for adults. If people are untrained, unwilling or unable to provide ventilatory breaths, you can do CPR for a period of time without providing ventilation because we've got good-size lungs which should be filled with oxygen which helps if the collapse has been sudden. For particularly children, they have a much more higher oxygen demand and

their type of cardiac arrest is more oxygenation and respiratory driven and therefore breathing is much, much more important and relevant for that part of the CPR.

Q. Because I think as you say in your statement, it provides that immediate -- and sometimes might even remove minor blockages in a child?

A. Correct.

Q. You go on to explain in your statement, that in a hospital setting, and can I just check what you mean by that, do you mean in an acute clinical setting when you talk about hospital setting at your paragraph 10?

A. In relation to what -- sorry, if we can expand that question, sorry?

Q. You go on to say that in a hospital setting CPR is supplemented by additional key skills provided by the cardiac arrest resuscitation team.

A. Yes.

Q. And I just wanted to know what you meant by "hospital setting" there.

A. So that could be any setting, really. So when you start cardiopulmonary resuscitation, so CPR, you're very much providing basic level life support, chest compressions and ventilation. There are elements where, depending on where you're situated, you might need more advanced skills to help manage that situation and that is where

we, you know, the element of additional skills in that setting arises. That, in a community setting, might be by calling an ambulance and getting highly trained paramedics to come along to the cardiac arrest or medical emergency or in a hospital setting you've got teams who have much higher-level skills, so anaesthetics to manage an airway, a very senior medical physician who might think more broadly about the cardiac arrest management in itself.

Q. I think -- I wasn't -- sorry, it may be that my question wasn't clear. I think what I was trying to -- and we'll come back to it in a moment, I was drawing a comparison with, say, for example, a mental health inpatient setting which is unlikely to have the cardiac arrest team/resuscitation team at its disposal in the same way as you would in an acute clinical ...

A. They should have a team, or a response team, which would be cardio arrest team, but the skill level may be slightly different, absolutely.

Q. There is, of course, occasionally a co-location, so if you have a mental health inpatient unit that is co-located with an acute clinical setting, there may be easier arrangements --

A. Correct.

Q. -- depending on contracts?

A. That's correct, it can often be supported by the main hospital resuscitation team.

Q. When you talk in terms of CPR being supplemented by additional key skills, looking again at your paragraph 10, are the additional skills you're referring to advanced airway management?

A. It certainly can be advanced airway management. So looking at tracheal intubation, so putting a breathing tube beyond the vocal cords into the windpipe. That is very much an advanced skill that isn't common to a lot of healthcare professionals who haven't had additional training.

Q. We'll come back to the training and what you might learn on what training in a moment, but just looking in terms of skills. So we have advanced airway management. Defibrillation?

A. Defibrillation can be a basic level skill. There are two types of ways we can really deliver defibrillation. So one is using an automated external defibrillator, they're the ones you see in train stations and the public which will do the job for you. They might ask you to press a shock button or not, but they analyse the heart and do levels of interpretation, or it might be manual defibrillation, which is more of an advanced skill which can be done at an intermediate level or

advanced level where you as a clinician are interpreting the heart rhythm to decide whether or not to deliver that shock.

Q. Mr Benson Clarke, I'm sorry to stop you for a moment but I'm being asked if you could slow down a little bit.

A. Sorry.

Q. You're giving a lot of very important detail and it's very important that what you say is -- we can transcribe and make a record of it.

A. Sure.

Q. So I will remember to slow down as well, but if I stop you from time to time, that is why. So thank you very much.

I was just talking -- we were talking about the additional skills, you were explaining about defibrillation. Resuscitation, drugs, you list in paragraph 10, is that, again, for a more specialist team?

A. Yes, that will be an advanced team. The majority of cases will require someone who is a qualified and licensed prescriber or have clearance, if you hold an advanced resuscitation provider certificate under the Human Medicines -- Human Medicines Regulations which allow advanced -- provides an advanced life support certificate of adults to give drugs in cardiac arrest

for adrenaline amiodarone but they --

THE CHAIR: Hang on. Sorry, you said that so quickly, I'm afraid I didn't hear a word of it.

MS HARRIS: No, if you --

A. I do tend to speak fast, so apologies.

THE CHAIR: Can you really, really try and slow down. Thank you.

A. Certainly.

So in terms of drugs within a cardiac arrest, it's very much within the remit of advanced resuscitation. The reason being is for individuals usually have to have a licence or qualification to prescribe medication. There is a cover from the Human Medicines Regulations which allow individuals in adult resuscitation only, so it doesn't relate to paediatrics, if you hold an advanced qualification with Resuscitation Council UK, an ALS certificate, you can give adrenaline and amiodarone as the two main cardiac arrest drugs under that exemption from the regulation.

MS HARRIS: Just to complete the list of the additional skills you refer to at paragraph 10, you list looking after the patient --

A. *(The witness nodded).*

Q. -- and then leading the team?

A. Yes.

Q. Including --

A. That's correct --

Q. -- someone to identify what the underlying cause of the cardiac arrest may be?

A. Absolutely.

Q. You go on to explain at your paragraph 11 that a significant proportion of cardiac arrests that take place in healthcare settings and in particular mental health inpatient settings, are what is known as a secondary cardiac arrest.

A. Correct.

Q. Before I ask you about that, shortly, what is a primary cardiac arrest?

A. So we term things as a primary cardiac arrest, it's usually due to the heart a primary organ. And that could be due to an acute coronary syndrome, so that is a heart attack, a severe heart attack which has caused a cardiac arrest to happen. It can either be due to structural problems with the heart, so hypertensive valve disease, so people might have higher levels of blood pressure put a strain on the heart itself. It can also be due to electrolyte abnormality, so things like potassium, which is a very, very key regulator for how your cells work and how the heart works.

So these are the type of things which may cause

abnormal heart rhythms, that is a primary cardiac arrest and these are usually treated with defibrillation.

Secondary cardiac arrest is where it's happened at the end of a disease process, or problem. So elements like asphyxia, where you've got low blood oxygen levels.

Q. Sorry, can I just pause you a moment before we go on to secondary cardiac arrest. Just going back to primary cardiac arrest, and one of the causes, you've explained, is electrolyte abnormalities or imbalances?

A. Yes.

Q. Can I just ask you this specific or discrete question: would those electrolyte imbalances arise, for example, in circumstances where there was malnutrition or where a person had an eating disorder or something of that nature?

A. It certainly can do. So if you are malnourished or dehydrated, which can happen with people with eating disorders, you do get electrolyte imbalances. Where the body gets so -- the word's cachexic -- so it gets very, very emaciated, it starts eating its own muscle and it can start -- and it doesn't exclude the heart muscle in that sort of sense so therefore you can get some slight structural changes to the heart which can cause problems.

There's also challenges in the management of eating

disorder where you start to introduce food back to an individual and you have to monitor their electrolytes very carefully because you can get a condition called refeeding syndrome, which is where you get spikes of insulin within the body and that causes some of the electrolytes, like potassium, to be pushed into the cells and therefore that can cause an arrhythmia. So it takes specialists to manage that level of balance with those. But all of those can cause that primary cardiac arrest.

Q. So that was primary.

THE CHAIR: Can I --

MS HARRIS: Of course.

THE CHAIR: I don't want to interrupt the flow. You were very clear at the beginning that there's a distinction between heart attack --

A. Yes.

THE CHAIR: -- and cardiac arrest. But there may be cases, you're suggesting, where heart attack in a sense becomes cardiac arrest.

A. Correct. It can lead -- a bad heart attack can lead to a cardiac arrest. So where the -- you've got a blockage in the blood vessel which feeds the heart muscle and that heart muscle dies it can affect the electrical current of the heart and that can lead to a cardiac

arrest. It's a very, very severe heart attack which will lead to a cardiac arrest.

THE CHAIR: Thank you. Sorry to interrupt.

MS HARRIS: No, not at all. Thank you, Chair.

You were beginning to give us some examples of events that might trigger a secondary cardiac arrest and I'm going to ask you, if I may, to focus on the kind of examples that might feature on a mental health inpatient unit. And at your paragraph 11, you list low oxygen levels so hypoxia, airway obstruction, overdose.

A. *(The witness nodded).*

Q. Ligature-related asphyxia --

A. *(The witness nodded).*

Q. -- and severe physical deterioration, all as possible triggers that would give rise to a secondary cardiac arrest.

A. Correct.

Q. Have I understood the position?

A. Yes.

Q. And you go on to explain what happens in a secondary cardiac arrest. And the cardiac arrest, as I think you began to explain, happens at the very end of the process that starts with the trigger event?

A. Correct.

Q. And then the patient deteriorates?

A. Correct.

Q. The patient loses consciousness?

A. Correct.

Q. The patient stops breathing?

A. Correct.

Q. And correct me if I'm wrong as a layperson, is that the point when you would say the person is in cardiac arrest?

A. So the point of recognition is not breathing or not breathing normally, we would say there you're in a cardiac arrest. We don't emphasise for individuals to check pulses unless they're advanced trained because, you know, in extreme situations we know that people don't -- it can be quite difficult to palpate a central pulse on an individual to see if their heart stopped pumping so our baseline is: if they're unresponsive, not breathing, not breathing normally, we assume everyone is in a cardiac arrest and will start treating them as such.

Q. As if it were a cardiac arrest?

A. As if it were.

Q. It may follow in fact from your last answer, would you agree that the trigger clinical events can very rapidly, very rapidly, cause a person to lose consciousness and suffer that cardiac arrest?

A. Certainly, yes.

Q. Which may result in death?

A. Absolutely.

Q. One of the key differences between a primary cardiac arrest and a secondary cardiac arrest, if we understand your statement, is that a primary cardiac arrest will result in what's known as a shockable rhythm, whereas a secondary cardiac arrest results in a non-shockable rhythm. Have I over-simplified that?

A. Essentially that's correct. So in a primary cardiac arrest predominantly they will be shockable, it means the defibrillator is what we need. The heart has gone into a chaotic rhythm or abnormal rhythm where we know defibrillation has the highest chance of getting a normal heart rhythm back and therefore a higher chance of survival.

Because, in a secondary cardiac arrest, we've got that period of deterioration, we have to figure out and reverse that cause because defibrillation won't work. The rhythm could look normal, but the heart might not be pumping; or in worst case scenarios we get a rhythm which is what's commonly termed as that flatline which is called as asystole. Both of these don't work with defibrillation, we need to give drugs, adrenaline, to try and reverse that, as well as look at the reversible

causes, so in a case of like a hypoxia injury, we need to give them high-flow oxygen, high levels of oxygen to try and reverse. But they have the worse survival rates.

Q. I'm going to pause you because you've given a lot of information very quickly --

A. I'm sorry.

Q. No, it's very helpful and it's very important information.

So going back, then, to your shockable and non-shockable rhythms, as you've explained, with non-shockable rhythms you give the drugs and --

A. Mm-hm --

Q. And you try and reverse it. And we'll come to it in a moment, but as we look through the standards and we look through the guidelines, defibrillation is mandated in any event. So help us with this: do you still recommend, mandate, whatever the -- and to what extent -- a defibrillator, even though you know you're working with a secondary cardiac arrest? Does that make sense?

A. Yes, absolutely, we would do, for all age groups: for children and adults. If someone is in cardiac arrest, we want the defibrillator on.

Q. Can I just stop you. So why would you use

a defibrillator in circumstances where there is a non-shockable rhythm, for those of us who are laypersons?

A. Depending on the type of defibrillator, it might have a monitor as part of it, so we could see what the rhythm is doing. If it doesn't have a monitor on there, we want to ensure it's there because actually, some of the management for a non-shockable cardiac arrest -- so in the secondary cardiac arrest -- if we give someone adrenaline, say, that might actually put them into a shockable rhythm and we would then need to give a shock quickly.

THE CHAIR: Sorry, say that again.

A. So in a secondary cardiac arrest, where it's typically non-shockable, in that primary -- in that first instance, giving adrenaline to an individual might actually cause them to go into a shockable rhythm, in a small number of cases. The reason we want that defibrillator on is because actually the longer it takes us to provide that defibrillation, that shockable rhythm degrades and goes into asystole, that non-shockable rhythm where the defib won't work.

So it's about that time critical instance of getting that shock in early if it's required.

MS HARRIS: So I am going to put, if I may, simply: you have

the defibrillator because if that rhythm becomes shockable, you need to shock it --

A. Absolutely --

Q. First of all, you need to see it if there's a monitor on it, straight away, and you want to shock it straight away?

A. Correct.

Q. Returning, then, to secondary cardiac arrests and deteriorating patients on mental health inpatient units, and given, as I say, secondary cardiac -- is it right that they need to be managed -- we've talked about the defib but they need to be managed differently, in essence, in that the first on the scene need to do two things, I think you say in your statement: firstly, they need to intervene straight away and provide the treatment to the level they're trained to provide?

A. Correct.

Q. At the same time as calling for expert health?

A. Correct. And that's the same for all healthcare organisations.

Q. Now, we'll come back to calling for help in a moment but can we consider how the first person on the scene might be able to intervene. So if we understand your witness statement overall, please correct me if I'm wrong, and I've got reference here for those who are following the

witness statement to paragraph 12, if the patient is found quickly enough, after the trigger event, and can I just say, that would have to be very quickly, wouldn't it?

A. Exceptionally quickly, yes.

Q. How quickly?

A. Depending on what the trigger was, so something like a ligature, you really want that as soon as possible. Very closely afterwards. Anyone who has a collapse, you want to get them as -- basically as quickly as possible. It's difficult to put a timeframe on --

Q. But we're talking about seconds and minutes rather than --

A. Seconds and minutes has the greatest chance of survival.

Q. As I say, if the person -- if the patient is found quickly enough and the person who finds the patient has the right sort of training and knows what to do and can identify signs of deterioration, then depending on what caused the emergency, that person might be able to intervene to stop the secondary cardiac arrest happening at all; have I understood your statement correctly?

A. If they've been found unresponsive we would say to assume them to be in that secondary cardiac arrest, certainly if they're not breathing normally. So in that case the individual should start by, you know, shouting

for help to get someone around them, activate the local emergency buzzers, whatever is in that local vicinity to get other people to help. They certainly don't want to be managing this in isolation. You need more people around you to help manage this event. And in which case, if there's something like a ligature, they might have a ligature cutter to hand, say, and they can get that off relatively quickly, hopefully, but then they're looking at starting the chest compressions and doing that basic level life support whilst waiting for other people to come to help.

Q. Can I just pause you for a moment.

A. Yes.

Q. Just going -- would you agree, then, that the key thing to avoid or the key moment to avoid -- I know you say you treat it as if it were a secondary cardiac arrest, but the key thing to avoid if at all possible is that patient going into secondary cardiac arrest?

A. Oh, certainly. In the sense that -- so whenever someone goes into cardiac arrest, primary or secondary, we treat the importance, as I say. If there is an element of deterioration and we spot that the person is deteriorating, before going into that cardiac arrest we would want to manage them and prevent them from going into cardiac arrest. If I've understood that question

correctly.

Q. I'm being asked if you could slow down again.

A. Sorry.

Q. It's all right, I'm getting the messages from my left, it's fine, and I'll try and remember to ask you from time to time, as well.

Just following on from that last answer, then, is it important, would you say, that staff on an inpatient ward are properly trained to recognise when that emergency response -- when that deterioration and that emergency response is required?

A. Absolutely. Whilst, you know, we teach people how to do resuscitation, the primary and most important element of this is to prevent people going into cardiac arrest, because you have a greater chance of survival for managing these individuals as they deteriorate rather than once they get into a state of cardiac arrest.

Q. You had started to tell us about the kind of interventions that might be of assistance in these critical seconds and minutes and I think you'd already started by saying removing the ligature --

A. *(The witness nodded)*.

Q. -- and of course that would require easy access --

A. *(The witness nodded)*.

Q. -- to ligature cutters?

A. Correct.

Q. I'll come back to that in a moment.

THE CHAIR: Sorry, you may have answered this but I was elsewhere. What is the -- I mean you may not -- every circumstance will be different, won't it, but the timescales you're dealing with, in terms of finding someone who has, say, got asphyxia and is deteriorating, and might go into cardiac arrest.

A. Yeah, it's -- (overspeaking) --

THE CHAIR: How long is a piece of string --

A. Exactly.

THE CHAIR: -- but can you give me some time frames? That would help me.

A. It is literally a piece of string. It's very difficult -- so for, as an example, an individual who has an asphyxial event, we roughly know that the oxygen blood saturations are -- so the amount of oxygen within your blood, we look at it as a percentage between zero and 100. We roughly know that when that drops -- so a normal level is between 94 and 98. When it drops to around 60 per cent, that individual is likely going to lose consciousness. And from that point on, within ten minutes, they're likely to be dead.

THE CHAIR: That's so helpful. Thank you.

MS HARRIS: So, and picking up to from that, we've dealt

with -- dealing with interventions, another very, very important intervention is recognising and managing airway and compromised breathing.

A. Correct.

Q. Dealing with those dropping oxygen levels?

A. Correct.

Q. And in broad terms, what would that involve?

A. So again, depending on the situation, if you've got an unconscious person, their ability to protect their own airway gets compromised. So we would expect individuals to be able to do simple things which we call manual airway manoeuvres, so using your hands to open the airway, in a position where you can then easily ventilate. It might also be a case where we then look at putting what we call airway adjuncts in, so devices to help support and keep the airway open, very simple airway adjuncts, and that also might include taking over, if someone has got an abnormal respiratory, a low breathing rate, that we might assist them to breathe before they actually go into cardiac arrest. So we can supplement their respiratory rate and give them oxygen.

Q. So give them oxygen, and we'll look later at some of the equipment that can be used in order to provide that oxygen but there are varying, as I say, there are varying levels and -- varying levels of ability and

qualification or knowledge --

A. Correct.

Q. -- or training required. So as you become -- there are certain aspects of providing that oxygen which would require certain levels of training, for example --

A. Correct.

Q. -- immediate rather than basic?

A. Yes.

Q. You also, at paragraph 12, refer to monitoring deteriorating vital signs.

A. *(The witness nodded)*.

Q. So how would that be done?

A. So we use the term "vital signs", historically people might have used the term "observations" and "obs", and that's very much looking at someone's respiratory rate so how often they're breathing a minute, looking at the oxygen saturation so the percentage of oxygen within their blood, looking at their heart rate, looking at their blood pressure, looking at their level of consciousness with that, as well. And their body temperature. So these are what we call vital signs. And everyone -- we have a normal range for adults and children quite happily, and we look for when there's deterioration or changes within that, and that should lead to how we escalate and raise a concern for an

individual.

The -- this is important, and it's been recognised and it's embedded throughout all of healthcare within the UK, the importance of monitoring vital signs and recognising when deteriorational changes happen, because it's well documented in the medical literature that, actually, you can get signs and symptoms of deterioration hours before something happens, if there's a physiological deterioration in that sense.

Q. I'm being asked to ask you to slow down, again, Mr Benson Clarke, I'm sorry.

You refer to the use of an early warning system.

A. Correct.

Q. What sort of system are you referring to?

A. So in England, we have a National Early Warning Scoring system.

Q. The NEWS?

A. NEWS2. It was created by the Royal College of Physicians. It's used throughout England's healthcare organisations as a set standard, so there's no deviation so clinicians are familiar with this tool. And what that does, is it gives us a scoring criteria for abnormality within your vital sign ranges. That then dictates the -- the total score dictates where you take that, what the escalation plan will be, and that

could be simply, if it's minor, to increase the frequency that you're observing your patient, or if you've got a greater level of concern actually activating an emergency team to come and see your patient imminently.

Q. But within our scenarios that we're -- have been -- you've been giving evidence about, you would have expected that emergency team to have been called from the outset anyway; is that right?

A. For stuff like asphyxia which is very, very acute and quick, you know, you're not going to pick that up in a form of doing a vital signs assessment. You'll see it quite -- well, not quite happily, but you'll see it being very evident so you'll call for expert help at that time.

Q. Particularly, as we've already established, and I appreciate it will depend on local variation, but it's unlikely, in the majority, as you say, of mental health inpatient units that there is that specialist resuscitation team, there will be other arrangements. I think you would say those with advanced training, for example -- you're nodding; is that right?

A. Correct, yeah.

Q. -- or a protocol by which the ambulance is called immediately, and so on and so forth?

A. Correct. Absolutely. But there's also elements where individuals within these facilities will have other physiological health needs, so it's still very important that they recognise when deterioration may happen, because you may get individuals who have severe asthma or other elements within their normal health journey which aren't related to mental health, but they're in a mental health institution because of the requirements of their mental health.

Q. So therefore emphasising the need to be aware of the --

A. *(The witness nodded)*.

Q. -- as I say --

A. Absolutely.

Q. -- the other diagnoses.

And the Chair has already asked you this, but again, can you, just to get some sort of idea -- speed is of the essence here?

A. Absolutely.

Q. You've already explained that once a person goes into cardiac arrest, they may be dead within ten minutes.

A. *(The witness nodded)*.

Q. Can I just ask you the kind of window of opportunity, you may not be able to give us an answer, between trigger an event and cardiac arrest. I know you're treating it as if it were anyway; how much time do you

have to prevent it?

A. So the scenario I very much gave was purely for asphyxiation where we've got it documented based on animal studies. It is very difficult to give a timeframe. The body has brilliant coping compensatory mechanisms to try and prevent deterioration and it's when those coping mechanisms don't work or they get to the point where they can't cope anymore, that's when someone will collapse. But what we do know is in, as I say, for physiological health, sometimes these signs and symptoms can present for up to 12 to 24 hours beforehand.

Q. Can I move, then, to ask you about the standards, the RCUK Quality Standards with all those issues and clinical issues you've just given evidence about very much in mind. In terms of the Quality Standards, RCUK first published those standards, the Standards for Cardiopulmonary Resuscitation Practice and Training, in November 2013; is that right?

A. Correct.

Q. And by way of background, prior to that time, RCUK had obviously already published resuscitation guidelines and you've explained it?

A. Yes, clinical guidelines, correct.

Q. So the standards, in effect, they weren't new as such;

they presented existing guideline-based principles, I think is how you describe it, as a single set of core standards applying across healthcare settings?

A. Correct. So it takes the clinical standards, or the clinical guidelines, and the quality standards then look at how can we manage healthcare organisations to reduce the risks and provide good governance to enable good-quality or high-quality resuscitation care to happen.

Q. In terms of the documents themselves, there's an introduction and overview document.

A. Correct.

Q. We'll look at that in a moment. Then they are divided into seven separate setting-specific documents?

A. Correct.

Q. And one of those sets out standards for mental health inpatient care.

A. Correct.

Q. And there is a separate equipment and drugs list for mental health inpatient settings.

A. Correct.

Q. Now, when those documents, the mental health inpatient-related documents, were published in May 2014, was that the first time that formalised national standards had been published in respect of mental health

inpatient care by RCUK?

A. That is correct.

Q. Now, you refer to them, I think for convenience within your statement, but it may be how they are always referred to, as the Quality Standards, is it MHIC that you say or do you say MHIC?

A. So that was just an abbreviation for the statement.

Q. For the statement?

A. Yes. The title is quite long.

Q. It is. In terms of their formulation, as a set of standards specifically for mental health inpatient settings, you explain -- and for those who are following, this is paragraph 28 of your witness statement -- that the Quality Standards overall were developed through a formal working group.

A. Correct.

Q. And you confirm at your paragraph 31 that there was no separate working group for the standards for mental health inpatient care?

A. Correct, but we did have representation from the Royal College of Psychiatrists.

Q. That's my next question. It included a Dr Williams from the Royal College of Psychiatrists?

A. Correct.

Q. And his name is on the documentation, that's why I --

A. It is.

Q. You have been asked a little bit more about that and you've explained at your paragraph 29 that you don't have a record confirming that any other named psychiatrist or psychologist or mental health nurse was a formal member of the working group?

A. No, we don't.

Q. So is this a correct summary: can we take from that that RCUK did not get input from any other psychiatrist, psychologist or mental health nurse?

A. Not for the initial writing group. However, it did go to consultation with organisations and public consultation.

Q. I'm going to come back as well, because I think you say at your paragraph 30 that you got feedback from individuals associated with mental health provider organisations and resuscitation services supporting mental health settings?

A. Correct.

Q. You also say, I'm trying to slow down as well, Mr Benson Clarke, but you also say that the draft standards were circulated through relevant professional networks?

A. Correct.

Q. Is that what you meant? And that may have included practitioners working in mental health environments?

A. Correct.

Q. Can I ask you this, looking back now, do you consider, or does RCUK consider, that the involvement of the Royal College of Psychiatrists and the consultation provided sufficient relevant mental health input?

A. That is difficult to answer, because I haven't seen the feedback which came from the consultation. So Dr Williams would have represented the College and part of their role would be to gather the thoughts of clinicians within that college. The -- part of that membership of the group was also the CPRO, which was the Council of Professional Resuscitation Officers, which has now been disbanded.

Q. Disbanded.

A. So that held, within that group, resuscitation officers and resuscitation practitioners across the country who would have had the opportunity to comment on the standards and that would have included individuals who work within mental health facilities.

Q. All right. There was, also just for completeness, a Patient Advisory Group involved?

A. Correct.

Q. But the background to those individuals isn't known?

A. Correct.

Q. Okay. In terms of the standards themselves, just

understanding how they come about, there is no fixed revision cycle; is that right?

A. That is correct.

Q. We know that they were most recently updated in 2020?

A. Yes, correct.

Q. And you've provided the original version to the Inquiry, I think we'll focus today mostly on that 2020 version.

A. Sure.

Q. But in terms of revisions, just to be clear about it, you explain, this at your paragraph 39 -- that the principal revisions between 2014 and 2020, you say principally reflected revisions to references, terminology, supporting material, including alignment with contemporary escalation and early warning scoring practices rather than any substantial changes.

A. Correct.

Q. And in terms of how those revisions came about, you explain that there was a writing group, I think you said --

A. *(The witness nodded)*.

Q. -- not a working group, a writing group?

A. A writing group.

Q. But the process for review didn't involve the same level of stakeholder involvement that the original --

A. Not to the original --

Q. All right. You also say and this is jumping ahead to your paragraph 57, that in broad terms, there was no substantive changes between the Quality Standards for Mental Health Inpatient Care published in May 2014, and the revised ones published in May 2020?

A. That is correct.

Q. You say that the version retained the same overall structure and materially the same standards, I think you identify that there were some additional example measures in the appendix?

A. Correct.

Q. And we know, and we'll come back to this a little later on in your evidence, that there were some additions to the equipment and drugs list?

A. Correct.

Q. We will also come back to this, towards the end of your evidence, but they're due for review again, aren't they --

A. They are.

Q. -- these standards? And that's in this calendar year?

A. Yes, so part of my strategic work plan this year was to always look at reviewing them, recognising that they haven't been reviewed for quite some time.

Q. And as far as you're aware, and as I said, we'll come back to this at the end, are they still on track to be

reviewed by the end of this calendar year?

A. We haven't set a timeline to start them due to competing priorities but I would like to get them done within this financial year.

Q. Sorry, did you say financial year?

A. We work to a financial year.

Q. Okay. Can we look at, then, together at the current version of the standards. What I'm going to do is I'm going to ask that some of them be put up on the screen and it should, all being well, Mr Benson Clarke, come up on the screen in front of you but you do also have paper copies --

A. I do.

Q. -- so you've got both options, if you like.

So I'm just going to make sure, it's your exhibit ABC 2, which is the current introduction and overview?

A. Mm-hm.

Q. Do we --

A. Yeah, it's on the screen.

Q. -- the URN for that, or you've got it? Ah. Oh, so we do. Thank you. And could we look, please, at page -- the bottom of page 3 then, I think, all being well, which -- and the part that -- we can actually see there, at the bottom of that list, I think we saw Dr Williams listed as part of the working group, but we'll start

with introduction and scopes. And just in terms of, then, of the introduction and scope, they read as follows:

"Healthcare organisations have an obligation to provide a high-quality resuscitation service, and to ensure that staff are trained and updated regularly and with appropriate frequency to a level of proficiency appropriate to each individual's expected role."

And if we look down your list we can see there at number 4, "Mental health -- inpatient care" listed as one of the specific settings.

But just before we leave that paragraph, do we see that the emphasis on training and update is to an individual's expected role?

A. Correct.

Q. Now, the reason I ask that, and it might seem like a trite observation, but is the assumption here that the organisation must equip an individual to do what is required of them as opposed to necessarily to what their job title involves? Do you see what I mean by that?

A. I do, and essentially it's similar to asking that a Registered Nurse takes on much more advanced skills that the doctor may sort of take, traditionally. What we mean in this particular indication is that the organisation should undertake a localised risk

assessment and training needs analysis based on their organisational structure, so that how do they then manage these events. And a great example of that would be if we look at ILS as a standardised course, that nurses should have this as a standard, but there might be elements where, because of interventions that are given, then also healthcare assistants also have this level of qualification, and that nurses also may be trained in additional skills or doctors specifically trained in additional skills to manage these airways because of what the organisational need is.

Q. So we're going to come back to ILS and HCAs in a moment. But I think the answer to the question was yes, these standards contemplate that there may be circumstances where certain professionals are given additional skills because of what they need to do --

A. Correct.

Q. -- on a day-to-day basis, but you leave that to the local or the organisation to determine?

A. That's correct, yes.

Q. All right. We can also see -- sorry, can we go to the top of page 4, please, that's the next page -- that one of the aims of the standards was to provide -- we're looking at number 3 first -- new standards for mental health inpatient care, and another one, up to number 2,

was to update existing quality standards but with a particular emphasis on simplification to improve implementation.

A. Correct.

Q. So to make things easier for organisations to follow?

A. Yes, so whilst the quality standards are designed in some way to be aspirational for organisations, we don't want them to be a blocker from providing good quality resuscitation care. So, therefore, within these documents we give references and recommendations on how these can be implemented, to enable individuals to achieve a level within these standards.

Q. We'll come back to the question of aspirational in a moment when we look at the terminology because you do try and distinguish what is aspirational --

A. Sure.

Q. -- and what is mandatory, if you like -- my word, perhaps, not yours -- in relation to language, but before we do that can we look at the core standards which is at the bottom of page 4, going over to page 5, please. And these are the ones that apply across all settings.

A. Correct.

Q. And if we can look at them briefly and I think then it will be time for a short break, but they can pick up, we

can already see, on how they dovetail with some of the clinical scenarios --

A. Yes.

Q. -- and issues that you've explained to us. So the first core standard is that the deteriorating patient is recognised early?

A. Correct.

Q. And we've already seen the -- well, you've already explained the importance of that, for example, in a mental health setting. And that there is an effective system to summon help in order to prevent cardiorespiratory arrest?

A. Indeed.

Q. And then number 2: that cardiorespiratory arrest is recognised early?

A. Correct.

Q. And that CPR is started immediately?

A. Correct.

Q. And of course we set this now against your evidence of the seconds and minutes and the tiny -- the short timeframes.

Number 3 is that:

"Emergency assistance is summoned immediately, as soon as cardiorespiratory arrest is recognised", if it hasn't been done already.

A. Correct.

Q. Number 4, if we can go to the top of the page, is:

"Defibrillation, if appropriate, is attempted within 3 minutes of identifying cardiorespiratory arrest."

Now, just pausing there for a moment, you've already explained why it's often and usually important to use a defibrillator anyway --

A. Mm-hm.

Q. -- and that's a very short amount of time that you would expect defibrillation to be taking place, within three minutes?

A. It is a short, very short period of time. But the reason being is within the clinical evidence is the quicker you get defibrillation in, and the marker that's used within the national and international literature is -- of three minutes, has the greatest chance of success of converting that rhythm into a normal rhythm.

Q. Understood.

Number 5, this is kind of moving on to after:

"Appropriate post-cardiorespiratory-arrest care is received by those who are resuscitated successfully", including safe transfer.

A. Correct.

Q. Number 6:

"Implementation of standards is measured continually

and processes are in place to deal with any problems identified."

A. Correct.

Q. So monitoring of how effective they are.

Number 7:

"Staff receive at least annual training --

A. Correct.

Q. -- and updates in CPR based on their expected roles", and there's that expected role element again.

A. Mm-hm.

Q. 8:

"Staff have an understanding of decisions relating to CPR."

And:

"Appropriate equipment is available for resuscitation."

A. Correct.

MS HARRIS: I'm going to ask you in a minute about terminology but I think, Chair, I'm told that that would be a convenient moment for a break, unless you have a question first?

THE CHAIR: Yes, I do. I have one and I'm sorry if you think you've already answered this one. You've talked about the need to defibrillate very quickly after cardiac arrest, you've talked about that hopefully

buying you time to reverse the damage of whatever it was that caused the cardiac arrest. I'm not going to ask you this time how long you've got, and because it will depend, won't it, on whatever the circumstance was that caused the cardiac arrest?

A. Correct, mm-hm.

THE CHAIR: But suffice to say it's a very short period of time.

A. It is.

THE CHAIR: What is the incidence of revival from that, from the event of cardiac arrest?

A. So in -- we monitor this nationally, within two arms, so we're looking at out-of-hospital cardiac arrests which are in a community base at home. That survival from the cardiac arrests to -- we call it survival-to-hospital discharge because that's a good marker for someone's essential survival. That is around 9.5 per cent currently. It's very low. Within an acute hospital setting, it's around 26 per cent. We don't have data for mental health hospitals, unfortunately.

THE CHAIR: Thank you. That's helpful.

MS HARRIS: Thank you, Chair. Five past 12, I'm told.

THE CHAIR: Five past 12.

MS HARRIS: Thank you.

(11.49 am)

(A short break)

(12.05 pm)

THE CHAIR: Mr Benson Clarke, before the break I asked you about the survival rates from cardiac arrest, and you told me about them in all settings, and then in acute hospital settings. Did that -- is there -- those figures cover both primary and secondary cardiac arrests?

A. Yes, yes.

THE CHAIR: Do we know what the same figures might be in relation to simply secondary cardiac arrest?

A. I don't have that information to hand off the top of my head, I'm afraid, but I can let you know.

THE CHAIR: Is that available?

A. We'll be able to get that -- I'll be able to get that information for you, yes.

THE CHAIR: And for today's purposes, could you just tell me whether that is a significantly poorer outcome.

A. Very much so.

THE CHAIR: Very much so?

A. Yes.

THE CHAIR: Thank you.

MS HARRIS: Thank you, Chair.

Mr Benson Clarke, can we return, then, to the standards and to the introduction and overview and can

we have a look at your exhibit ABC 2 again and the top of page 6, please and reference, we referred to the terminology, because you've given evidence that certain aspects of this -- you recognise that certain aspects of the standards may be aspirational, to use your word.

A. Mm.

Q. When we look through the standards we notice the language that is explained here, and it says in terms of terminology:

"The term 'must' has been used when the consensus is that the standard promotes normal practice and is obligatory."

So that would not be aspiration -- those would not be aspirational requirements?

A. That's correct.

Q. "The term 'should' has been used when the consensus is that the standard promotes normal practice."

Again, not aspirational, would you agree?

A. I would hope not, yes.

Q. "The term 'Recommends' is used when the consensus is that the standard promotes best practice".

So those might be aspirational aspects?

A. Correct.

Q. All right. That can come down now, thank you.

And instead, could we put up, please, your exhibit

ABC 5 which are the Quality Standards for Mental Health Inpatient Care, and look at the bottom of page 1, please. It's the last paragraph. We won't need to look at the terminology again because it's the same, isn't it, within this documentation?

A. It is.

Q. But do we see this, looking at -- that:

"Resuscitation Council UK recognises that the standards in this document ..."

This is the Quality Standards for Mental Health Inpatient Care?

A. Correct, yes.

Q. "... may provide challenges for some mental health services and the organisations that are responsible for providing them. Intentionally, these standards are aspirational in certain areas."

And you've just explained a bit about that.

"Where appropriate, each section contains links to implementation tools or examples of good practice. Each section also contains guidance on measures to assess adherence to standards."

Off the back of your last answer is the organisation -- sorry, I was going to say how is an organisation to know which aspects are aspirational? Is that by reference to the terminology?

A. Yes, it should be referenced throughout the document. The terms "should", "must" and "recommend" should appear within the standards as written.

Q. Do you think your recognition that these may be aspirational might give an organisation some flexibility in not complying or not adhering to your standards?

A. I would hope not.

Q. Why is it that you recognise, as set out here, that these standards provide challenges? What is it about them?

A. The -- I guess the challenge element would be because they are -- mental health hospitals and institutions can be very different depending on where they are and how their setup is made. We mentioned earlier about if they're collocated, they might have pull from additional resources from acute Trusts. Those which are standalone organisations may have more differing challenges because they may not have the same level of medical cover, where they can pull from the acute hospital. It might then mean there's differences in training, and elements, and where they might be located so -- as in a sense of their escalation is calling for an ambulance, and even in some of these collocated sites they still might need to call an ambulance to get the patient to the acute part of a hospital.

So we recognise that by nature of where some of these institutions are, there can be challenges.

Q. So those are kind of geographical issues?

A. *(The witness nodded)*.

Q. Are there any other aspects of a mental health or features specific to a mental health inpatient unit that you might consider would provide challenges to implementing your standards?

A. The only other -- excuse me -- the only other thing I can possibly think of in those sorts of senses is that we do know nationally is that there's higher turnovers in staffing pools as well. So therefore training elements can become quite challenging in those sorts of senses as well.

Q. All right. Thank you.

Can we have a look a little bit more, then, and we'll go to part 1 or section 1, which is Standards for Service Structure, and that's at the top of page 3, please.

Don't worry I'm not going to read them all out but just pick up some key features. So at 1 we see that every healthcare organisation that admits mentally ill people must have an identified resuscitation service structure.

A. Correct.

Q. And that at 2:

"Every organisation must have an identified board member who is responsible for resuscitation services. This was required in England by Health Services Circular 2000/028," and that dates us back to the year 2000, doesn't it?

A. That's correct.

Q. So this has been a governance requirement for some considerable time?

A. Very much so.

Q. And it goes on, if we look at the bottom of point 2, to say that's to ensure that a resuscitation policy is agreed, implemented and regularly reviewed within the clinical governance framework.

A. Correct.

Q. If we look then at 3, it says:

"The resuscitation service structure must be part of each responsible authority's management structure."

So therefore clinical governance, clinical risk, quality improvement, education service structures.

A. Correct.

Q. And it says at 4 that it must include local resuscitation experts.

A. *(The witness nodded)*.

Q. Can I just ask you who, what is meant by, or what is

intended by "local resuscitation experts"?

A. So a local resuscitation expert could be either a resuscitation officer, so someone who has a clinical interest and skill in resuscitation practice.

Q. Can I stop you? Because obviously the standards require every organisation to have one. Do you mean a separate one, or just -- can it be the same person within the --

A. It could be the same person within the organisation -- (overspeaking) --

Q. Sorry, I interrupted you.

A. No, that's fine. It can also be a doctor who has interest or training within resuscitation as well. So someone who is familiar with resuscitation who has had training in advanced level resuscitation, is familiar with resuscitation governance.

Q. Looking at 5, it says that:

"The lead person responsible for the resuscitation service structure must have an active and credible involvement in resuscitation."

What do you mean by "credible involvement"?

A. So that's quite a broad term because actually what we don't want people doing is resuscitating everybody, every day, that type of thing. So when we talk about someone who is credible in the field of resuscitation, so they will be individuals who are trained to a high

level advanced life support to a standard where they are proficient in teaching that element, who have understanding and knowledge of resuscitation risk management and governance.

Q. Moving to 7, the service structure is responsible for implementing operational policies governing CPR practice and training.

A. Correct.

Q. And can we have a look at number 8, please, because I think this would appear particularly relevant given the clinical evidence you have given. It says:

"In the absence of other organisational arrangements, the resuscitation service structure must also be responsible for implementing operational policies that govern prevention of cardiac arrest, including recognition of patients who are deteriorating before they arrest."

A. Correct.

Q. So this recognises, again, this small window of opportunity and the need to act quickly.

A. Yes, and in some organisations, you may get a different governance group that look at prevention of deteriorating patients as a whole, and a separate element that look at cardiac arrest and resuscitation management. But what we very much say is that if they

don't have one looking at the deteriorating patient, that must fall under the remit of the people who look at the resuscitating governance.

Q. Would that be a best practice, an ideal world to have a separate group of people looking at the prevention?

A. Not necessarily. It depends on the expertise you have in your organisation.

Q. Okay. If we can move to the top, please, of page 4 rather than go through, we see the responsibilities of the resuscitation service structure listed there and I'm not going to read them all out but just some key bullet points are: ensuring the implementation and adherence to national resuscitation guidelines and standards?

A. Correct.

Q. We also note, looking a little bit, five down, "Planning adequate provision of training."

A. *(The witness nodded)*.

Q. It's particularly key, would you say?

A. Oh absolutely, yes.

Q. I mean, they're all key but training is a particular focus, I think.

"Determining requirements for and choice of resuscitation training equipment".

And:

"Preparing and implementing policies", again,

including those relating to prevention of cardiac arrest.

A. Correct.

Q. And "recognising patients who are deteriorating."

A. Correct.

Q. And of course we have recording and reporting and quality improvement, and suchlike.

Interestingly, if we look down a little bit further at 13, it identifies that there must be defined financial support. So --

A. Correct.

Q. -- there have to be clear resources allocated.

A. Correct, yes.

Q. Section 2 of the Mental Health Inpatient Care Standards deals with resuscitation officers which I just asked you about and you explained that they may be part of a local expert contingent?

And I just wondered if we look at point 14, which is page 6, I think. I just wanted to ask you about this. It says:

"In order to maintain standards and clinical credibility, it is recommended that responding to and participating in cardiac arrest management is an integral part of the RO's clinical responsibility."

What does that mean?

A. So for organisations which have a resuscitation officer on site, who work within the hospital, if a cardiac arrest call should go out, it should be part of the expected role that they should attend.

Q. So it's an on-the-ground experience requirement, a "do", not just a "say"?

A. Essentially, yes.

Q. A doer?

A. Yes, absolutely.

Q. All right. Do you have any position as in RCUK, on who should supervise resuscitation officers? Who do you say should supervise them?

A. That's a tricky conversation -- not conversation -- question. It depends on the environment. So as an example, in an acute hospital, they will either come under education, because of the level of training that they give to people. However, they are very much clinical specialists. So you often find them either under intensive care as an escalation in that sort of sense, and sometimes they actually end up in corporate, which is an odd place for them to be.

For mental health organisations, it's very difficult. Depending on what their governance structure would be, they should sit under a clinical service, predominantly. But you might find they also fall under

education.

Q. Can we look at part 3 or section 3 please, and I think that's the top of page 10. The title is cut off it must be on the previous page, but this is training, am I right, Mr Benson Clarke?

A. Yes, correct.

Q. And let's look at the standards here.

So in terms of training, and particularly number 1, it says:

"All healthcare staff must undergo resuscitation training at induction and at regular intervals thereafter to maintain knowledge and skills."

And that:

"Training must be to a level appropriate for the staff members expected clinical responsibilities."

A. Correct.

Q. And you've already given evidence around what you mean by "expected" --

A. Correct.

Q. -- and how there can be contemplation of additional skills.

In terms of whom these training standards, or to whom they apply, you give some clarification in your witness statement about this, and for those who are following your witness statement it's paragraph 60 of

your second witness statement and you say this:

"... the terms 'healthcare staff' [which we've seen in number 1], 'clinical staff', 'staff who care for patients in any mental health inpatient setting', and 'medical, nursing and other clinical staff' are used to describe staff with patient-facing clinical care responsibilities."

A. Correct.

Q. So that's who you're talking about as those terms are used variously within the standards?

A. Yes, and I recognise that in our document we've used those terms interchangeably.

Q. You say:

"These terms are not intended to create separate or mutually exclusive categories."

A. Correct.

Q. "Healthcare assistants may fall within these terms --

A. Correct.

Q. -- where their role includes patient-facing clinical care responsibilities or an expected response in a clinical emergency."

A. Correct.

Q. The exception, you explain, is where the standards refer specifically -- I've put the word specifically in, but you say refer to non-clinical staff, which you say

specifically refers to staff without clinical care responsibilities, and you refer to administrative staff.

A. Correct.

Q. Moving then to number 3, you say:

"This training must include use of an early warning scoring system to identify deteriorating patients ..."

You've already given some evidence about that.

A. Mm-hm.

Q. "... including a use of escalation protocol to ensure early and effective treatment of patients in order to prevent cardiac arrest. The scoring and escalation system must be the same as that used in actual clinical care and used to of the early warning score (NEWS) is recommended."

A. Correct.

Q. So there's an example of perhaps an aspirational or something that gives the organisation flexibility in any event.

And it's echoed in point 4 below, which is dealing with -- and we'll come back to this in a little while --

A. Mm-hm.

Q. "According to NICE Guideline 25 ... an NPSA Rapid Response Report, staff who care for patients in any mental health inpatient setting must have competences in monitoring, measurement, and interpretation of vital

signs. They must have the knowledge which is appropriate to the level of care they are providing ..."

A. Correct.

Q. So, again, it's in terms of what they're actually doing rather than their job role:

"... to recognise patients' deteriorating health and respond effectively to acutely ill patients."

At 5 there is reference to RCUK's Immediate Life Support course. And it's got a very specific requirement. It's:

"... recommended as a minimum standard for staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion. This guidance recommends that clinical staff in each mental health inpatient facility should receive regular update training in physical health skills in addition to ILS in response to an assessment of need undertaken by each organisation."

A. Correct.

Q. And you gave some evidence earlier about the importance of being able to monitor physical health at the same time. And is that particularly important, then, in cases where restrictive interventions are used?

A. Absolutely.

Q. And why is that?

A. So, as an example, if we are giving tranquilisation to a patient, we will give them a drug which could reduce their respiratory function and respiratory rate so it's really important that -- you know, every medication we give can have a consequence -- that we're continually monitoring our patients to make sure they're safe and that we can intervene if need be.

Q. Can I move on to 7 and it says this:

"According to Resuscitation Council UK guidelines, training must be in place to ensure that clinical staff can undertake [CPR]. Training and facilities must ensure that when cardiorespiratory arrest occurs, all clinical staff can as a minimum:

"recognise cardiorespiratory arrest;

"summon help;

"start CPR;

"[and] attempt defibrillation if appropriate within 3 minutes of collapse using an automated external defibrillator or manual defibrillator."

A. Correct.

Q. Can I ask you this, well, firstly, "all clinical staff" would include any patient-facing clinical care or response in an emergency, which would include a healthcare assistant?

A. Yes, correct.

Q. That's first. In terms of defibrillators, you've already given some evidence about this, an automated external defibrillator, an AED, I think you've already said in your evidence, it gives you prompts, it tells you what to do --

A. Yes.

Q. -- (overspeaking) -- manual one is slightly more problematic.

Help us if you can with this: is there any particular guidance, are you aware, of what type would be on a mental health inpatient unit?

A. So predominantly they will be AEDs, the automated version. And that's because clinicians need to be competent and confident in rapid recognition of analysing heart rhythms. So within the guidelines we say that you need to be able to correctly identify and diagnose that rhythm within five seconds, which is exceptionally quick.

The majority of, particularly, nursing staff who don't necessarily work in a cardiac area or emergency department or higher level care area where they're used to looking at heart rhythms, you'll find that AEDs are the go-to device even in acute hospitals and they can be used everywhere.

Q. I was about to say, is that because of the level of

training required or not required for an AED?

A. They are designed to be used with minimal to no training whatsoever. And that's why we see them in public places.

Q. In terms of non-clinical staff, could we just drop down to 11 please. It says here that:

"The expectation is that non-clinical staff have the resuscitation skills that would be expected from a layperson. As a minimum, non-clinical staff should be trained to:

"recognise cardiorespiratory arrest;

"summon help; [and]

"start CPR using chest compressions."

Now, having looked at what you said in your witness statement, do we take that to refer to, as you say, people without patient-facing responsibilities --

A. Yes, correct.

Q. -- such as admin staff. So HCAs, healthcare assistants, would be in that first bracket?

A. They'd be in the clinical element absolutely.

Q. Right. So in terms of the assumptions that underpin all of this, can I ask you, is it right, then, that they work on this basis: that sometimes HCAs are regularly, solely responsible for observing patients who are at risk of a clinical event that might cause cardiac

arrest?

A. They certainly might be in some organisations. Particularly if an individual is -- we might use the term being "specialled" so where they're being one-to-one monitored so -- (overspeaking) --

Q. So level 3 or 4 observations, for example?

A. Yes.

Q. Or somebody who is, for example, maybe in a ligature risk or an overdose risk?

A. Absolutely.

Q. Okay. And are they drafted, then, these standards, on the basis that HCAs are often responsible for checking vital signs?

A. In most healthcare organisations, that role of checking vital signs is often delegated to healthcare assistant staff.

Q. And they're --

A. Not exclusively.

Q. Sorry, I spoke over you. You may need to give that answer again.

A. I said but it's not exclusive in that sense.

Q. No, but they may do it -- (overspeaking) --

Sorry, Chair, I interrupted you.

THE CHAIR: No, finish and --

MS HARRIS: They are often the first on the scene of an

emergency?

A. They can be, yes.

THE CHAIR: You've talked about the training that you would expect people to have, in these circumstances. How long would a training course that covers the things you've recommended last? How long would that take?

A. As in the duration of the course --

THE CHAIR: Yes.

A. -- or in between training?

THE CHAIR: The duration of a course to get people --

A. Sure.

THE CHAIR: -- to the standard that you would expect?

A. So for -- I'll start with our ILS course because that's very easy to do within the programme. That's a full-day training.

THE CHAIR: Four days.

A. Full day. One full day.

MS HARRIS: So that's ILS?

A. That's ILS. We have a set programme for that which is the national standard. And that can be split up between e-learning which takes the theory away, and then half a day practical. But the length of time spent on that training is a day.

For basic level life support, that's very much -- it depends on the organisation and how they've set their

training up. They would need to do hands-on skills for chest compressions, managing ventilation, and using an AED. But they might also add additional levels of training within that, sort of, like, the recovery position, how to manage choking, or other elements what's requirement to their role, but it can vary depending on what the organisation require.

THE CHAIR: But an average one to get somebody competent in basic level skills?

A. It's very variable between different organisations, and competence is a difficult thing in itself because that's measured over time. So what you're essentially doing when you provide training is making sure people are -- they can use the skills, they can recognise deterioration, and that's why we recommend that people have refresher training, to make sure those skills get embedded. But it is very difficult to say a programme because it really depends on the length of time that they, the organisation, allow that individual to do.

THE CHAIR: But if you -- if I said I'm going to a course that's going to take half a day, you wouldn't consider that absurdly ambitious?

A. No, not at all. Some hospitals will do four hours, half a day. Some might even reduce it down to an hour. And support that with online e-learning, because it's the --

there is a compromise that is often seen about taking frontline clinicians away from the workplace to do mandatory training. And I know that's being reviewed by NHS England at the moment, looking at the amount of time lost from providing direct clinical care. But actually, we have to weigh that up by essential skills that individuals need so that they can provide good, robust quality care on the wards.

THE CHAIR: Thank you.

MS HARRIS: Can I just pick up on something the Chair just asked you. So when you were talking about courses that may be half a day, four hours, maybe even reduced to an hour, would that be basic life support training with some enhancements? For immediate, would you still consider that ought to be longer and a full day?

A. So yes for basic life support. If they are using an RCUK ILS course, they are not allowed to change the programme.

Q. Right.

A. Well, they can add to it with bespoke training but they can't reduce the content.

Q. All right. We'll come back to that in a moment but you're not the only providers of ILS; that's right, isn't it?

A. No, there are -- so whilst the guidelines and standards

from national bodies will recommend an ILS-level course, they will benchmark that against our standards, and what's in our course, but there's no remit for it to be an RCUK-accredited and validated course.

Q. All right, we'll come back to that in a moment but I just wanted to pick up on that.

In fact, it's right, you maybe can help us with this, is it right that the vast majority of providers, or a lot of providers, only require their doctors and their nurses to complete ILS training?

A. It very much can be the case, yes.

Q. Okay. Just going back, then, to your standards, because we have a number of standards which will apply to all staff, so that's clinical staff -- that's everybody working?

A. Sure.

Q. And we look, number 12, is that:

"All staff must know how to summon help and be aware of the protocol for the settings in which they work. This could be dialling 999 or a standard telephone number within the organisation. We recommend that this should be a common national number, 2222, as recommended by the National Patient Safety Agency."

So to pick up there, it's, as a must, everyone must know how to get help?

A. Within their organisation, yes.

Q. And obviously it will vary from organisation to organisation, unit to unit, and ward to ward.

A. *(The witness nodded)*.

Q. But everybody needs to be clear as to how to summon help in emergency --

A. Absolutely.

Q. -- and what that might involve.

Similarly, at 13, I think you refer to "all staff" again, you say:

"A variety of methods to acquire, maintain and assess resuscitation skills and knowledge can be used for annual updates of all staff ..."

A. Correct.

Q. So you reference life support courses, simulation training, in-house training, mock drills, rolling refreshers, e-learning, video-based training/self-instruction, et cetera, but again you are contemplating that this is all staff that are assessed and who must maintain their skills?

A. Correct.

Q. At 14, "there must be a system for identifying resuscitation equipment for which staff require special training." And there we have your defibrillators --

A. *(The witness nodded)*.

Q. -- although I think you've said you need almost none for AEDs?

A. That's correct, yeah, it's more so about -- well, we look at the training regarding defibrillators in the workplace, how do they change batteries and insert pads, and stuff, rather than the use of the device. That's for specialist training.

Q. All right, that's helpful. And at 15:

"All new members of staff must have training resuscitation as part of their induction programmes. Even those who have current training, require resuscitation training on induction, to ensure they are familiar with the local policies and equipment."

A. Correct.

Q. Because they do vary from ward to ward and unit to unit, as you've explained?

A. Hopefully not from ward to ward but certainly different organisations will buy in different equipment. So one hospital, hospital A, may have a very different AED or some devices to hospital B and it's about familiarisation with equipment, what it looks like, but certainly also the policies are really important to be aware of.

Q. Where it is, I suppose, is another one?

A. Well, where the location of equipment is but how do we,

particularly when you think about if part of your response of your hospital is: are you a 999 hospital? Do you actually have collocated sites, and what is your avenues and -- and all these bits are guided by those local policies.

Q. At 18, there's a very specific, it says:

"Specific training for cardiorespiratory arrests in special circumstances [and you give examples] (for children of all ages who have collapsed, patients who are secluded or subject to restraint and patients who have suffered blood loss), must be provided for medical, nursing and other clinical staff in the relevant specialities."

At paragraph 62 of your witness statement, you say this:

"The same role-based approach applies to Standard 18, where healthcare assistants are expected to be involved in responding to special circumstances, they should receive training appropriate to responding to those special circumstances in the same way."

A. Correct.

Q. Now, we'll come to some special circumstances in a moment because there are some examples here, but the significance here is that it's for anybody that might need to be involved, which would include healthcare

assistants?

A. Absolutely.

Q. And at 19, at the top of page 11, another "All clinical staff" must receive training in recognising, monitoring and managing patients whose conditions are deteriorating?

A. Correct.

Q. So if that's part of an HCA's role, they must receive that training?

A. Absolutely.

Q. In fact at paragraph 63 of your witness statement for those who are following it, you say:

"RCUK would expect healthcare assistants working on mental health inpatient wards to receive training in recognising, monitoring and escalating concerns about deteriorating patients appropriate to their responsibilities."

A. Absolutely.

Q. We'll come on to training again in a moment, but are some of those skills, then, beyond what might be learnt in basic life support training?

A. You often find that basic life support training looks at what we class as technical skills. So recognising that a cardiac arrest has happened, summoning for help, doing chest compressions or performing chest compressions,

providing ventilatory breaths and use of an AED. Where we look at deterioration, that's often excluded from basic life support training. It's usually excluded.

Q. Excluded -- (overspeaking) -- so in order to attain the necessary skills in identifying deterioration, an individual needs to go on an ILS course?

A. Well, there are other courses which are available to look at deteriorating patients. So -- set at different levels. So it might be a case where organisations will utilise one of those courses, rather than necessarily an ILS course. But this should be determined by their training needs analysis.

Q. So whilst candidly accepting there are other ways to meet those needs --

A. *(The witness nodded)*.

Q. -- is a safe way to meet those needs for an individual to go on an ILS course?

A. I would certainly say so.

Q. Yes. There's considerable emphasis in your witness statement, and we've -- and in your evidence -- about the early recognition of deteriorisation and the immediate recognition of cardiorespiratory arrest. Does RCUK provide detailed guidance on learning or training regarding the specific factors that should or should not inform early recognition of cardiac arrest?

A. So we include that within our immediate level courses and advance level courses, so it's certainly part of our course curriculum.

Q. So it's part of your course curriculum but not part of any guidance or the standards? That's something you'd have to be on an ILS -- an RCUK and ILS course to access?

A. For one of our products, certainly, but there are other resources and standards out there. The most common one which has a training package associated with it would be from the Royal College of Physicians in association with their NEWS2 programme (unclear), so that tells you about the importance and how to recognise elements within, and that's quite a generic programme.

Q. Can I ask you a little bit further about RCUK's position on who should get what training. We've looked at point 5 in the training standards which is that RCUK's immediate life support course is recommended as a minimum standard for staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion, and --

A. Correct.

Q. -- you've already dealt with that, and you've already helped us that there are, in essence, three levels of training, the basic life support, the immediate life

support, and advanced life support training.

A. *(The witness nodded)*.

Q. And it comes in different guises and we won't need to go into that. You have also given evidence that immediate life support is more comprehensive than your basic life support training, which I think is something someone like me could do. But in broad terms, and we've looked at some features, what other skills or knowledge does ILS training provide that BLS training does not provide?

A. So from a standard outset, the ILS training will go through in more detail recognition and prevention of cardiac arrest, using a structured assessment tool called the ABCDE approach, and basically it looks at how you assess an airway, someone's breathing, their circulation, we class D as disability, and that's looking at their neurological function, and then E is exposure, and everything else around the patient. And that's a structured system that's used internationally for assessment of a deteriorating patient. The course also goes into a bit more on how to manage an airway and recognise those airway problems. So that might also include that when a patient has a cardiac arrest, that they could put in a supportive airway device like a supraglottic airway, sort of like an i-gel, or something, and that basically protects the airway and

allows ventilation to be delivered much more effectively and easier.

The course also covers -- so it covers chest compressions, it covers defibrillation, either using an AED or if you need to use a manual defib you can use that, but the key thing about the ILS course is it introduces the concept of leadership and those non-technical skills because you're managing quite a few people in your local environment and what that does, it enables a structure to be delivered whilst you are managing that event, waiting for an advanced team to come and help, either be it a hospital-based resuscitation team with more advanced skills or a paramedic crew.

So it really enables that facilitation of utilising the cardiac arrest algorithms and putting them in place to make sure care is very much effectively given.

Q. In terms of the RCUK's ILS training can we just have a look at the regulations around that, and that's your exhibit ABC 8 at page 1. We see, and you've just given us, if you like, a synopsis of what the course includes --

A. Yes.

Q. -- including the ABCDE approach, but its objectives are, this is the ILS:

"To train healthcare personnel in causes and prevention of cardiopulmonary arrest. The ABCDE approach [as you've said] initial resuscitation and defibrillation, manual and/or AED and simple airway management. To train healthcare personnel to manage patients in cardiopulmonary arrest until the arrival of the resuscitation team and to train healthcare personnel to participate as members of the resuscitation team."

A. Correct.

Q. Is it that last point, then, that would include those elements of leadership?

A. So the leadership element would come into that, that second point until that arrival of the team --

Q. The management part?

A. The management.

Q. Okay.

A. But what we wouldn't want is for those individuals to -- you know, as the advance team arrives, sometimes what you see happening in clinic environments is ward members of staff might then go away and leave the cardiac arrest management to the advanced team, whereas, actually, there's no reason why they shouldn't stay and be part of that team approach and managing that patient altogether.

Q. In light of your previous answers, there's no reason, is there, that healthcare personnel should not include

healthcare assistants?

A. Absolutely no reason at all.

Q. Can I just ask you this: do you need any additional clinical qualifications or anatomical learning in order to take an ILS course? Could I take an ILS course?

A. So the way ILS is delivered, we would expect people to have a bit of knowledge of physical health but that comes in the form of the course manual. The course is open to any healthcare professional. It's also open to members of the public who might need it for their role, so we get firefighters on the course, we get police officers, prison guards, we've even had air stewards on the course as well, because it gives people the skill to manage that event in those circumstances whilst they're waiting for more expert help to arrive.

Q. I'm not going to ask us to jump to it but healthcare assistants I think are listed in that list of --

-- (overspeaking) --

A. There's absolutely no reason why a healthcare assistant could not do an ILS course and in many acute hospitals they do.

Q. For completeness, because this Inquiry has heard a lot of evidence about the care and treatment provided to children, and we're looking very carefully at the provision of mental health care for children, can we

just confirm the position in relation to the paediatric ILS regulations, and I think that is your exhibit ABC 10, at page 1. And this -- these regulations, actually, are a little earlier, aren't they, they're 2019 --

A. They are, yes.

Q. -- and I should have said it's 2021 for the ILS, but -- they sort of pre-date. But the objectives effectively mirror --

A. *(The witness nodded)*.

Q. -- but with obviously some modification for paediatrics. So it's to "understand the structured ABCDE approach" that you've given evidence about that facilitates rapid recognition --

A. Mm-hm.

Q. -- of seriously ill children, "Provide appropriate initial treatment interventions to prevent cardiorespiratory arrest; treat children in respiratory or cardiorespiratory arrest until the arrival of a resuscitation team or more experienced assistance; and become members of a paediatric resuscitation team."

So with emphasis, again, on prevention.

We can see that, if we look again, it says that the paediatric ILS course will address the needs of those personnel who need more advanced skills than those

taught during basic life support, but who do not require the more comprehensive two-day European paediatric advanced life support --

A. Correct.

Q. -- the EPALS course.

A. That's correct.

Q. Can you confirm, we don't need to necessarily go to it, that healthcare assistants also appear in the appropriate candidate list for this as well?

A. Absolutely.

Q. You pick up this at paragraph 107 in fact of your witness statement where you say:

"ILS was developed for healthcare professionals who may have to act as the first responder in an emergency. Its purpose is to give individuals the skills to recognise deterioration, identify cardiac arrest, start immediate resuscitation, use defibrillation where appropriate, summon expert help, and manage the patient until a cardiac arrest team, ambulance clinicians or other advanced responders arrive."

A. Correct.

Q. So the term "first responder" is the first person to arrive at the scene of an emergency?

A. Yes, yes. In this setting, yes.

Q. Just again following on from that, this Inquiry has

heard evidence from bereaved families and from staff who work on mental health inpatient units, that because of the way units after staffed -- and you've already talked about recognising some of the challenges around staffing in mental health inpatient units -- and because of the way observations are sometimes carried out by HCAs, and you've already acknowledged that they are sometimes delegated to HCAs, a healthcare assistant will often be the first at the scene of an emergency.

A. *(The witness nodded)*.

Q. And whilst we know that your evidence in your witness statement is that RCUK don't expect all healthcare assistants working on mental health wards to have immediate life support training as a blanket requirement, you do say that healthcare assistants can access ILS training where this is needed and appropriate for their specific role and organisational need.

A. Correct.

Q. Would you agree, then, that if HCAs are going to be first responders, they must be ILS-trained?

A. Very much depends on, again, that environment and the level of support they've got around them. So if they are, if they're truly on their own in an area and they're expected to be involved in something like the rapid tranquilisation then they should have the skills

to support the level of care that's required of them. If it's generic support, it might just be basic life support, and recognition that they need, in that sort of instance.

You will find that in a lot of training that if individuals are taking vital signs, they should have training to say when -- what is normal, what is not normal, and escalating that to a registered healthcare professional who can then take that information and act accordingly. That would definitely be a baseline standard. But in some areas, you will find that there are only -- a healthcare assistant may only be trained in basic level life support because they have a supportive structure with mental health nurses around where they can add -- you know, they can -- what word am I looking for? They can ... words have lost me. Escalate -- where they can escalate their concerns in a very timely manner.

Q. So basic life support training would be sufficient if they had access to more qualified staff --

A. Exactly.

Q. -- and were supported by those staff?

A. Exactly.

Q. However, what if a person had to remain on their own with a patient whilst awaiting for the crash team or

ambulance response?

A. If that individual is that sick, where they've put out an escalation call, for more appropriate help, then I would expect a registered healthcare professional to be with that patient.

Q. What if staffing issues meant that it was an HCA? Should it be an HCA with ILS training?

A. An ILS-trained HCA could support that but realistically that should be a registered healthcare professional.

Q. Can I ask you this: if it were to be recognised by an organisation that HCAs are often first on the scene, they might be required to stay with a patient whilst awaiting the ambulance or the crash team, should they be ILS-trained, if the organisation knows that's going to be the position?

A. If there's an expectation to, then --

Q. Sorry, better word than mine, for sure.

A. Sorry, if there's an expectation that that's what the organisation are saying should happen then yes, they should have the appropriate level of training to manage that situation --

Q. And --

A. -- and that would be an ILS-type level qualification.

Q. As a minimum standard?

A. As a minimum standard. But ultimately, and

realistically, there should be, in that situation, a registered healthcare professional with that patient.

Q. Can I flip it on its head, if I may. If those circumstances were to arise and an HCA who was not trained in ILS, is it safe, then, for patients who are at immediate risk of ligature or airway obstruction to be solely observed by non-registered staff? That are not ILS-trained?

A. Again, that would very much relate to if they've got appropriate help immediately available, so a ward with registered healthcare professionals on, that might be appropriate. If there's a reduced level, then they absolutely need some form of -- a way to manage that patient, recognise what's going on and escalate, so that we don't miss the deterioration and the risk that happens. So ILS would be appropriate in that situation.

Q. So if you're likely to have a situation with reduced staff levels, then that increases the need for a higher level of training within the -- (overspeaking) --

A. Because we need to reduce the risk of the -- the clinical risk within that area.

Q. Can I ask you, slightly separate question: do you, RCUK, have a position on the minimum frequency for monitoring vital signs in mental health inpatient settings?

A. So we would follow the recommendations that are part of

NEWS2 which has it sort of listed out within the escalation protocol within there that tells you how often you should be doing more frequent observations.

Q. Does RCUK have a position on the use of Oxevision?

A. It's not a company I've heard of, or brand, but we wouldn't have a position on a specific brand or product on the market.

Q. I think you know what Oxevision is.

A. I haven't got a clue. Sorry.

Q. I shan't ask you any more about Oxevision specifically, then.

Can I ask about local need. One staff witness has given evidence that he considers, and this is from one of the providers the Inquiry is concerned about, that he considers HCAs should receive ILS training in the same way as nurses because he describes how HCAs will often be the first on the scene, or they might need to get things out of the grab bag but they don't know what is in the bag. Now would you agree with that staff witness's assessment?

A. If they're first on the scene and needed to respond, absolutely. For recognition of equipment, that's slightly different, because that's equipment recognition. And you'll see that in the -- if they've got an advanced resuscitation trolley which might have

an intubation kit, you have a very limited set number of clinicians who could truly intubate during a cardiac arrest. So people need to be familiar with what the equipment looks like and what it's called, to help with the process of that clinical task.

Q. I've asked you a lot of questions around who should get it and who shouldn't get it and you've dealt with local need and you've dealt with scenarios. Do you consider there would be any merit in updating the Quality Standards so there's greater clarity on who you expect to receive ILS training?

A. We can certainly put elements within that as guidance. It would ultimately be down to a local risk assessment and training needs analysis, because as I say, not every hospital is set up the same. But certainly we can put lines in there guiding people towards if they are undertaking certain roles or have a certain level of responsibility, then they should have a minimum requirement of X, Y and Z level of training.

Q. I'm told that we're due a break in a minute, but before we have a break, can I ask you about a separate aspect of the standards, and this is section 4, which is preventing cardiorespiratory arrest and it's at page 13 of your exhibit ABC 5.

And I can deal with this very quickly because

I think it is the same point, but point 2, again, the RCUK's position is that:

"An organisation must have an education programme for ward staff and responding clinical personnel that is focused on preventing patients' deterioration."

And again you pick this up in your witness statement at paragraph 65, where you say:

"This may include registered nurses, healthcare assistants, and other patient-facing staff."

It's the same point throughout, isn't it, about what that person is expected to do --

A. Correct.

Q. -- and the role they're expected to take?

A. *(The witness nodded)*.

Q. Whilst we're on this part, do we note, again, the re-emphasis at 4 that:

"An early warning scoring system must be in place to identify patients who are critically ill and therefore at risk of cardiorespiratory arrest."

And there is an example where the NEWS or paediatric early warning score is recommended.

A. Correct.

Q. Where staff are conducting routine observations, would you expect them to be specifically trained beyond the use of NEWS2 in recognising signs of physical

deterioration?

A. So NEWS2 is quite comprehensive. If you are a healthcare assistant undertaking observations and vital signs, I would expect them to be able to calculate the NEWS score and report that appropriately to the registered healthcare professional on the unit.

Q. Can I ask you to have a look at 6. Again, this is a must:

"Organisation must have a clear, universally known and understood mandated, unambiguous graded activation protocol for escalating, monitoring, or summoning responses to a deteriorating patient and its use should be standardised."

I think that's very emphatic.

A. Absolutely. And that is NEWS, in a nutshell.

Q. And 8:

"When acute clinical crises are identified, a 999 ambulance must be called if there is no designated resuscitation team, outreach service or rapid response team that is immediately available."

A. Correct.

Q. And at 9:

"The organisation must have a clear and specific policy that requires a clinical response to 'calling criteria' or early warning systems ('track and

trigger'). This must include the specific responsibilities of onsite/oncall doctors and nursing staff and include when to call the Ambulance Service".

A. *(The witness nodded).*

MS HARRIS: And before -- I'm going to move on short only to ask you about responding personnel but, Chair, I'm told that we are due a break ... And I am asked if we can now return at 1.50.

THE CHAIR: 1.50. Thank you.

(1.00 pm)

(The Short Adjournment).

(1.50 pm)

(Proceedings delayed)

(1.54 pm)

THE CHAIR: Ms Harris.

MS HARRIS: Thank you, Chair.

Mr Benson Clarke, I just want to ask you please about section 5 of the Standards for Mental Health Inpatient Care which is your exhibit ABC, and in particular the top of page 15, please. Thank you very much. And I want to ask you about resuscitation teams and responding personnel.

You've in fact covered quite a lot of this already during the course of your previous evidence but if we just look, please, at number 1, point number 1, under

"Resuscitation teams and/or responding personnel", it draws together some of the evidence that you've given in so far it says:

"Unless the organisation that delivers mental health care is situated on the same site as an acute hospital, which provides a resuscitation team that is specifically contracted to deliver an on-call service ... a 999 ambulance should be called immediately for any patient who collapses. In the interval before an ambulance arrives, staff of the mental health service should be capable of DEPLOYING the skills that are identified in point 4 below."

And if we jump down to point four below, please, which is on page 16, you indicate that:

"The staff who respond immediately must have the following minimum skills", so that's the mandatory as far as RCUK are concerned.

A. Correct.

Q. "Competent delivery of CPR; defibrillation (AED); basic airway interventions, including bag-mask ventilation and/or supraglottic airway; skills required for immediate post-resuscitation care."

And strongly recommended, although to be determined by local policy and clinical need:

"... intravenous cannulation ... intraosseous access

... drug administration ..."

And local policy and clinical need would presumably include an organisation making sure that particular members of staff were skilled, for example healthcare assistants, if they were the ones that were going to be staffing and/or responding as contemplated by point 1 --

A. Correct.

Q. -- if that makes sense.

It may also be an obvious point but you stipulate that all facilities as in you, RCUK, stipulate that all facilities must have access to an outside line.

A. Correct.

Q. Can I ask you, please, then to look at section 7 of the standards which I think begins or we want to look at the middle of page 20, please.

A slightly different aspect, and these are special circumstances although the section is quite small. The standards indicate that:

"Organisations must have policies and procedures in place for resuscitation in special circumstances (eg blood loss due to trauma, suffocation, application of a ligature to the neck and hanging, self-harm, seclusion, rapid tranquilisation etc)."

Now, whilst I appreciate that is a non-exhaustive list by the "etc", do you consider that drowning also

might be a special circumstance?

A. Yes, it would be.

Q. As outlined in paragraph 69 of your witness statement for those following, you indicate that the standard requires organisations to identify circumstances in which resuscitation may need to be adapted to the patient or clinical situation and to plan accordingly. And you indicate that it is intended to set organisational expectations for local policy, training, equipment and escalation, rather than reproduce detailed clinical guidance.

In the supporting documentation, we -- I think it's a little bit further down the page -- can we go down, scroll down a little bit? Yes, it's at the bottom there, isn't it, 5, which is a document you've produced as an exhibit. So as part of the supporting documentation to help healthcare providers in formulating these policies and procedures, you produce the European Resuscitation Council Guidelines for resuscitation, which provides guidance on cardiac arrest in special circumstances.

Now, I'm not going to produce that paper and ask you to look at it because it's quite a dense paper, isn't it?

A. It is indeed, please.

Q. It's about 50 --

A. 54 pages.

Q. 54 pages long? And it sets out, doesn't it, various special circumstances, including asphyxia-induced hypoxia, ligature, choking, suffocation -- I'm just selecting a few examples.

A. Sure.

Q. It also includes electrolyte abnormalities about which you gave evidence earlier, traumatic cardiac arrest from significant blood loss, cardiac arrest from poisoning, which would include overdose.

A. Mm-hm.

Q. Special environments which would have the section on drowning, those kind of matters are covered in that paper.

But it is, as you say, quite a dense paper.

As you've already outlined in the earlier part of your evidence, emergencies arising in special circumstances in mental health inpatient units require special interventions sometimes.

A. *(The witness nodded).*

Q. You're nodding. Is that a yes?

A. Correct, yes, sorry.

Q. We've already covered several times, if possible, as soon as the deterioration is identified?

A. Correct.

Q. Can I just ask you this, then: given the importance of the adaptation for special circumstances in a mental health inpatient setting, and given the aim which we saw this morning of the Quality Standards is one of simplification, would it not be preferable, do you think, for RCUK to provide at least some further guidance around special circumstances?

A. So we do, we've got that published within our Resuscitation Guidelines. So within that there is a, a chapter specifically referenced as special circumstances and it's based on the European Resuscitation Council Guidelines, and what we would do is we would direct people who want the full science behind those recommendations to the European Resuscitation Council Guidelines because that's where we derive ours from.

So we've got them -- sorry. We've got the guidelines published, they're just not within the Quality Standards.

Q. Moving to a slightly different topic if we may, restrictive interventions, and we've touched on these already.

A. Mm-hm.

Q. We've already looked at the standard, which says -- and

I'm not asking anybody to go back to it -- that RCUK's immediate life support ILS course is recommended as minimum standard for staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion.

A. Correct.

Q. And the foundation to this is referenced in the CQC's Brief guide which is called "Immediate Life Support training for services that may use restrictive interventions".

A. Correct.

Q. And that, in turn, refers to the NICE guideline, which is NG10, which was published, I think, May 2015, "Violence and aggression: short-term management in mental health, health and community settings."

And the point I think that from all of those documents, is that if an organisation is asking whether they've got sufficiently trained staff, the question they should ask themselves is: are all relevant clinical staff trained in BLS and CPR? And all staff who may deliver or be involved in restrictive interventions trained in ILS?

A. Correct.

Q. And so, again, just to underline, ILS training is considered a minimum standard for those who may be

involved in restrictive interventions?

A. Correct.

Q. And we talked a little bit around the physical health aspects, et cetera, earlier this morning.

Given that cardiac arrest in healthcare settings is often secondary to another event, and observing deterioration and intervening promptly is particularly necessary, and we've been through all of that, where staff are carrying out rapid tranquilisation, physical restraint and using seclusion, is there need for even greater focus, then, on monitoring for signs of deterioration?

A. So once they have certainly given that tranquilisation, yes.

Q. Is this addressed in guidance, in RCUK guidance, the need for greater focus?

A. We don't have a section specifically on that, but that would be part and parcel of, if you were to give someone one of those drugs, about how you manage the administration of that pharmacological agent.

Q. Might it be sensible to address it in the guidance?

A. We can certainly add it.

Q. And I don't want to go through it again because I think you've already recognised that it could apply to healthcare assistants if they are doing that role.

Are there any local circumstances that would override the need to ensure that staff, including healthcare assistants, tasked with monitoring patients subject to restraint or in seclusion, are trained in ILS?

A. Sorry, could you say that again?

Q. Yes. I think I can see -- are there any local circumstances that could override that requirement, that minimum standard of ILS-trained staff then monitoring ...

A. I mean, the basis would be for levels of training, the organisation would be expected to do a detailed risk assessment, looking at where the risk lies and how they can mitigate and reduce that, and that should inform the training needs analysis. If an organisation has identified that individuals should have a certain level of training and choose not to follow it, then they really need a good, clear governance process as to why they're deviating from that risk they've identified. If they fail to identify the risk, that's where national standards and guidelines such as the Quality Standards can help them with that decision-making sort of pathway, to say that individuals should have a required level of training. But organisations really do need to be clear about why, and if they've identified the need for that

level of training, they really should follow it.

Q. So a risk assessment would need to be carried out. So if, in fact, an organisation had in some way misinterpreted those guidelines, as indicating that what they needed was access to BLS-trained staff, not ILS-trained staff, firstly, would that be a concern?

A. It would be, and that's part of the rationale as the governance structure, have those experts in resuscitation or access to those experts in resuscitation to help guide them with that thought decision process. It needs to be a group decision in that sort of sense by the Resuscitation Committee to really make those recommendations.

Q. Can I move on to asking you a little bit about scenario-based training and simulation. It's clear from your witness statement that you consider -- I say you, RCUK -- consider it is of particular importance that those working on mental health inpatient units and indeed other specific settings are trained and practised in responding to special circumstances, the type of scenarios we've just been through. I think you've explained that your ILS training is not mental health specific but I think you have explained that things can be added, and in your earlier evidence you said there are course providers that can add to or can bring in

certain elements of the training. Did I understand that correctly?

A. For our ILS course, we do have mental health related scenarios.

Q. Yes, I'm going to come on to those in a moment, but in terms of specific skills, the ILS training is ILS training and then you add the scenarios in --

A. Yes, standardised level of skillset, yes.

Q. And in fact, just picking up on what you said in your witness statement makes clear, I think it's around about, would it be the end of 2018, beginning of 2019, RCUK identified the need for specific mental health-based scenario training to be added?

A. Correct.

Q. And I won't take you to it in detail, but for those following it, at paragraph 92 of your second witness statement, you say that:

"RCUK has developed mental health-specific ILS course materials and simulation scenarios for healthcare professionals working in mental health inpatient settings which include scenario-based training content, assessment materials, to assess those who undertake it, and instructor resources tailored to mental health environments."

A. Correct.

Q. And I think we can probably summarise it in this way: it was developed through your ILS subcommittee at the beginning of 2019?

A. Correct.

Q. It was drafted and then piloted at three mental health Trusts?

A. Correct.

Q. You received feedback?

A. Correct.

Q. I think took some, didn't take some?

A. Correct.

Q. And then issued those particular scenarios, I think in about July 2019?

A. Correct.

Q. And I think you also explain at your paragraph 92 that there's been subsequent revisions and updates.

A. Correct.

Q. Is that both to those materials and the ILS training?

A. It's predominantly to make the course content align with the changes in Resuscitation Guidelines.

Q. You say in your paragraph 92 that "Development of the mental health-specific ILS training involved input from subject matter experts and clinicians experienced in mental health resuscitation training."

A. Correct.

Q. Now, we know you were involved in that, you were involved in that committee. Who were the subject matter experts and clinicians?

A. So we had two people within the actual group who deliver training regularly to mental health organisations. One of them was a private -- owned a private training company who would deliver RCUK ILS courses, and was very familiar with risk management and governance within mental health hospitals. We also approached, as I say, for the piloting, three sites who were delivering a lot of ILS training, and asked them to give comments and feedback on their experience of using the material and where adjustments may need to be made.

So we had quite an extensive bit of feedback from experts in the area.

Q. All right. Can I just ask you then a little bit about your ILS training.

A. Mm-hm.

Q. I think you gave evidence this morning that there is an e-learning part; is that right? And then there's a practical face-to-face part?

A. Yes, we've got several modalities for delivering the content. So one is a full-day programme which is a combination of lectures, skills, and then that's embedded within simulation practice.

We have -- recognising that organisations are time poor with clinicians, and don't want to take them away from direct patient care for a whole day, we developed the e-ILS course, so the theory and content is delivered by e-learning so when they come to the day for hands-on training they can focus on skills and scenarios.

Q. Would your preference -- would RCUK's preference be that all staff should be trained face-to-face in an ideal world?

A. So they still do get face-to-face training,

-- (overspeaking) --

Q. Certainly for part of it --

A. -- for part of it and that's the skill element which is -- it's much more technical, and the management of the cardiac arrest. But the theoretical element is an easy part to move on to e-learning. Essentially, it was we moved the lecture components on to interactive e-learning which allows learners to learn at their own pace. It gives them the opportunity to test their knowledge. So from an educational viewpoint it's a lot more interactive and a lot more engaging for the learner.

Q. Can I ask you this, do you -- is there any way, in your course materials, of making sure that an individual is undertaking their own training? Do you know what I mean

by that?

A. -- (overspeaking) --

Q. Verification?

A. -- everything is tracked, if it's a-- if you want to go into the nitty-gritty of can we guarantee that the person is doing their own e-learning --

Q. And not doing somebody else?

A. Yes -- no, we can't. However, to get the qualification it's on their performance on the day. So what they're assessed by the instructor on as learning those skills.

THE CHAIR: And if they've done the e-learning they still do a full day, do they?

A. They do a half day.

THE CHAIR: They do a half day?

A. Yeah.

MS HARRIS: How would you say that your ILS training addresses the ability of mental health inpatient workers to use it, once they've done it, promptly, accurately, and confidently? The Inquiry has heard evidence of chaos and uncertainty. What is it about your ILS training that overcomes that?

A. That's a good question to ask. Cardiac arrests by nature, as we've already mentioned, are the ultimate medical emergency. They are scary. They are frightening when they happen. It does get a little bit

chaotic at times because people don't see them that often. What the trainer tries to do is enable that person who is going to be leading the event, the cardiac arrest, in the first instance, to try and gain that element of leadership and control by using technical and non-technical skills of leadership, so having more situational awareness, looking at how they're communicating to individuals, having good task allocation, which might actually also mean sending extra people who have turned up away because what often happens in these situations, where they happen so infrequently, you find people come out of the woodwork to get involved, and actually then it becomes managing crowds and the situation.

So the ILS course in that first instance gives a structure for the team leader to follow, it gives a structure for team members to follow as well, so they're all singing from that same hymn sheet, which enables that confidence to be delivered.

The challenge with training -- and this is for any course, not just an RCUK course -- is you can deliver the skills and knowledge at a time, and we recommend, you know, at least yearly training, but you need to have that embedded in other ways, as well, so that familiarity is there if it should be called upon, so

that people can guide themselves and reset to follow that set pro forma, as it were.

Q. When you talk about embedded, would that be something in the order of drills on the ward or monthly drills?

A. Drills are a really good example. So that's where you -- you not only just test people's knowledge of enacting in a clinical scenario, you're also then simulating the processes around it. So are people familiar with -- they need to dial this number? Are switchboard then familiar with how they put the call out to the cardiac arrest team? If a patient needs to be transferred to a hospital via an ambulance, do they know whose responsibility that is? What number are they going to ring? Is it 999? Do they have a dedicated number? Who is going to transport the patient?

So you're actually testing not just the technical element but the procedures and processes and by adding that familiarity you make things a lot more slick for the individual and that reduces any potential for other sort of clinical misevents to happen.

Q. Can I go back to your course content on this particular topic. You have, I think, scenarios and simulated or simulations --

A. Yes.

Q. -- I don't know if I've described them properly. In

terms of -- we have seen your current course content and can you confirm that the mental health scenarios included in your current course content are, I think, an acute asthma?

A. Yes.

Q. A chest pain?

A. Correct.

Q. A hypovolemia? Have I pronounced that correctly?

A. Yes.

Q. Anaphylaxis?

A. Correct.

Q. Asphyxiation following a ligature?

A. Yes.

Q. And a hyperglycaemia?

A. Correct.

Q. So that's the range of circumstances, the scenarios. Does RCUK provide BLS training as well?

A. We are currently developing a basic life support level course. At the time of this investigation we didn't have a BLS programme.

Q. Would BLS training ever include scenarios or the same sorts of scenarios?

A. Not typically because BLS training tends to focus on the technical skills. So if people did frame it around a scenario, it would all be very much the same: if

there's a collapsed person what are you going to do? You ask them to go up, confirm cardiac arrest, put out a cardiac arrest call, start chest compressions, ventilate the patient and use an AED. So it doesn't go above and beyond managing that and having that decision or thought-making process.

Q. I've just been passed a Post-it. We both need to slow down again. My fault.

I think you have already touched on this as well. Do you agree it's really important for staff that work together to train together as a team if possible?

A. If possible, it's beneficial. One of the challenges in all healthcare environments is understanding the level of training and knowledge for the members who may respond have. So you can't assume that somebody will be trained to a much higher level just by the nature of their role or what they can or cannot do. So it's really important to have that and actually, within our standards, we recommend in all settings that you have a team huddle at the beginning of the shift to identify who is -- who has got what skills and can take on what role.

Q. Moving to your simulations or the purpose of simulation training -- we won't look at them -- but the purpose of simulations, I think you say within the document, is

they're designed for healthcare professionals who may be called to act in the role of first respond to a patient at risk of or in cardiac arrest.

A. Correct.

Q. That's the purpose of them. And your current simulations in your ILS course materials, I think there are three that arise from, or are based around, a patient with chest pain; does that sound about right?

A. Correct.

Q. There's one simulation which is based on a patient having been found in a bathroom having cut their wrists, I think, with a razor?

A. Okay.

Q. There is a fourth simulation which is an unresponsive patient who has been admitted with episodes or frequent episodes of overdose, and is an overdose scenario. And I think the sixth is based on a patient being found unresponsive after having a ligature?

A. Correct.

Q. Is that a correct summary of the six simulations. Bearing mind that's, if you like, the topics, those are the backgrounds of the simulation, are you, RCUK, confident that your mental health-specific simulations are comprehensive enough to cover all of the special circumstance scenarios?

A. That would be challenging because we can't cover all of them, and the difficulty is finding that medium where you have physical health deterioration, and also elements which are going to be more prevalent within that mental health environment such as ligature. So we tried to strike a balance but the education within the programme is transferable so it's about understanding and having that systematic approach to the abnormalities that happen that you see when you look at stuff like vital signs or managing that cardiac arrest and thinking how you are going to manage that. You have to remember that ILS is very much for those first few minutes or until that expert help arrives. So it's about stabilising the situation and you might then have to rely on expert help for managing the cardiac arrest, such as -- a cardiac arrest due to overdose is actually quite difficult to manage once they're in cardiac arrest. And that would require an advanced team in an acute hospital setting. But what we can do is give them the skills and knowledge to, as I say, take the ligature off and if they're in cardiac arrest then they just manage that in the format that the ILS gives them. It's a very transferable level qualification.

Q. Okay. Can I just ask you, again, some specific questions about the scenarios. So three of the

scenarios, including the ligature scenario, include in the description of the patient of reference to pallor.

A. Yes.

Q. And as I understand it, tell me if I'm wrong, is pallor being used here to describe paleness?

A. So when we look at pallor we certainly do. I'm just seeing if we've got the materials here. I can't see them. Yes, so you're looking at an element of perfusion can be seen in skin colouring. What we're very much moving to, and understand and are very much aware and certainly this a lot more prevalent in medical literature that actually pallor is not necessarily a reliable indicator for individuals with certainly darker skin tones and black skin tones.

There are ways that we can assess elements of cyanosis, which is where you've got low blood option levels because the pinker elements of skin, very much like the pink skin within your mouth, the mucosal membranes, will show if that's got a little bit of a bluish tinge, but we're moving very much away from using colour as an instigator for assessment because it's a poor indicator for darker skin tones.

Q. That answers several more of my questions, in fact. So you're moving away from that because would you -- does your current training then not reflect those differences

and those --

A. We have it as an awareness. But we also say -- ask people not to rely on it. And we give that rationale as why you shouldn't rely on it either.

Q. Moving away from pallor, can I ask you about petechial marking, do you agree that petechial marking which sometimes occurs when someone has applied a ligature, is also not as prominent on darker skin tones?

A. That is correct.

Q. And you say you're moving away -- and will then future RCUK material address the limitations not only from pallor but also in relation to petechial markings?

A. Absolutely, and that's already in our course manuals.

Q. Perhaps it follows then that you would agree that warning should be incorporated as regard the limits of those sorts of visible checks and in particular pallor and bruising?

A. Absolutely.

Q. Staying just with features in particular to darker skin tones for a moment, do you also agree that darker skin tones do not prevent oximeter machine readings but those readings can overestimate blood oxygen levels in people with darker skin tones?

A. That is correct and there was a patient safety alert to that effect a good few years ago.

Q. Is there anything within your literature or your training that covers that point and informs staff of the limitations or assumptions that should or shouldn't be made in relation to darker skin?

A. Yes, we have a paragraph relating to that within our assessment -- recognition of management of deteriorating patient chapters in our manuals.

Q. At paragraph 13 of your witness statement, which is when you give some of your introductory remarks, you explain that:

"the underpinning principles for CPR are consistent across patient groups. However, there are clinically important differences between adults and children and infants."

A. Correct.

Q. Would you agree it's also important, certainly if you're considering early recognition as a fundamental principle, would you agree it's also important to address perceptual bias in recognising clinical signs in black and people with other darker skin tones?

A. Yes, and certainly that's within our course materials, and that goes across the board for any age of assessment.

Q. You've already explained that you think monthly drills, or I think I may have said monthly, but that drills are

a good way of embedding this simulation or the simulated practice -- sorry, I said monthly. How often would you say drills should be carried out?

A. Again, that would be down to an organisation's choice, but more frequent is better than less frequent.

Q. And would you agree that if a provider was going to be using unannounced simulations, that it would be important that they would, say, take place at different times of the day?

A. Absolutely. The -- my personal preference is always unannounced because when you tell people that you're going to do them, because we are -- or the healthcare system, it's full of busy clinicians, by indicating that at a certain time, certain day, you're going to be doing this, people then opt out because you're taking them away from clinical care but actually this is just as important as clinical care so the unannounced element is much, much better for realism.

Q. So day and night?

A. Day and night.

Q. Ideally. And including agency or other temporary staff?

A. Anyone who would be working on that shift, if you put out an emergency simulation, they should take on a role within that simulation.

Q. So it should be at weekends, as well, for example?

A. Any time. Because you're not just assessing clinical knowledge; you're assessing the robustness of the response system, which has to work 24/7.

Q. In terms of frequency of training required for staff, I won't go back to it, but we've seen in the standards, I think, that you say at least yearly or there's a yearly --

A. Correct.

Q. -- training and update. Again, the Inquiry has heard evidence from a staff witness who considered he thought that ILS should be done twice a year, "because when you need to resuscitate you only have one chance to get it right, and as mental health nurses, we don't need to resuscitate very often". We've come back down to that. Would you agree with that, would you agreed that twice yearly might be optimal?

A. For areas where they have low instances, we have to remember that skill does degrade over time if you're not using them so having more frequent training would be beneficial to the workforce. What the duration of that training might look like, I'd leave down to the organisation to decide.

Q. So is that likely to feature in any review of your standards -- (overspeaking) --

A. We do say that at least yearly or more frequent

depending on local need, and that training may not be a standard ILS course every six months, say, but it could incorporate other learning strategies and techniques to help reinforce that education.

Q. So kind of refresher update --

A. Absolutely.

Q. -- in the meantime. Other evidence the Inquiry has received, that in one particular case, seven out of ten staff members were not compliant with their mandatory training. In those sort of circumstances, might you consider even more regular training than twice yearly?

A. That's a great question and one that NHS England are currently looking into themselves about frequency of mandatory training and potentially reducing the amount of mandatory training that clinicians face. The challenge there is it's often not the willingness or unwillingness to attend the training; it's usually because there may be something like a staffing issue in the environment where it's then deemed it's not safe for an individual to go and attend their training because patient clinical need will always take a priority. So there needs to be a way of looking at the system to enable that opportunity for those individuals to meet that training requirement.

Q. I'm going to move off training for a moment now and just

on to the most recent and up-to-date equipment and drugs list. I'm not going to look through them in detail but I just want to ask you one or two questions. That's your exhibit ABC 6 and if we could have that up please and on page 1.

The first point is in relation to drugs and equipment, is that service providers must ensure that their staff have immediate access to appropriate resuscitation equipment and drugs, which is perhaps an obvious place to begin.

And I think it also goes on to say that:

"The defibrillator sign should be used so that everybody knows where to find the defibrillator."

A. Correct.

Q. I think you've already dealt with my next set of questions, if we look at 2, which is that:

"All settings must have a means of calling for help, (eg landline, telephone, [internal or external], mobile telephone with reliable signal, or alarm bell)."

And you've already given evidence that should be very much part of any drill or process so that people understand how that works.

A. Correct.

Q. You don't, as in RCUK, you don't mandate a mobile telephone, do you?

A. No, we don't. We have it as an option if that works for the local environment but we're very acutely aware that mobile phone technology may not work in every environment, but as long as the organisation has a robust way of summoning help, that works, is tested, and if it fails, they have a robust system in place to still enable that emergency response, that's the key thing.

Q. Yes, it's a means for calling for help, and all staff need to know what it is?

A. Absolutely.

Q. If it's a phone, it may sound obvious, but where that phone is?

A. *(The witness nodded)*.

Q. The number to call?

A. Correct.

Q. The number to call if there's an outside line required?

A. *(The witness nodded)*.

Q. And can I ask you this: whilst you don't mandate a mobile phone, it's important, isn't it, that the phone is portable, that it can be carried to the site of the patient?

A. If that's a requirement of the organisation, absolutely. One of the challenges with portable phones is they need to be charged. So at some point that device itself

needs to be plugged in which means you may not be able to take it around with you. So not every device works perfectly in that sort of sense. But as long as there is a system and process, so that when an event happens, there's no delay in getting that response to a -- particularly if it's a 999 response centre, that you are able to give that correct information to the call handler who can send the most appropriate response to the individual.

Q. That's what I was going to ask. How can that be done if the phone or the person on the phone isn't with the patient?

A. Mobile phones aren't without their risks in mental health hospitals and that's the challenge we have to think about, the risk/benefit for -- if you're -- if you've got a device with you which could then become problematic for delivering patient care. It's all very much down to that localised risk assessment.

Some organisations have emergency call bell buttons which go straight through to an emergency service. Others may have that 2222 system and strategically placed phones within the vicinity. It's just about having that knowledge and awareness of that process on how quickly to get that response out --

Q. But you don't --

A. -- in a safe environment.
Q. But you don't think it is essential for a person to be able to take instructions from, for example, the Ambulance Services with the patient?
A. But again, they certainly can do, and depending on the situation, they should do. But that's why you need that -- you know, that ILS sort of level clinical response so we can be maintaining elements of resuscitation. The Ambulance Service will provide more advanced level resuscitation, which may be out of the skillset of the individuals to deliver. So the call handler wouldn't be instructing people to do advanced-level resuscitation over the phone, but as long as that message goes to the call dispatch that there is a cardiac arrest and therefore that that rapid response ambulance can be sent to your location, that's the key thing, but it's minimising that time from recognition to placing that call.
Q. I understand.
A. That's where the gaps will need to be shortened.
Q. You've already given evidence that people should know, and in fact you've suggested a huddle at the beginning of a shift, that people know whose responsibility is what, which presumably would include who is going to call 999 or who is going to -- you know, which roles

people are going to assume. Should that also include who is going to let the paramedics in, for example?

A. *(The witness nodded)*.

Q. Who is going to do the door, or who knows the door code?

A. Absolutely. And those types of things don't need to be limited to clinical members of staff, that's how you can incorporate ward clerks and ward administrators to help guide and help support because in some of these areas, particularly high, sort of, locked-down areas within mental health hospitals it's really important that part of the delay is not getting through the building to provide that life-saving support.

Q. So there needs to be a process for that?

A. Yes.

Q. All right. Again, jumping to a slightly different question and going to the equipment list, and this is at page 4 of your ABC 6, there we are. So this is the list of equipment suggested availability and this is in the airways section, I think, for adults.

A. Correct.

Q. And it suggests that ligature cutters should be immediately available on adult wards. As we can see, it's the number 1. Before I ask you about ligature cutters, why is there not a similar requirement for paediatric CAMHS wards?

A. There should be, and that will be corrected.
Q. That will be corrected, did you say?
A. And it will be corrected.
Q. Does RCUK consider that all staff should carry ligature cutters?
A. Again, it's that risk-benefit ratio in those areas where it's higher risk, either having identified in a key location, or key locations -- there should be more than one so you're not traipsing around the clinical area looking for clinical cutters -- or absolutely that it might be seen as appropriate for individuals to carry them as well. But it's that risk-benefit ratio of: is it riskier holding a ligature cutter around in the areas or not, essentially depending on the patient cohort.
Q. Are you able to give any information as to your view on what would be a key location for ligature cutters?
A. It depends on the local environment. But you would want it somewhere accessible and central and safe.
Q. A further question, and I think it's on page 14, please, and this relates to drugs. This is where I think -- it's the -- maybe I've ... where are we? Let me start by asking this question, and then we'll have a look at the second part.

Naloxone is, I think, an accessible drug at the moment.

A. Mm-hm.

Q. Would RCUK consider revising the requirement for it to be accessible for it to be immediate on mental health (unclear) --

A. So the thing with -- naloxone has a short drug life anyway, so when you give to it a patient you're going to need to give several and subsequent doses afterwards. If -- so naloxone is also -- is a reversal agent for opiates, so morphine-based drugs. The reason it's there is because obviously it reduces your respiratory drive by making your respiratory rate drop. You can counteract that and manage that by good quality ventilation before naloxone even comes on the scene. But certainly that's why it's accessible rather than immediate because your first action would always be to ventilate that individual to give them those breaths.

Q. The part I wanted you to look at, sorry, on page 14, if you have it in front of you, is about the storage of drugs because you give a little bit of information about that at paragraph 42 of your witness statement and it's around keeping resuscitation drugs locked away. And we look at, it says when we look at point 3, it says:

"When deciding how and where to store emergency drugs, a local risk assessment is required to balance the risk of access to drugs by patients and visitors

against the risk of a delay in access to emergency drugs in an emergency."

That's probably self-explanatory. Sorry, it's now my fault. I need to slow down again. Apologies.

I think you explain in your paragraph 42 that this reflects a concern that arose, I think, some time ago --

A. Correct.

Q. -- when CQC inspectors advised that drugs on resuscitation trolleys should be locked away.

A. Correct.

Q. And I think you responded to that, and now you suggest a local risk assessment because it's important that key drugs are in fact readily accessible and not locked away?

A. That's correct.

Q. I think that can be taken down now. Thank you.

Just moving on now to some -- towards -- you'll be relieved some of the ends of the questions. Can I just ask you about the status of these standards and we touched on this at the beginning.

As you explain in your witness statement, at paragraph 38, RCUK do not undertake direct distribution of these to NHS mental health trusts or to private mental health inpatient providers, or indeed any sort of NHS provider; is that right?

A. Yes, so at the time that these were written initially, we had -- the organisation is small. We are a headcount of 40, which is very small for the remit that we cover. And obviously we're not a statutory, regulatory or accrediting body. So historically our method of communication would be with our core audience of instructors who would predominantly then be resuscitation officers or medics with that interest in resuscitation. We have a lot more -- a better communications and engagement team so that when we do this, the next time around, so this year, we have a greater sort of contact list of people within NHS England and any other devolved nations who to contact. We would certainly contact the Royal Colleges. We would contact like the British National Formulary, the Medical Health Regulatory Authority, so we've got a much, much more bigger impact of people to contact to ensure these get distributed within the organisation.

Q. So a much wider distribution for the --

A. Much, much wider.

Q. If they become the 2026 Quality Standards -- the 2026 Quality Standards.

We know, however, that you provide -- I don't know if "advice" is the word you would use, but you've set out in your witness statement at paragraph 78, and

you've been able to identify examples of when people have contacted RCUK for advice on interpretation of various guidance?

A. Correct, yes.

Q. If you are approached, or if you were to be approached, by individual wards or institutions, would you provide perhaps not training but training or advice on the location and storage and contents of standard equipment, for example?

A. So that's not something we'd be able to provide over the phone, you really need to have a detailed assessment of the environment. If we were to receive an enquiry like that what I would recommend is actually liaising with a local acute trust resuscitation team and asking one of those resus officers to go down and have a look and walk through the space with them so they can do that risk assessment together.

Q. So RCUK wouldn't do it but you might make suggestions of others where they could get the assistance?

A. Yes, correct.

Q. All right. So I think that perhaps answers my next question. So you yourself wouldn't go to specific wards -- as in you the organisation, not necessarily you yourself -- to assess the requirement to have multiple grab bags or particular equipment on that ward?

A. No, that's outside of our remit, unfortunately.
Q. All right. You also explain at paragraph 24 of your witness statement that you don't mandate the implementation of the standards?
A. Correct.
Q. And you don't operate any formal compliance or accreditation or assurance process in relation to their adoption?
A. Correct. We are a non-statutory, non-regulatory body. So we have no jurisdiction in this field.
Q. So inspection and regulation of resuscitation and the provision relating to resuscitation sits with those who regulate healthcare more generally --
A. *(The witness nodded)*.
Q. -- so the CQC --
A. The CQC --
Q. -- NHS England, to a certain extent, and those that regulate individuals, GMC, NMC, if you're dealing with particular individuals' actions?
A. Correct.
Q. You make clear that whilst the CQC have reference to RCUK standards, and we've seen an example of that, or you've given evidence about an example of that, you don't have any involvement in CQC inspections?
A. No, we have none at all.

Q. Not do you direct or inform CQC inspections?
A. We might get asked for our opinion on elements of what an assessment may or may not require. I can't think of any off my head, but it would be advice and guidance. If they chose to take it up, it would be down to the CQC.
Q. Okay, so they might ask you about what an inspection -- what might be required?
A. Correct.
Q. Are there circumstances in which they might come back to you and say, "This is what we found, what do you think about this?"
A. To my knowledge, that's historically never happened within the organisation.
Q. Do you think there's a role for an independent body to oversee the implementation of your standards?
A. I certainly do think there is an element for that. Resuscitation is one of those elements within healthcare which is so important, vital, recognising my own bias as a resuscitation specialist, but actually it can often be almost a, you know, a secondary thought in certainly it's another thing we have to do in terms of training but, actually, if we want to make that change and increase survival, then having some form of monitoring system would be much more beneficial above and beyond

what is sort of standard auditing at the moment.

Q. Similarly, then -- and we've already seen and you've given evidence about the fact that RCUK recognises challenges with the implementations of the standards in mental health inpatient settings. Would you consider there's a place for additional guidance and support for mental health inpatient settings, as to how to implement your standards?

A. Certainly, and that's something we can work with our community of practice to help give options and suggestions to individuals. But if there is a great and global area or challenge, then this is something that NHS England should be looking to help support and reduce that sort of inequality.

Q. I suspect we'll be asked to slow down again in a moment -- no, it's my fault, so I'll go through the other questions slowly.

In your view, what is the best way that a Trust could be monitored regarding implementation, compliance, accreditation? Both internally and externally?

A. Currently I think that needs to sit with the CQC or NHS England.

Q. I know you've indicated in evidence that it hasn't happened historically, but would you consider -- and you've just told us you're a small number, 40 -- but

would RCUK consider, if asked, providing representatives to join CQC on visits or inspections or to provide specific recommendations?

A. We would be more than happy to have conversations with them to help guide and advise. Within that organisation of 40, I have a clinical team of about six, so it's -- that would be a very difficult task for us to go and assess or go along with them to assess. A part of their overarching assessment, because it is one little section, although albeit a very, very important, about the whole governance they're looking at for a hospital or clinical area. But we can certainly have a conversation about what a good assessment looks like and what should be happening.

Q. And given the small number, I may know the answer to this next question, but do you consider it would be helpful if you did have some form of statutory power to ensure compliance with the guidance and the standards?

A. I would love that ability, but it's probably not within my gift to say, yes, or no without the trustees saying that, but I can certainly say that as we are the expert body in resuscitation within the UK, we would be ideally placed to help provide that level of assurance.

Q. In terms of -- yes -- in terms of compliance, your standards record as a "must", and we've been through

this, action that healthcare staff receive resuscitation training at regular intervals. We've been through that.

Again, turning that on your head, if staff who are working in -- or who staff -- sorry, working in mental health inpatient units who are not up to date with their training remain on the wards, if that makes sense, whether that be ILS or BLS, would you consider that a breach of your standards?

A. Certainly we would want enough training on that area to make sure it's safe for patient care.

Q. That was my next question.

A. And that's the key thing. It's about safety.

Q. Because it would create a risk to public safety, wouldn't it, in your view?

A. Exactly. And the kind of example I would give there is our certificates are dated. They're valid for a year. And someone who is two days out of that validation date suddenly wouldn't lose knowledge so there's that mitigation sort of risk whereas someone who may not have had training for five years, that would be a much greater concern, but it is about being overarchingly maintaining that patient safety and being able to provide that appropriate response.

Q. And finding the balance between the need for compliance with the mandatory resuscitation training, and you've

already given evidence about this, with the need to ensure there is sufficient staffing levels?

A. Correct.

Q. Even if those staff may potentially be out of date on their training?

A. I would -- well, the date element is really key. Because you can be out of date one day post or you can be out of date, as I say, five years, and that would be a much, much greater concern.

Q. Would you consider issuing further guidance for Trusts that disregard or that they don't use non-compliant staff?

A. That's a difficult question to answer because, again, it's about one element of their role against their whole role within that department. And by taking away somebody, you might then cause other issues and a clinical risk within that environment.

Q. Do you provide any guidance on staffing levels and staff allocation?

A. We don't, that's outside of our remit.

Q. Would you consider agency staff generally undesirable because of the risks around the training and the risks around the fact they haven't been training or haven't done simulations with the team? Sorry, that was probably two questions in one.

A. Again, it's a difficult question to answer because I don't think -- I can't remember the word you used for the beginning part of that question, sorry, but I don't think agency staff are undesirable, again, because resuscitation is only one part of their role whereas, actually, the needs of the environment can be quite great depending on what's needed in that ward area and therefore they do serve a benefit, you know, agency staff keep the NHS afloat in a lot of clinical areas and they're very much considered as part of the team.

We know that teamwork works better in these sorts of skills and drills as we talked about when you're using the same people so they get used to the processes, and they can be a challenge if you have an outsider within that or even a newly employed member within that area, who is not familiar with those sorts of skills and drills or the procedures. But that's about making sure that the induction process to that area is more -- is robust.

Q. I'm going to finish with just a couple of separate topics and the first is the question of data collection. I think, if we, with reference to paragraph 114 of your statement, it's right that RCUK do not undertake monitoring of individual cardiac arrest incidents?

A. Sorry, say that again, sorry.

Q. That you don't take individual monitoring of individual cardiac arrest incidents?

A. Correct.

Q. But there are two bodies that do?

A. Correct.

Q. The National Cardiac Arrest Audit and the Out-of-hospital Cardiac Arrest Outcomes Registry?

A. Correct.

Q. And you've noted, I think, in your paragraph 135, a limitation in the availability of national data specifically relating to resuscitation events within standalone mental health inpatient environments?

A. That is correct.

Q. Because there's no body that's -- with a remit for collating or analysing that data.

A. There's no body but there's also challenges in, if I look at the National Cardiac Arrest Audit, their criteria for entry on to the audit criteria, mental health hospitals, unless they're part of an acute hospital site, they may not get entry on to the register. So there does need to be a specific way of gathering and collecting information from this patient cohort, certainly.

Q. I mean, the long and short of it is that at the moment the result -- the trends and outcomes of cardiac arrests

in mental health inpatient units cannot easily be analysed?

A. That's correct.

Q. And they can't be compared, really, with either the OHCAO Registry or the NCAA Registry?

A. Correct.

Q. Okay. Audit and review. I won't ask that it be put up for speed purposes, but section 12 of the Quality Standards relates to audit and reporting after a CPR event.

A. *(The witness nodded)*.

Q. And standard 2 provides that:

"All CPR attempts must be reviewed."

A. *(The witness nodded)*.

Q. "When appropriate a root cause analysis must be undertaken and the action plan implemented. A suggested guide for reviewing cardiac arrests is available in the supporting tools below."

Now, can you confirm that the supporting tool in fact is the tool that refers on the --

A. Correct.

Q. -- that appears on the next page?

And that if the answer to any of the questions in that supporting tool raises a concern, the tool recommends a full root cause analysis and action plan.

A. Correct.

Q. None of the questions expressly state or suggest that immediately following the event, an accurate and detailed record should be made of the timings of key events such as when the patient was found, when the emergency alarm was activated, when an AED was applied, et cetera. Do you have detailed guidance on what information should be recorded immediately after event?

A. There should be evidence about what to document during a cardiac arrest which goes through those processes. Because that forms part of your requirements as a healthcare professional for documenting -- or the legal requirement for documenting the care you give during an event. So there are elements within the Quality Standards which say about the location, time, onset of rhythm, what drugs were given, CPR started, all those types of things and along with any other pertinent medical history.

Q. They don't reference what I'm going to call preservation of evidence, or of items. So CCTV, other recordings, retention of the ligature.

A. No.

Q. Do you think they should?

A. The -- that's a good question. If it's there and it's relevant to the patient's medical records, absolutely.

Certainly the preservation of the knot of a ligature is often quite important, but there's no reason, as long as it, you know, it fits within the requirements of GDPR in that sort of sense, you know, you're not monitoring other patients, but there's no reason why it can't be put into a medical note as a reference.

Q. And do you think guidance might be of assistance in that regard?

A. It could be. It's outside of our sort of scope of practice to say what should or shouldn't in that sort of sense, but it certainly could be looked into.

Q. Have you considered developing specific quality standards or guidelines for auditing resuscitation attempts?

A. We've -- we have some guidance within the Quality Standards but we don't have a set national standard for the requirements for an audit. That very much sits either with the National Cardiac Arrest Audit or the Out-of-Hospital Cardiac Arrest Audit, but they do follow a set template called the Utstein template or formula which looks at the, you know, the rhythm, you know, if you got return to spontaneous circulation, survival to discharge, and those types of things. So there are sort of recommendations in other documentation.

Q. In terms of review and audit, can I just ask about what

you would expect to happen immediately after a cardiac arrest on a mental health inpatient ward. Are you aware of the concept of a hot debrief?

A. Hot and cold debriefing, yes.

Q. Can you explain in a sentence what a hot debrief is?

A. So a hot debrief is one that's done directly after the event. It's a touch base just either to have a quick lessons learned about what's happened, to look at what's going to happen next, restocking of the trolley, you know, these types of things that need to happen immediately. That then feeds into the cold debrief which often usually happens afterwards and is much more structured and organised, and that's where you start looking at the detailed root cause analysis about what was going on with the patient, were there signs of deterioration? Were there, sort of, organisational or was it healthcare-related instances which may have contributed to the cardiac arrest that we know of?

So we look to identify where errors may have happened to try and reduce them but also to look for areas of good practice to reinforce those going forward.

Q. That's kind of a wider ward-level debrief?

A. Yeah, much more. Much more in-depth looking at the ward and procedures.

Q. Do you then consider that any learning from cardiac

arrest events should be disseminated to all the staff at --

A. Absolutely.

Q. Do you have any opinion or views as to the best way of sharing learning in that sense?

A. It very much depends, again, on the organisation. Very acutely aware that if people just send constant emails about learning, they may or may not get read. So it depends on what works well for that organisation. Do they have regular team huddles? Do they have ward-based team meetings where information and learning can be shared? It kind of depends on the communication system that works better for that hospital.

Q. Have you ever considered recommending that organisational audits are shared with you, RCUK, so that you contract national learning from cardiac arrest incidents on mental health inpatient wards?

A. Not something we've considered. But again, we don't collect data on, you know, those sorts of granular stuff from individual organisations. We look at sort of wider, published data, but if there were a national audit set up, then that would be something we'd be really keen to look into.

Q. Just then coming to the end of the questions I have to ask you, you've already given evidence that the Quality

Standards are being reviewed this year?

A. Correct.

Q. You've already alluded to changes and matters that are going to be addressed as part of that process. How dramatically do you expect those standards to change, then, when they're reviewed?

A. A good question. The -- when we -- as an example, when we update our clinical guidelines, we give organisations up to a year to get them embedded, generally. That's our recommendation. We'd probably follow suit with clinical Quality Standards. The reason being if there's a change in policy, that needs to be learnt and disseminated and education needs to happen across an organisation because if we change a document, and an organisation changes, we need to make sure that people on the shop floor, so in those wards and clinical areas, know what's happened, and what's changed and what's why. So we need to give time and flex for that to happen but I would certainly expect it to change within a year.

Q. Within a year. At paragraph 134 of your witness statement, and you've alluded to this, as well, as we've gone through your evidence, you've set out that RCUK recommends that the ongoing NHS England review of statutory and mandatory training requirements should consider ILS training as a minimum standard within

inpatient mental health facilities proportionate to local risk assessment and service configuration.

A. Correct.

Q. Why do you consider it's important that the NHS England review considers this change in minimum standards specifically?

A. So the NHS review, NHS England review, they're looking at mandatory training across the board and part of that is also looking at resuscitation training. And what we want to ensure that quality isn't dropped, and it doesn't become an exercise where everyone then just learns about basic level life support but we want to ensure that, you know, safety is paramount within the workforce. So we want to ensure that clinicians have that understanding of recognition of deteriorating patient. We want them to be able to provide good-quality or high-quality CPR and safe defibrillation.

ILS, for us as an organisation, really is that standard about how you manage the event locally to help support the team before the more advanced team arrive, and taking elements of that away, would actually possibly compromise patient care. Certainly when we look at all the stuff we've talked about today, particularly when you look at tranquilisation and stuff,

that's the element, the standard we would want to maintain and deliver.

Q. And would that include healthcare assistants, then, in terms of a recommendation that all clinical staff or frontline staff are provided with that ILS training?

A. If it's appropriate for their clinical role, absolutely.

THE CHAIR: If it's appropriate for?

A. Their clinical role.

THE CHAIR: I'm just a bit -- I'm struggling a bit as to where you land on all of this. Because earlier you had implied that you weren't actually pressing for ILS for all healthcare assistants, other than those with an interface with patients. In a mental health setting, can you envisage -- can you actually envisage that there wouldn't be a necessity for all healthcare assistants, given what you've told us, to be trained to ILS standards?

A. As I say, it very much depends on what their clinical role is within that organisation, because what we certainly understand is that the role of the healthcare assistant can be very varied depending on where they work and what their role is and what they're doing. Certainly if there's an expectation for them to be involved with managing or supporting a deteriorating patient or even the people recognising that

deterioration has happened because they are the only person looking after that individual whilst being supported by the team, then absolutely certainly.

If there is a broader requirement that actually says for the safety element for all patients that it should be a global, everyone should have ILS, we'd be very, very supportive of that, but we recognise that not every healthcare assistant works in the same sort of way across the organisations depending where they -- what their clinical role is.

THE CHAIR: Okay, thank you.

A. But what I wouldn't want to do is disadvantage patient care by saying that everyone needs training which could also then become a bottleneck into training, but also by not allowing people to access training who should be -- or should be, if that makes sense.

MS HARRIS: It does, but could I pick up and ask this, then: would you say that everybody needs ILS training if they are potentially a first responder?

A. Yes. That is a very reasonable request, yes.

Q. And could you make that recommendation even if NHS England didn't?

A. We certainly would do. Our position wouldn't change, you know, in that sense we will happily make recommendations to training, to practice, to clinical

guidelines, even if there were changes within NHS England which may go against that sort of recommendation. But we're working with them to help guide and advise and support so hopefully that wouldn't be the situation.

MS HARRIS: Thank you very much, Mr Benson Clarke. That's all my questions -- unless, Chair, you have anything else --

THE CHAIR: I haven't.

MS HARRIS: -- you would like to ask?

What happens now is we have a 10-minute break to see if there are any other questions from any others that have arisen during the course of your evidence. And if there are, we will come back. And if there aren't, we won't. So I will say very much for helping us today.

THE CHAIR: I'd like to reiterate those thanks. Thank you very much.

THE WITNESS: Thank you very much.

THE CHAIR: Thank you.

(3.00 pm)

(A short break)

(3.15 pm)

THE CHAIR: Thank you Ms Harris.

MS HARRIS: Thank you, Chair.

Thank you, Mr Benson Clarke. Two short matters.

The first matter is returning to your evidence about skin colour or darker skin colours, and pallor and petechial markings being a poor indicator or not being a reliable indicator in persons of darker skin tones.

In terms of your current training materials, do any of those training materials make those limitations clear?

A. It's within our course manuals that there are limitations. We go into quite some detail. The challenge within course materials is that a lot of the mannequins are historic and they are very Caucasian-looking. Manufacturers are bringing our more different-coloured mannequins to reflect proper skin tones, so essentially the scenarios become quite generic in that sort of sense because it's -- it's disrespectful and a little bit discoherent to say that: I want you to imagine that this white mannequin in front of you is a different shade than what we would like it to be, and recognising that actually that does patients a massive disservice. So once the equipment matches up with the requirements, we will certainly be able to do that.

Q. You've already indicated you're moving away from that in any event --

A. *(The witness nodded)*.

Q. -- and, I think you indicated that future materials are

likely to be updated or future standards are likely to be updated?

A. Absolutely. Much more reinforcement of that as a sign that people need to be much, much more acutely aware of.

Q. And is there any more that should be done before updating those materials?

A. As I say, it's within our course manuals which every candidate who is on a course gets and as we go through those detailed assessments, we talk about differences within skin tone. Anaphylaxis is a great example where you might get hives and flushing on the skin. Well, that is not going to be present. So we talk about how to spot different signs and symptoms to confirm your diagnosis.

Q. Okay.

Slightly separate topic. The standards do not mandate that a doctor on call or, indeed, any healthcare professional on a ward should hold the ALS qualification, but appears to assume a prompt response by ambulance crewed with a paramedic, and we've already heard or you've given a lot of evidence about how, particularly, given the geographical location of mental health inpatient care, the urgent -- prompt response, apologies, or the expert help is likely to be paramedics, ambulance service, or perhaps

a resuscitation team if collocated.

Do you have any concerns about the fact that the standards don't mandate that the doctor on call should hold an ALS qualification, or do you think, in the circumstances, and given the particular circumstances of mental health inpatient unit, that at least someone on duty should have the ALS qualification which allows for advanced airway management, for example, in case there is a delay in the ambulance or designated resuscitation personnel attending?

A. So what we do say, within the Quality Standards, it's within the training -- yeah, training starts at section 3.21, that members of mental health resuscitation teams that have specific involvement in resuscitation, particularly team leaders, require a level of training above and beyond provided by local ROs. These people should be encouraged to attend a nationally recognised course such as advanced life support.

So we do make the provision that if you're going to be the team leader of a cardiac arrest and you've got that advanced level or an expectation of advanced level skills such as like being a doctor then you certainly should have that ALS-level training.

Q. But that's a slightly different question, isn't it, than

this one, which is: do you think that a person with that level of training should -- there should always be a person --

A. Oh sorry --

Q. Sorry, I may have asked it badly -- that there should at least be somebody on duty on the ward or in that mental health inpatient setting who has that level of qualification, given the challenges in getting expert help in?

A. Certainly there should be someone, if you're having a cardiac arrest team, for the hospital, then you should have someone with that level of qualification.

Q. Again, I don't think that's the question. The question is: given that in mental health inpatient care you are more often than not, or certainly very often, relying on a 999 telephone call or a team coming in from another location, in those circumstances, do you consider that there should be one person on duty in the unit who has got that advance level training?

A. When you say "unit", do you mean --

Q. The mental health inpatient unit --

A. -- the ward or the hospital?

Q. Well, if it's -- if it's -- it's different, isn't it, because you're talking about a hospital, I suppose, if they're collocated.

A. Or --

Q. I'm asking you -- if it's a mental health inpatient unit, which is not collocated --

A. Yeah.

Q. -- with an acute clinical setting and therefore there may be a delay in the expert team arriving, in those circumstances, what would RCUK's view be on whether there should be a person on that unit on duty as part of the staffing rota, with that ALS training?

A. So sorry, my clarifying point was that they're often not isolated wards when they're in their own mental health facility, you might have several wards together, and it's whether or not you're saying they should have one person on every shift in the ward or within the building at a time, sorry --

Q. Within the building. It's my fault.

A. Within the building. So certainly I would say that would be one of our highly recommended elements that the medical cover certainly could do and should do, recognising that within their training they would have gone through acute care, an element within and therefore that would be an appropriate level for them.

MS HARRIS: Thank you. Those are my additional matters. Chair, did you have any --

THE CHAIR: No, thank you very much indeed.

MS HARRIS: I'm asked now if we can have a break until 3.40, at which point the evidence of Beverly Switzer will be played.

THE CHAIR: Thank you very much indeed.

(3.22 pm)

(A short break)

(3.46 pm)

THE CHAIR: Good afternoon.

MR GLANVILLE: Good afternoon. Chair, this afternoon we are playing the evidence of Beverly Switzer, a member of staff at EPUT. Ms Switzer has given oral evidence to the Inquiry by way of a pre-recorded session, which you granted on the basis of special measures.

Please could we play the video.

(Pre-recorded evidence of Beverly Switzer)

MS ONABANJO: Could you read the words of the affirmation.

BEVERLEY SWITZER (affirmed)

Questioned by MS ONABANJO

MS ONABANJO: Thank you.

Could I remind you to please keep the pace slow so that the stenographer can transcribe the proceedings. Thank you.

Can you state your full name for the record, please.

A. Beverly Susan Switzer.

Q. And you have provided one witness statement to the

Inquiry, dated 7 June 2026; is that correct?

A. Correct.

Q. And you have a copy of that statement in front of you?

A. Correct.

Q. And the final page of that statement, at page 8, bears your signature, and a statement of truth?

A. No signature.

Q. Your signature has been redacted.

A. Okay, thank you.

Q. But you confirm that that is your signature -- that that is your statement?

A. Yes.

Q. Have you had an opportunity to read it recently?

A. Not recently.

Q. Do you confirm that the contents of the statement are true to the best of your knowledge and belief?

A. To my belief, yes.

Q. And are you content for that statement to stand as your evidence to the Inquiry?

A. Sorry?

Q. Are you content for the statement to stand as your evidence to the Inquiry?

A. Yes.

Q. Thank you.

I will start by asking you questions about your

qualifications and your experience. You say at paragraph 2 of your witness statement that you currently work within EPUT Dementia Services?

A. Correct.

Q. Is that correct? And at paragraph 5 you say that you started working at EPUT Community Dementia Services in 2022; is that correct?

A. Yes.

Q. Thank you.

Do you recall what month you began working at that service?

A. To be honest, no. I keep thinking, was it the August or was it the February? Around that time. I think it might have been the February, March time.

Q. Thank you.

What is your role? What is your current role within EPUT Community Dementia Services?

A. I am a healthcare assistant as well as, now, being a -- apprentice nursing associate.

Q. And as a healthcare assistant, what kind of tasks do you undertake in your role?

A. I generally do the initial memory monitoring, and that is monitoring medication that patients have been put on after having a diagnosis of dementia. It's also to see how they're doing, how the families are doing, whether

they need extra support with OT referrals, Adult Social Care referrals, if they're having any side effects with their medication, if there's any behavioural issues that we can refer to the dementia services, the DST office, or even the Intensive Support Team, and I also do ECGs.

Q. And when you say the "DST office", what is --

A. Dementia Support Team.

Q. Thank you.

Prior to your role, your current role, you worked at the Peter Bruff Ward, didn't you?

A. Correct.

Q. And you worked there -- you began working there in August 2020?

A. Correct.

Q. What was your role there?

A. Healthcare assistant.

Q. And at that ward, what types of tasks did you undertake as a healthcare assistant?

A. Physical observations, level 1s, 2s, and 3s. Obviously engaging with patients, supporting them if they need any support with personal care, being a voice for them if they needed to speak up but didn't feel like they could.

Q. Thank you.

The focus of my questions today would be about your time at the Peter Bruff Ward. Before I move on to my

next set of questions, I'll just like to remind you again to keep the pace slow for the benefit of the stenographer. Thank you.

Prior to working on the Peter Bruff Ward, I note from paragraph 3 of your statement that you say you were a Senior Healthcare Assistant at Cambian Fairview, which is now Cygnet Care; is that right?

A. Correct.

Q. I note that you were a Senior Healthcare Assistant there. Did you have experience prior to working in that role?

A. In -- what, within Cambian?

Q. Within healthcare.

A. Yes. I've been doing healthcare since 1997, and that was with mainly learning disabilities, autism. And --

Q. And was that, similarly, as a healthcare assistant?

A. Yes.

Q. Thank you. And so you have substantial experience as a healthcare assistant?

A. Yes.

Q. Thank you.

Turning now to the Peter Bruff Ward. What type of ward was it? Was it an acute ward, an inpatient ward? And what types of patients did you see on that ward?

A. It was -- when I first started there, it was an

assessment ward. It was originally designed as an assessment ward. So patients would come in, they'd be assessed, and then -- as to whether they were to go home with treatment or whether they were to be forwarded on to a different ward for longer-term care.

Q. And were these both male and female patients?

A. Male and female, yes.

Q. And do you remember what the size of the ward was? How many beds were on the ward?

A. I think it's 17 or 18-bedded ward. And we also had, like, an isolation bit as well. Like, it's not -- it's like a -- the only way I can describe it is like a seclusion bit, where someone who -- sorry, someone that was -- the people that I saw going there, that were violent, aggressive, and things like that.

Q. You've mentioned that it was designed to be an assessment ward?

A. Yes.

Q. And you say at paragraph 6 of your witness statement that:

> "... due to a lack of available beds on ... longer stay wards ... patients would be there for longer than ... planned."

A. Yes.

Q. In your experience, how long were patients typically

admitted onto the ward?

A. It could -- it varied from patient to patient. I knew of patients that had been there for a few weeks; I knew patients that had been there for a few months. The longest patient I can recall is nine months.

Q. In your experience, if it was functioning as an assessment unit as designed, how long would you have expected patients to remain on the ward?

A. This is my own personal preference, I must add, but you would expect a week, sort of, like, seven days, because then a bed may have become available for them to go into, or they're getting the right treatment into place for them to be able to return to their own home.

Q. What impact did these extended stays by patients have on the ward, in terms of patient care and, for example, the availability of therapeutic activities for them and planning discharge?

A. Once again, it's individualised, isn't it, to each patient, I believe. I've only ever worked on the -- Peter Bruff. I've never worked on any of the longer-term wards. So I don't know what benefits they would get on the longer-term wards. I can only go by my experience, so I honestly couldn't answer that.

Q. Thank you.

the Inquiry has heard evidence from Zoe Bunting,

and she was the Ward Manager at the Peter Bruff Unit from November 2020 and she became Acting Manager -- Acting Matron, I apologise, in 2022, and so is it correct that she was the Ward Matron, or Ward Manager, or Acting Matron, for the majority of the period that you were working on the Peter Bruff Ward?

A. Yes.

Q. Thank you.

I will now ask you some questions about therapeutic activities and care planning.

At paragraph 8 of your witness statement, you say there were OT activities, so occupational therapy activities, throughout the week. Can you describe the range of activities that were available to patients on the ward.

A. It would be things to engage them, like ping pong ball. They'd be doing that -- arts and crafts in -- I'd say mainly it was around the arts and crafts more so than anything.

Q. And how frequently were these activities available for patients to access?

A. They were -- there was -- I can recall there used to be an activity list, weekly activity list, put up on the board, Monday to Friday, but there was times, you know, if the occupational therapist was off sick, these

activities wouldn't happen.

Q. Yes, and the Inquiry has in fact heard evidence from Zoe Bunting to say that the activity timetable was impacted by the availability of occupational therapy staff.

What impact did the non-delivery of therapeutic activities have on the patients on the ward?

A. Individualised, once again. You know, it's -- you know, with some, we'd try and find something else for them to do. You know, they would -- there's people that would purchase their own diamond art. So, you know, us, as healthcare assistants, if we could, we'd engage with them with playing cards. You know, inviting them to do their diamond art within the communal area. And trying to, you know -- obviously they were upset at the fact that what they were expecting wasn't happening, but it was obviously out of our control, so we'd try, as healthcare assistants, to put something else in place. But obviously with shortage of staff and everything, it's not always possible to give them that engagement in that way. That's why the occupational therapist people used to come in, to be able to that.

Q. Zoe Bunting has told the Inquiry that she noted a significantly improved atmosphere on the ward when the activity programme was fulfilled. Is that --

A. *(The witness nodded)*.

Q. -- consistent with your experience?

A. Yes, because it gave them something to look forward to.

Q. Thank you.

Turning now to care plans. You say at paragraph 21 of your witness statement that care plans were "person centred".

The Inquiry has heard evidence that, in practice, care plans were sometimes completed without input from patients or from their families, sometimes because of staffing pressures. Were you aware that sometimes it was not possible to involve patients and their families in care planning?

A. If the patient wasn't engaging, because sometimes you get patients that would come in onto the ward and they didn't want to engage, so then it became traditional planning. But obviously when they're on the ward, we would -- if there was -- you know, if they were -- they had a decision whether to take any medication that was prescribed for them, it was their choice to say, "No, I don't want it", but I was never involved in any of the planning at all. It was just we were able to read up the care plans once they were in place.

Q. You refer to "traditional planning". What do you mean by that?

A. Traditional -- there's two types of care planning. You've got person-centred and you've got traditional, which is what the professionals do. They come in: Right, this person needs that, they need that, they need that. So that that is traditional.

Person-centred is where the person is the one that puts their input as well. Everybody is involved.

Q. Are you aware of circumstances where the care planning wasn't -- the care planning wasn't person centred as a result of factors other than that the patient themselves weren't engaging? So, for example, were there circumstances where traditional care planning had to be undertaken because of pressures on staff?

A. I can't answer that one because I never was involved with the actual care planning.

Q. Thank you.

You say that care plans were updated by nursing staff, and you've just told me that you weren't involved in that. What arrangements were made to ensure that you, as a healthcare assistant, knew about changes to risk assessments, for example, or updates to the care plan?

A. Handovers. Handovers. Or if you was on shift and something happened where a risk assessment had to be altered, we would be told.

Q. And so, when you say, at paragraph 22 of your statement, that "Any changes or concerns regarding a patient's care plan being updated were always handed over from shift to shift" --

A. Yes.

Q. -- is that what you mean?

A. Yes.

Q. That updates and anything you needed to know, as a healthcare assistant, regarding the care to be provided to a patient would be told to you at handover?

A. At handover, yes.

Q. You also say that care plans were "easily accessed" via the records system on the ward. In practice, did you have time to review patient care plans?

A. Not always, no.

Q. And how often would you review a patient's care plan in full?

A. Me personally, if a patient -- a new patient came on, I would look at their care plan when it was all up on the system and obviously just to see for myself. But to look at it again, with updates, I would say I wouldn't look for updates, I was -- they were handed over.

Q. And in terms of not looking for updates, is the reason why you wouldn't look for updates that you would expect that any updates would be provided to you verbally, or

were there other factors, such as not having the time to read updates to the care plans?

A. Sometimes it was not having the time to actually sit there and read the updates. But generally, it was because it was handed -- you know, it would be handed over from shift to shift.

Q. And how -- in your experience, how full were those handovers from shift to shift? Did you -- were you able to get all of the information? Did you -- in your experience, did you get all of the information that you required in relation to the updates that may have been made to a patient's care plan?

A. I'll be totally honest -- yeah, the handovers was half an hour long, and I do personally feel sometimes that wasn't long enough to get a full spec of what had happened from the previous shift or from the previous few days. Because you'd be more mindful that the previous shift were waiting to go, so it's like sometimes it could have been -- I feel it could have been a bit rushed.

Q. And were other matters discussed at those handovers other than changes to care plans?

A. It was about how the patient's presentation had been, you know, how they'd been within the last 24 hours, generally. Or if there was something important that we

still needed to know on a daily -- that was left on the handover, or we were advised, you know, to have a look at anything that we needed to look at. But that was generally -- would be for the nurses on shift more than the HCAs.

Q. And in relation to observations, did you rely on the information from these handovers or would you use -- would you go to the care plans as part of your observations?

A. What do you mean, sorry?

Q. So, in conducting observations, for example, would you look to care plans or would you rely on the information that you obtained from handovers?

A. Me personally, would rely on information at handovers.

Q. Thank you.

I will now turn to asking you about safety on the ward. You have explained at paragraph 20 of your statement that you "had no concerns" about patients feeling safe, because no safety concerns were raised with you.

Were you aware of any formal processes, for example patient meetings, community meetings, through which patients were encouraged to raise their concerns about safety on the ward?

A. There was -- I don't know whether it was daily or

whether it was weekly, but there used to be what they called patient huddles, where patients could get together and talk about any concerns that they had, you know, quite freely.

And, you know, if patients came up to us with concerns themselves, individually, then we would either ask them -- or make them feel comfortable to address them to the Ward Manager and -- you know, this is me, personal, I would advise them, you know, if they want me to support them, I'll come in there with them. But I've never had any patient say that they didn't feel safe.

Q. And how frequently did the patient huddles take place?

A. I can't recall if it was daily or weekly.

Q. Who organised them?

A. The Ward Manager.

Q. And how well do you think that forum worked, in terms of patients raising their concerns and those concerns being addressed?

A. Ooh, I've ... there was never anybody come back to me to say "Well, I don't think anything's going to be done about that."

The Ward Manager would always -- everything would be written down and she would investigate, you know, if it was little things, and like -- generally it was about food, and stuff like that, you know, they're not getting

enough food choices, and -- that's from what I can recall.

Q. Thank you. And I'm only asking about your personal experience.

A. Okay.

Q. You say at paragraph 35 of your statement that:

"A patient's threats to self-harm were always treated seriously ..."

How frequently did you observe patients threatening self-harm?

A. Depending on what patients were in. You know, it's -- once again -- you could -- I would say weekly you'd have someone that was threatening. So it's about giving them the support, to be there with them, you know, to try and get them out of that mindset by getting them to express why they're feeling like it, and escalating it even further, like to the nurses, to making sure that they were aware.

Q. And you've said that -- you've just said that you would get other staff members involved, and in your statement you do say that if you felt you couldn't confidently manage a situation, you would get another member of staff to take over. What would happen in a situation where the ward was short staffed? How would that situation be dealt with?

A. You'd obviously, if the patient was feeling that way, we'd have to keep that patient safe, and it was about making sure you knew where they were. They would sometimes be -- if they were feeling that way and we didn't have the -- it's horrible to say, but if we didn't have the staff available to give that time, then they may have been moved up an observation level. So, instead of being checked once in an hour, they were checked four times in an hour.

Q. Thank you.

I now want to ask you some questions about sexual safety. Do you remember there being any incidents of sexual safety on the ward, either involving patients or involving staff?

A. No.

Q. And do you remember whether you had any training in relation to sexual safety?

A. We do, yeah, we do have training around sexual safety and, you know, raising alarms and whether we feel uncomfortable, reporting any concerns and everything. Whether it be patient, staff, patient on patient, staff to patient, and vice versa, we were always told to report it. But I've never experienced anything.

Q. And in your experience, did you understand the processes for reporting sexual safety issues?

A. Yeah.

Q. Thank you.

I will now ask you some questions about staffing on the ward.

At paragraph 24 of your statement, you say that staffing levels were adequate, but you also note, in the context of carrying out observations, that sometimes staff could be stretched. You recall missing breaks, and there were occasions on which management could not secure bank or agency staff to provide additional support. And you say that:

"This would cause burn out for some staff resulting in absents. I have known staff turn over to be quite regular on the ward myself only being there for 2 years before moving on."

How frequently would you say you missed breaks as a result of staffing pressures?

A. Not regularly missed. We would -- it wouldn't be, like, once a week or twice a week, anything like that. It would be on the rare -- it was a rare occasion that we'd miss breaks, but there were times where we did miss breaks because, you know, staff had come in and they'd gone home sick. And at the site we had what was called a site buddy, which is an extra member of staff for where they were needed. They could have been put onto

another -- one of the wards, because there was only ever one site buddy, so it was a case of: we'll continue doing the obs. And we just looked after each other when we were still there.

Q. When you say that the turnover was quite regular, how frequently would you say staff turned over?

A. When I started there, it was like -- about one, two members of staff would leave a month. And then you'd get new staff members. And then there -- I think there was an occasion there was, like, four members of staff were leaving in the space of a couple of months, or less than a couple of months.

Q. And did these staff leaving create unfilled vacancies?

A. Normally the vacancies were put out if -- if they were -- there was -- no, I know of one staff member that was sick, and was long-term sick, and their vacancy, as far as I'm aware, I don't believe was filled. So, because they're still ongoing sick, even though the shift would -- that they would have been on was filled, it wasn't a case of it was a permanent member of staff.

Q. Thank you.

You refer to staff experiencing burnout. Did you experience burnout?

A. Yes.

Q. You also refer at paragraph 35 of your statement to

suffering from compassion fatigue. Was that compassion fatigue and burnout part of the reason, or the reason, that you decided to leave inpatient work?

A. Yes.

Q. And were there any steps, any actions, that the Trust could have taken to mitigate burnout or compassion fatigue?

A. I was being burnt out because of doing long days. It wasn't just about the ward; it was about my home life as well. So it -- one was going into the other. I had support where my home life was, through my -- I was seeing my Ward Manager. And it was like -- I'm just going to have to be -- it was like work and home life were very similar, is the way I can put it. So I wasn't able to leave my work at work and my home life at home, because it was too similar, two similar things.

Q. But in terms of the compassion fatigue, is there anything that the Trust could have done, any steps that could have been taken to improve that situation for you?

A. I don't know if there could have been.

Q. You refer to the long shifts and you make reference to this in your witness statement as well, to 12-and-a-half-hour shifts, and you say sometimes there is insufficient time to decompress between shifts, and this has an impact on staff.

What impact did these long shifts have on staff performance, and how did that translate into impact on patient care?

A. It could be, like, if you're doing it two long days in a row and you've not had time to decompress from one shift, and you've had a busy shift the day before, then you go in to do another busy shift the following day, it -- it just wears you out. So the -- you know -- it was wearing me out, but I wouldn't let it impact how I cared for the people on the ward.

Q. Thank you.

When I started the questions in this section, I noted that in your statement you started off by saying the staffing levels were adequate, but then we've just talked about some of the pressures on staff --

A. Yeah.

Q. -- and some of the difficulties with staff. And Zoe Bunting, who was your manager, who has also told the Inquiry that managing staffing levels has always been a challenge, and she said, for example, that staffing constraints had a direct impact on the ability to deliver observations as prescribed, and they also had an impact on other areas, for example the extent to which care planning could be collaborative and the extent to which engagement with families could be done adequately.

Is that consistent with your experience?

A. I would agree with that.

Q. Thank you.

I will now ask you some questions about the training that you received. I'll come on later to training about observations, but for now, focusing on paragraph 28 of your statement, where you say that NHS bank staff received the same training as permanent staff, but agency staff did not.

Do you know how the Trust ensured that agency staff were nevertheless conversant with the Trust's policies and procedures, and the specific policies and procedures for the ward, before they came to work on the ward?

A. I'm not aware of ...

Q. Did you observe any differences in understanding, in the level of understanding of policies and procedures between permanent staff and bank staff on the one hand, those who had Trust training, and agency staff on the other hand?

A. Are you on about the difference in the training?

Q. Did you observe any difference in understanding? Was it your experience that there was a better understanding of policies and procedures by -- that permanent staff and bank staff had a better understanding than agency staff, who had not received training?

A. I wouldn't feel there was much different, but obviously they don't -- I don't know what the agency staff's training are. All I know is they're not trained by the NHS.

Q. Thank you.

You explain at paragraph 27 of your statement that you received basic life support training. And you considered that the training was adequate. But you do say that it did not prepare you for the initial shock of finding someone unresponsive.

The Inquiry has heard evidence from another witness who said that none of the training courses involved any practical scenario training. Do you think that basic life support training which includes a practical scenario would have helped?

A. When I've done -- I've done -- with the NHS, I've done the enhanced one that -- basic life support. So obviously I've had that extra bit of training to what the normal training, baseline training is. And I think everyone should have it. Everyone should have that extra bit of training, to be honest.

Q. The Immediate Life Support Training; is that what you mean?

A. (No audible answer).

Q. But in terms of dealing with the shock of a live

situation, is there anything that you think could be done to mitigate that?

A. I honestly don't know. Obviously because we use the Annies, which is the dummies, then it's -- you know, people are sitting there: it's not a real person.

Q. Thank you.

A. So it's -- so, you know, you can't do CPR on a real live person, can you? So I don't think there is any preparation out there, unless the instructor is really hard on the trainees and, say, make it into, in inverted brackets, a real-life situation kind of thing. Do you know what I'm trying to say?

Q. What I understand you to be saying is that it is difficult to replicate --

A. Yes.

Q. -- the circumstances of a real-life scenario.

A. Yes.

Q. Thank you.

We've now been going for 30 minutes, and we -- we can take a break if you would like to?

A. I'm fine.

Q. You're fine to carry on?

I'll now turn to asking you questions about therapeutic observations and engagement.

You explain at paragraph 11 of your witness

statement, on page 2, that you only ever used three levels of observations on the ward. So, level 1 is once an hour check; level 2 is four checks within an hour, and also knowing where the patient is; and level 3 observations is always within eyesight; is that correct?

A. *(The witness nodded)*.

Q. Do you know what level 4 observations are?

A. Level 4 observations are where you're next to them.

Q. Yes, so within an arm's length --

A. Arm's length, yes.

Q. In practice, did you have sufficient time to engage with patients while carrying out observations?

A. If you was on a level 3 with someone, yes, because you're -- you know, generally, if you was on that level 3, you'd engage with that person. Level 2s, you're going round -- obviously level 2 is -- whoever was doing level 2s did the level 1s as well. So you're going round just seeing where people are.

Some people would come up and talk to you while you're doing that observation, so -- and you try and engage with them but you knew that you had to make sure everybody else was in a safe place, everyone else was there.

Q. And so you would not necessarily engage with patients if you were carrying out level 1 or level 2 observations?

A. No, you'd try not to, because you was looking -- you was trying to be aware of where 17, 18 patients were. But when you was on level 3, you was able to, because it's more of a one-to-one.

Q. Thank you.

You explain that when you started off on Peter Bruff Ward, recording of observations used to be paper --

A. *(The witness nodded)*.

Q. -- and that this resulted in the timing of checks being estimated. Can you explain why paper records resulted in estimation of the timing of checks?

A. Because we weren't wearing watches and things like that, you know, and we couldn't -- we'd just, "Oh, it must have been two minutes later."

You'd get distracted by other patients. As I was saying a bit before, someone would come and ask you a question or they wanted to engage with you.

So it just wasn't accurate timing because you didn't have the watches on you to be able to go: right, okay, and write it down.

Q. And when would the time be recorded? Would it be whilst you were carrying out --

A. Yeah.

Q. -- the observations? But what you are saying is you didn't --

A. We'd have -- we'd have a board, write it as we were going along, once we'd seen that person.

Q. And in your experience, was this the practice on the ward: that the times would be recorded in this way, would be estimated in this way?

A. Generally, yes.

Q. Did you have any concerns about the reliability of times that were recorded in this way?

A. Sometimes it wasn't accurate.

Q. And so you would accept that, for example, estimating times could affect subsequent investigations into -- if an incident occurred, in terms of establishing exactly when the patient was last observed?

A. Yes.

Q. Thank you.

You explain at paragraph 12 of your statement that you sometimes experienced barriers to completing observations. And you give an example of an alarm going off, or another patient needing support. You then say that some changes were made in 2021, which meant that you would not need to attend any alarms unless it was you that raised it. Prior to these changes being made in 2021, how often were you diverted from observations?

A. I would say daily, with the patients -- you know, with -- like I've expressed earlier, with the patients

wanting to come up and engage with you, delaying the check on the next person.

Q. And would you be pulled off one-to-one engagement by these distractions?

A. If you was on a level 3, no. You stayed with your person.

Q. But level 1 and level 2 --

A. Level 1 and level 2, you could be, obviously, distracted.

Q. Why were changes made in 2021 which resulted in you not needing to go away, for example, to respond to an alarm?

A. I don't know why. I can only guess. And it possibly could have been due to the incident that happened on the ward.

Q. And is the incident you're referring to the death of Adam Steel?

A. Yes.

Q. And how were you informed of the changes to the way that observations were to be carried out after the incident?

A. I believe that we were just told that it was -- we were going to go to, like, a pad version, and it was -- the Ward Manager told everyone that whoever's on level 1s and level 2s, to redirect people to another staff member.

Q. And so that electronic tablets were introduced?

A. Yeah.
Q. And was this at the same time that Oxevision was introduced?
A. Oxevision was already there when I started.
Q. When you started?
A. Yeah.
Q. Thank you.
A. And obviously -- sorry, I missed the Oxevision part. With Oxevision, when I came on shift, I always used to use it just to check in the morning, just to check where everybody was. And it was stopped us doing that, we had to go and do a visual check, because sometimes we'd look through people's doors but we had to, after the incident, open the person's doors and check for breathing.
Q. Thank you. And I will return to Oxevision and the changes after Adam Steel's death. I will return to those in detail shortly.

In terms of staffing pressures and observations, did you witness staff falling asleep or becoming disengaged during observations?
A. Not falling asleep, but you would see, you know, someone's doing their observation and they're -- you know, they're in the dining room and they're checking who's in there, and someone's gone up to speak to them.

So that's -- generally, because we were doing other stuff, we weren't watching who was doing the observations, if you know what I'm trying to ... or am I mishearing?

Q. No, no. My question was: did you witness staff not being able to carry out observations adequately because of the pressures on their time?

A. I can only say what was on my time. And sometimes, you know, there was times where you were trying to get the four in the hour, and you've just spent 15 minutes with someone else because the -- within them four checks in the hour, it wasn't at set times. So -- because otherwise the patients would get used to -- "Oh, right, 15 minutes, they'll be back." So it was a case of you could do five minutes apart and then leave it for 15 minutes. But you'd gauge what the ward environment and the individuals were like.

Q. Thank you.

I will now ask you questions about the training you received on observations. And if I take you to paragraph 13 of your statement, you say that:

"The training I recall was from ... staff that knew the system."

Your reference to "the system" there, are you talking about the Oxevision system?

A. Yes.

Q. Okay. So I will leave the Oxevision system for the moment, and ask you questions about training on observations in general.

Did you undertake any training on observations before you started working at EPUT?

A. I cannot recall taking any.

Q. And what about training on observations at any point in your career?

A. I can't recall any. It was from -- learning from staff-to-staff, from what I can recall.

Q. And is that the same in relation to how to engage with patients? Did you receive any training in relation to that?

A. To engagement?

Q. Yes.

A. Um ... I don't know if it was -- if it was before that, but I -- the only things I'm thinking about is, like, open questions, closed questions, and ...

Q. And in terms of that, where did you receive that training?

A. That would have been with EPUT.

Q. With EPUT.

Were you required to complete an observations competency checklist when you started at Peter Bruff

Ward?

A. I can't recall.

Q. Thank you.

You say that you were informed that the policy for engagement and observations could be found on the intranet as well as being in a folder on the ward. You say you don't recall any training on it, other than to read it. Was reading the policy mandatory?

A. I don't recall if it was -- you know, all policies and that are -- I don't know about reading the policy, we get told -- I was told to read up on all the policies, and we're shown where the folder is. We get told it's on the intranet. And we do spend whatever time, you know, within the first week we're shadowing, so we do go through the folder.

Q. So, do you recall reading the policy?

A. I don't recall reading it.

Q. Do you recall whether anybody checked, any manager checked, whether you had read the policy?

A. No.

Q. Would more formal training on observations and engagement have been -- would that have been useful to you in carrying out and understanding the purpose of observations?

A. I think it would have been beneficial.

Q. Thank you.

I will now ask you some questions about Oxevision. So I've taken you to paragraph 13 already, where you say the training "was from other staff that knew the system". You say you can't recall whether there was online training. You say that you were able to advise and train new staff members when they were shadowing you.

You also say at paragraph 15 that you had no specific training for Oxevision other than being shown how it works. And you say that:

"... a better explanation with training at the time would have been more beneficial."

Would it be correct, therefore, to say that the training that you received on Oxevision was informal?

A. Was in fault?

Q. Informal.

A. Informal. It was from another staff member.

Q. And how was it delivered? Was there a specific time allotted for that training or --

A. It was whoever you were shadowing, and you was obviously shown around the ward, shown where everything was, fire points, and you was then shown the Oxevision and just told how it works. And then shown, obviously, "You press ..." and then what -- you press "Vitals" and then

you could -- things would come up and be recorded.

Q. And so the people who you were shadowing would show you how the system worked. And who would that be, typically?

A. Another HCA.

Q. Another healthcare assistant.

And how did the managers on the ward, for example the Ward Manager, satisfy themselves that you were competent in operating the system?

A. They didn't, that I recall.

Q. Do you recall ever being given a copy of the Oxevision Standard Operating Procedure?

A. No.

Q. Do you recall ever being told about or given any training informally, or guidance, about how the procedures would be -- the procedures in the SOP would be implemented, and how they would be updated?

A. No.

Q. You mentioned giving patients leaflets about Oxevision. So, apart from those leaflets, did you see any written information about Oxevision and how it functions and how it's supposed to be used?

A. I can't recall, no. Just the leaflets that we used to hand to the patients to make them aware that it was there.

Q. And when you say that it would have been -- a better explanation with training would have been beneficial, at the time that you were being shown how Oxevision worked, did you have concerns about the training that you had received in relation to it?

A. Not at the time.

Q. In terms of using Oxevision, what was your understanding of the purpose and how it was to be used?

A. It was there -- it alerted you when someone came out of their bedroom. It let you knew (sic) whether someone was in the room, whether the room was empty. And we would use it just for a quick visual check, especially if we had concerns about whether -- a patient's mental state. So it would be like an extra, that you would use it against the four other checks.

Q. So if somebody was on level 2 observations --

A. Yeah.

Q. -- you're saying that the check via Oxevision was an extra check --

A. Should have been an extra check. But I know that some people used it as one of their checks.

Q. And to what extent did people use it as one of the checks? Was this widespread, in your experience, on the ward? Or was it a few people that used it as one of the four checks?

A. I don't know if it was widespread or not. But I know, you know -- and I put my hand up, myself included -- had used it a couple of times as a check.

Q. Can you talk us through how Oxevision and the electronic pad that you used with it, how that is used to carry out observations? If you would walk us through how you would use the system to carry out -- in the course of an observation.

A. The pad wasn't the -- the Oxe pad -- you know, we had the Oxevision on the screen, and the pad was separate. The pad would give your level 1s and 2s and it was like your paperwork on a pad. So I don't -- I can't recall if that was connected to the Oxevision.

Q. So if you were using the Oxevision system, in connection with an observation, how would you use the Oxevision system? What would you do?

Could you take us through the steps of how you would use the system.

A. You would press on the room number.

Q. And where would you press on the room number?

A. On the screen.

Q. And where is this screen?

A. In the office.

Q. In the office.

A. You'd see where the person -- if the person was in the

room or not. You could see if they were moving. There is a bit on there that you could press "Vitals", and it would tell you their pulse rate, and I can't remember what else. I think there was two things it would tell you. Breath rate. I think it's pulse and breath rate. Then it'd be after, I think it was, like, 10 or 15 seconds, it would go off.

Q. So you could use the Oxevision system remotely from the office to check on vital signs, the pulse rates and the breath rate, and you could also use it remotely to observe a patient?

A. Yeah.

Q. And you've already said that sometimes, if a patient who was on level 2 observations, for example, that remote observation could count as one of the four observations within an hour?

A. Yeah.

MS ONABANJO: I think it's a convenient time to take a break.

(A short break)

MS ONABANJO: When you were giving your answer in relation to the way in which you conduct level 2 observations, you explained that you might not engage individually with patients because you try to be aware of -- you would be trying to be aware of 17 or 18 patients.

Does that mean that one person would have been responsible for, for example, conducting level 2 observations in relation to 17 or 18 patients?

A. Yes, and you did that for an hour. Sometimes, obviously, you'd end up going on and doing it for two hours.

Q. So there were times where the entire unit was on level 2 observations and it was the responsibility of one person to conduct those observations?

A. More so on the level 2s, yes.

Q. Thank you.

In terms of the accuracy of time recording of -- on paper, you explain that one of the reasons why time can't be recorded accurately was because healthcare assistants weren't wearing watches. But could that have been remedied by wearing a watch? Would that have then ensured that you were then able to record time accurately?

A. For me it would have been. I'd be able to look right at the time. Or even more clocks.

Q. More clocks in the unit?

A. More clocks within the unit.

Q. Within the unit. Thank you.

Then could you tell the Inquiry whether you are aware of Oxeobs? Oxeobs, whether you're aware of what

Oxeobs is.

A. Oxeobs?

Q. Yes.

A. I just believe it's the Oxehealth obs, or --

Q. And what is your understanding of what that is?

A. I'd have to -- I'll have to say no.

Q. My question was whether you're aware of the -- a device, an electronic device, that was connected to the Oxevision system --

A. Oh, the hand one, yes.

Q. Yes -- that was used to take observations?

A. We never used to take that round with us. That was -- you know, someone would have it.

Q. And so the only way that you would conduct observations using the Oxevision system was, as you've described previously, from the --

A. Either on the little small thing or in the office on the ...

Q. So, on the little small thing, could you have used the little small thing in the way that you could have used the screen in the office?

A. Yes, you could do.

Q. And were you, as a healthcare assistant, able to use the device in that way?

A. I could use it in that way if I wanted, but for level 2

obs, we used to just walk round.

I'm getting confused, sorry.

Q. In the course of your evidence earlier you were explaining that you -- the handheld devices weren't used to carry out observations. I'm just trying to understand what the nature of -- what the type of the handheld devices that you had, what it was and what it could do, and how you used it.

A. When we had Oxe -- just the Oxevision, before it went from the paper to the tablets, it's -- the Oxe one and the new one were two separate things. So the hand tablet for the Oxevision is the same as on the screen.

Q. The same as on the screen in the office?

A. Yes.

Q. Then what was the change?

A. The change was we had tablets come in where you had to record level 2 obs and level 1 obs of, like, where they were. And there was bits in there that you could put "in bedroom", sort of like "sitting in lounge", "awake", "asleep", and things like that. You had to put in what the person was doing when you did that check.

Q. And you would move around with that --

A. Yes.

Q. -- with that tablet?

A. Yeah, you was not able to visually see them on that

tablet.

Q. Thank you.

I will now ask you some questions about Adam Steel's case.

In the statement that you provided to the inquest into his death, that is exhibited to your statement to the Inquiry, you explained that you used the -- that you conducted a preliminary level 2 observation.

A. *(The witness nodded)*.

Q. What did you mean by preliminary level 2 observation?

A. When I used to go in, as I've said earlier, in the morning, that was a thing that I did: that I would check the Oxehealth to see where everybody was, to see whether they were asleep, awake. Just for my own peace of mind.

Q. And this was the check in the office that you --

A. That was the check I did on the monitor in the office.

Q. Did that constitute one of the four levels --

A. On that day I put it down as one of the four, because I was then given the level 2s.

Q. Thank you.

I will now ask you questions about learnings from the death of Adam Steel. You say that following the death -- at paragraph 34 of your statement:

"You were informed that Oxevision was NOT to be used as a level 2 check and all checks had to be visual even

if it meant opening a patient's door and ... waking them up."

How was that learning communicated to you?

A. Team meetings.

Q. And are you aware whether that learning was shared just at your ward level or whether it was Trust-wide?

A. I don't know if it was Trust-wide but I knew it was on our ward.

Q. And did this information impact the way in which staff conducted observations in practice?

A. As in?

Q. Did -- in your experience, did staff comply with that --

A. Yeah.

Q. -- direction?

Zoe Bunting has given evidence to the Inquiry to say that she personally issued reminders of face-to-face checks being required for level 1 and level 2 observations.

A. *(The witness nodded).*

Q. Were those reminders given after the death of Adam Steel?

A. Yes.

Q. Thank you.

I will now ask you about the extent to which patients consented to the use of Oxevision. At

paragraph 16 of your statement you say that:

"Some patients did not like the idea that, of Oxevision being used and would cover up the camera with stickers or paper."

A. *(The witness nodded).*

Q. Was it your understanding that those patients weren't consenting to the use of Oxevision?

A. Some of them, yes, I would agree, they didn't -- it was like they did not want to be -- they didn't feel comfortable. And I would explain to them again that it was there not to spy on them or, you know, to watch them; it was there to check that they were safe.

Q. And what process was followed if a patient insisted that they did not want to be observed using the Oxevision system, whether they said it in words or by their actions they demonstrated that they did not want to be observed?

A. We would just report it, like, escalate it to -- as an HCA, we'd escalate it to the nurse in charge. And then I don't know where -- to be honest, I don't know where it went from there.

Q. And so you don't know action would then be taken --

A. No.

Q. -- as a result?

You describe the fact that patients could be

observed from the stations --

A. *(The witness nodded)*.

Q. -- and you could go into the live feed of them in the bedroom. To what extent were patients aware of the fact that they could be observed at any time when the Oxevision system was on in their bedrooms?

A. They were informed upon entrance to the -- once they came onto the ward.

Q. And how were they informed?

A. We'd verbally tell them, and there was leaflets that we gave.

Q. And do you recall what information was contained in the leaflets that they were provided with?

A. Not the exact information, but it was around of how -- that it was there and how it worked.

Q. Thank you.

I will now ask you about the response to investigations in general, and the support that you were provided. You have said at paragraph 36 of your statement that you considered the investigation following Adam Steel's death to have been timely and professional.

Were you given an opportunity to contribute to that investigation and to the recommendations arising from it?

A. Not with recommendations arising from it, but obviously contributing the fact of witness statements, and obviously speaking with the police.

Q. Were you informed of how the recommendations that flowed from -- apart from the one that we've discussed, were you informed of how any other learnings from that incident, how the compliance were to be monitored, and how -- any steps that would be taken in relation to the learnings from that incident?

A. No.

Q. You describe in your statement going into shock after finding Mr Steel deceased. Following that incident, was there a formal debrief undertaken?

A. I cannot recall a formal debrief, because we continued with the rest of the day. Obviously, Mr Steel was found first thing in the morning, and we continued with the shift. And it was just supporting each other as a team. So if we needed time out, we could. Zoe said if we needed to speak to her, we could. And being able to take a step back throughout the day when we needed to.

Q. And how would you describe the adequacy of the support that you were provided with in that process?

A. As a team, we supported each other good, then.

Q. You describe the communication and leadership on the Peter Bruff Ward as "positive", and you say that the

learning incidents were shared. What was it that contributed to the positive leadership in the ward at the time?

A. Can you rephrase that for me?

Q. In what way do you consider that the leadership was positive? How did that manifest, and in what way did you feel the benefits of positive leadership on the ward?

A. On that day?

Q. Not on that day, just generally.

A. The leadership I class as the nurses in charge. And whilst I worked there, the nurses in charge, in my opinion, were good nurses. They supported their staff as well as they could.

Q. And you do say in your statement that Ward Managers were visible --

A. Yes.

Q. -- that daily huddles took place at which concerns could be raised, and they shared new practices.

A. *(The witness nodded)*.

Q. Do you know whether there were any steps to record actions arising from those huddles, and to monitor what steps were taken in relation to actions raised -- in relation to concerns raised at those huddles?

A. Obviously the huddles were recorded, and then it would

be the Ward Manager that would escalate any concerns or anything else. As to how -- what the process was after that, I wouldn't know.

Q. Thank you.

And finally, coming on to your recommendations. You have -- you suggest that the Inquiry should consider crisis services beyond inpatient wards, and you refer to an occasion where a Crisis Team describes and cites suicidal behaviour as "attention seeking". Was this in any way related -- did this circumstance arise out of your employment with EPUT?

A. It's through -- it was whilst I was working for EPUT, and it was personal circumstances that made me see the parent side, and what a family member struggles -- can struggle with to actually get the support from the mental health services -- not just wards, but even the Crisis line, to begin with.

MS ONABANJO: Thank you.

Those are all the questions that I have for you. Thank you.

(Pre-recorded evidence of Beverly Switzer concludes)

THE CHAIR: Mr Glanville?

MR GLANVILLE: Chair, that concludes the evidence for today. We will continue the evidence tomorrow at 10.00 am when will hear evidence from two comparator trusts on their

use of Oxevision, namely Tees, Esk and Wear Valleys NHS Foundation Trust and Leicestershire Partnership NHS Trust.

THE CHAIR: Thank you very much. Tomorrow morning at 10.00.

(5.02 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X