

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

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

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

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

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

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

25

1 **Update statement by MS HARRIS KC**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 Issues with the basic practicalities of making those
19 emergency calls.

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

1 was needed for an outside line.

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

7 999 calls being made by staff on non-portable
8 phones, which were sometimes not available, and who
9 therefore could neither see the patient nor provide
10 proper, up-to-date information to emergency service
11 operators.

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

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

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

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

1 allowed through a series of locked doors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Number 3 is that emergency assistance is summoned

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

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

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

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

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

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

16 And number 9, appropriate equipment is available for
17 resuscitation.

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

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

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

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

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

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

25 As previous outlined, Chair, one of the issues this

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

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

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

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

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

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

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

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

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

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

1 governance framework.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 actively exploring what data is available.

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

5 **THE CHAIR:** Thank you.

6 **MS HARRIS:** Chair, that update having been completed, can
7 I invite you to take a ten-minute break and come back at
8 10.50 to allow, I think, Mr Benson Clarke to come back
9 and for arrangements to be made.

10 **THE CHAIR:** Yes, until 10.50.

11 **MS HARRIS:** Thank you.

12 **(10.39 am)**

13 **(A short break)**

14 **(10.51 am)**

15 **THE CHAIR:** Ms Harris.

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

18 **ADAM BENSON CLARKE (affirmed)**

19 **Questioned by MS HARRIS KC**

20 **MS HARRIS:** Good morning.

21 **A.** Good morning.

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

25 **A.** Adam Benson Clarke.

1 Q. Mr Benson Clarke, you have provided two witness
2 statements to the Inquiry. The first is dated
3 15 May 2026, and the second is dated 22 June 2026. And
4 you should have a copy of both of those statements in
5 front of you.

6 A. Mm-hm.

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

9 A. Sorry, yes.

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

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

14 A. Yes.

15 Q. Which contained a statement of truth?

16 A. Correct.

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

20 A. That is correct.

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

23 A. Correct.

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

1 **A.** Yes.

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

4 **A.** Nothing to update.

5 **Q.** And do you stand by those statements?

6 **A.** I do.

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

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

17 **A.** Correct.

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

20 **A.** Correct.

21 **Q.** It's a registered charity?

22 **A.** It is.

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

24 **A.** Correct.

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

1 that since last November?

2 **A.** Correct.

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

4 **A.** Correct.

5 **Q.** From about June 2023?

6 **A.** Yes.

7 **Q.** And before that, you were Courses Manager/Clinical Lead

8 from 2017 to 2023?

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

10 **Q.** And you are giving evidence here on behalf of

11 Resuscitation Council UK.

12 **A.** I am.

13 **Q.** Which I think is sometimes known as RCUK for short; is

14 that right?

15 **A.** That's correct, yes.

16 **Q.** Well, we might do that to stop me stumbling over it.

17 And we know from paragraph 3 of your witness statement,

18 and I'm not going to ask you about it in detail, that

19 you're giving evidence on behalf of Resuscitation

20 Council UK, but some of the information within the

21 statement was provided by others?

22 **A.** Correct.

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

24 **A.** I am.

25 **Q.** When did you qualify as a nurse?

1 **A.** In 2006.

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

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

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

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

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

11 **A.** Many times. I specialise in resuscitation in a hospital
12 setting.

13 **Q.** When was RCUK first formed?

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

21 **Q.** And does that remain its purpose?

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

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

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

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

22 **Q.** So you also deliver courses?

23 **A.** We do.

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

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

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

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

11 **A.** That's correct, yes.

12 **Q.** So what do the core membership do?

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

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

25 So these individuals very much make up people who've

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

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

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

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

11 **A.** That's correct.

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

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

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

1 the organisation responsible for issuing practice
2 guidelines and standards.

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

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

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

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

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

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

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

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

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

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

21 **Q.** Do others provide such accreditation?

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

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

25 **A.** Yes, yes.

1 **THE CHAIR:** Can you give me an example?

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

3 **THE CHAIR:** Perhaps you could let us know.

4 **A.** Certainly.

5 **MS HARRIS:** Before I go on to ask you about your guidelines

6 and your standards, can I ask you to help us a little

7 bit about cardiac arrest and secondary cardiac arrest,

8 which you deal with in your statement. And to go

9 straight to it, at paragraph 9 of your second witness

10 statement, you describe cardiac arrest as the ultimate

11 medical emergency.

12 You're nodding, can you --

13 **A.** Yes, sorry. Yes. It very much is the ultimate medical

14 emergency. It's time-critical where seconds count.

15 **Q.** Sorry, time critical?

16 **A.** It's time critical.

17 **Q.** And in terms of from what happens from a clinical

18 perspective, is this right: when a person is in cardiac

19 arrest, their heart stops pumping blood around their

20 body?

21 **A.** Correct.

22 **Q.** And that's different, although it seems like an obvious

23 thing to say, from a heart attack, say, where the heart

24 continues to pump?

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

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

7 **Q.** That was my next question.

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

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

14 **A.** Yes.

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

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

1 caused the cardiac arrest.

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

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

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

14 **A.** Yes, that is, yeah, correct.

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

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

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

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

7 **A.** Correct.

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

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

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

17 **A.** Yes.

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

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

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

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

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

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

24 **A.** Correct.

25 **Q.** -- depending on contracts?

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

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

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

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

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

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

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

6 **A.** Sorry.

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

10 **A.** Sure.

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

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

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

1 for adrenaline amiodarone but they --

2 **THE CHAIR:** Hang on. Sorry, you said that so quickly, I'm

3 afraid I didn't hear a word of it.

4 **MS HARRIS:** No, if you --

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

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

7 you.

8 **A.** Certainly.

9 So in terms of drugs within a cardiac arrest, it's

10 very much within the remit of advanced resuscitation.

11 The reason being is for individuals usually have to have

12 a licence or qualification to prescribe medication.

13 There is a cover from the Human Medicines Regulations

14 which allow individuals in adult resuscitation only, so

15 it doesn't relate to paediatrics, if you hold an

16 advanced qualification with Resuscitation Council UK, an

17 ALS certificate, you can give adrenaline and amiodarone

18 as the two main cardiac arrest drugs under that

19 exemption from the regulation.

20 **MS HARRIS:** Just to complete the list of the additional

21 skills you refer to at paragraph 10, you list looking

22 after the patient --

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

24 **Q.** -- and then leading the team?

25 **A.** Yes.

1 **Q.** Including --

2 **A.** That's correct --

3 **Q.** -- someone to identify what the underlying cause of the

4 cardiac arrest may be?

5 **A.** Absolutely.

6 **Q.** You go on to explain at your paragraph 11 that

7 a significant proportion of cardiac arrests that take

8 place in healthcare settings and in particular mental

9 health inpatient settings, are what is known as

10 a secondary cardiac arrest.

11 **A.** Correct.

12 **Q.** Before I ask you about that, shortly, what is a primary

13 cardiac arrest?

14 **A.** So we term things as a primary cardiac arrest, it's

15 usually due to the heart a primary organ. And that

16 could be due to an acute coronary syndrome, so that is

17 a heart attack, a severe heart attack which has caused

18 a cardiac arrest to happen. It can either be due to

19 structural problems with the heart, so hypertensive

20 valve disease, so people might have higher levels of

21 blood pressure put a strain on the heart itself. It can

22 also be due to electrolyte abnormality, so things like

23 potassium, which is a very, very key regulator for how

24 your cells work and how the heart works.

25 So these are the type of things which may cause

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

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

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

10 **A.** Yes.

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

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

25 There's also challenges in the management of eating

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

11 **Q.** So that was primary.

12 **THE CHAIR:** Can I --

13 **MS HARRIS:** Of course.

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

17 **A.** Yes.

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

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

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

3 **THE CHAIR:** Thank you. Sorry to interrupt.

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

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

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

12 **Q.** Ligature-related asphyxia --

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

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

17 **A.** Correct.

18 **Q.** Have I understood the position?

19 **A.** Yes.

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

24 **A.** Correct.

25 **Q.** And then the patient deteriorates?

1 **A.** Correct.

2 **Q.** The patient loses consciousness?

3 **A.** Correct.

4 **Q.** The patient stops breathing?

5 **A.** Correct.

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

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

20 **Q.** As if it were a cardiac arrest?

21 **A.** As if it were.

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

1 **A.** Certainly, yes.

2 **Q.** Which may result in death?

3 **A.** Absolutely.

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

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

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

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

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

7 A. I'm sorry.

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

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

13 A. Mm-hm --

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

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

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

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

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

13 **THE CHAIR:** Sorry, say that again.

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

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

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

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

3 **A.** Absolutely --

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

7 **A.** Correct.

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

17 **A.** Correct.

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

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

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

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

5 **A.** Exceptionally quickly, yes.

6 **Q.** How quickly?

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

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

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

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

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

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

12 **Q.** Can I just pause you for a moment.

13 **A.** Yes.

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

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

1 correctly.

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

3 **A.** Sorry.

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

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

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

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

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

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

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

25 **Q.** -- to ligature cutters?

1 **A.** Correct.

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

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

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

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

11 **A.** Exactly.

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

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

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

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

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

4 **A.** Correct.

5 **Q.** Dealing with those dropping oxygen levels?

6 **A.** Correct.

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

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

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

1 qualification or knowledge --

2 **A.** Correct.

3 **Q.** -- or training required. So as you become -- there are

4 certain aspects of providing that oxygen which would

5 require certain levels of training, for example --

6 **A.** Correct.

7 **Q.** -- immediate rather than basic?

8 **A.** Yes.

9 **Q.** You also, at paragraph 12, refer to monitoring

10 deteriorating vital signs.

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

12 **Q.** So how would that be done?

13 **A.** So we use the term "vital signs", historically people

14 might have used the term "observations" and "obs", and

15 that's very much looking at someone's respiratory rate

16 so how often they're breathing a minute, looking at the

17 oxygen saturation so the percentage of oxygen within

18 their blood, looking at their heart rate, looking at

19 their blood pressure, looking at their level of

20 consciousness with that, as well. And their body

21 temperature. So these are what we call vital signs.

22 And everyone -- we have a normal range for adults and

23 children quite happily, and we look for when there's

24 deterioration or changes within that, and that should

25 lead to how we escalate and raise a concern for an

1 individual.

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

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

12 You refer to the use of an early warning system.

13 **A.** Correct.

14 **Q.** What sort of system are you referring to?

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

17 **Q.** The NEWS?

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

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

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

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

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

23 **A.** Correct, yeah.

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

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

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

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

12 **Q.** -- as I say --

13 **A.** Absolutely.

14 **Q.** -- the other diagnoses.

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

18 **A.** Absolutely.

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

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

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

1 have to prevent it?

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

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

20 **A.** Correct.

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

24 **A.** Yes, clinical guidelines, correct.

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

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

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

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

12 **A.** Correct.

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

15 **A.** Correct.

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

18 **A.** Correct.

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

21 **A.** Correct.

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

1 inpatient care by RCUK?

2 **A.** That is correct.

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

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

8 **Q.** For the statement?

9 **A.** Yes. The title is quite long.

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

16 **A.** Correct.

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

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

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

24 **A.** Correct.

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

1 **A.** It is.

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

7 **A.** No, we don't.

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

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

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

19 **A.** Correct.

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

23 **A.** Correct.

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

1 **A.** Correct.

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

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

14 **Q.** Disbanded.

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

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

22 **A.** Correct.

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

24 **A.** Correct.

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

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

3 **A.** That is correct.

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

5 **A.** Yes, correct.

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

8 **A.** Sure.

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

16 **A.** Correct.

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

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

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

22 **A.** A writing group.

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

25 **A.** Not to the original --

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

6 A. That is correct.

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

11 A. Correct.

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

15 A. Correct.

16 Q. We will also come back to this, towards the end of your
17 evidence, but they're due for review again, aren't they
18 --

19 A. They are.

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

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

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

1 reviewed by the end of this calendar year?

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

5 **Q.** Sorry, did you say financial year?

6 **A.** We work to a financial year.

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

13 **A.** I do.

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

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

17 **A.** Mm-hm.

18 **Q.** Do we --

19 **A.** Yeah, it's on the screen.

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

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

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

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

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

15 **A.** Correct.

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

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

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

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

17 **A.** Correct.

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

20 **A.** That's correct, yes.

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

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

4 **A.** Correct.

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

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

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

16 **A.** Sure.

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

23 **A.** Correct.

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

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

3 **A.** Yes.

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

7 **A.** Correct.

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

13 **A.** Indeed.

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

16 **A.** Correct.

17 **Q.** And that CPR is started immediately?

18 **A.** Correct.

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

22 Number 3 is that:

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

1 **A.** Correct.

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

3 "Defibrillation, if appropriate, is attempted within

4 3 minutes of identifying cardiorespiratory arrest."

5 Now, just pausing there for a moment, you've already

6 explained why it's often and usually important to use

7 a defibrillator anyway --

8 **A.** Mm-hm.

9 **Q.** -- and that's a very short amount of time that you would

10 expect defibrillation to be taking place, within three

11 minutes?

12 **A.** It is a short, very short period of time. But the

13 reason being is within the clinical evidence is the

14 quicker you get defibrillation in, and the marker that's

15 used within the national and international literature

16 is -- of three minutes, has the greatest chance of

17 success of converting that rhythm into a normal rhythm.

18 **Q.** Understood.

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

20 "Appropriate post-cardiorespiratory-arrest care is

21 received by those who are resuscitated successfully",

22 including safe transfer.

23 **A.** Correct.

24 **Q.** Number 6:

25 "Implementation of standards is measured continually

1 and processes are in place to deal with any problems
2 identified."
3 **A.** Correct.
4 **Q.** So monitoring of how effective they are.
5 Number 7:
6 "Staff receive at least annual training --
7 **A.** Correct.
8 **Q.** -- and updates in CPR based on their expected roles",
9 and there's that expected role element again.
10 **A.** Mm-hm.
11 **Q.** 8:
12 "Staff have an understanding of decisions relating
13 to CPR."
14 And:
15 "Appropriate equipment is available for
16 resuscitation."
17 **A.** Correct.
18 **MS HARRIS:** I'm going to ask you in a minute about
19 terminology but I think, Chair, I'm told that that would
20 be a convenient moment for a break, unless you have a
21 question first?
22 **THE CHAIR:** Yes, I do. I have one and I'm sorry if you
23 think you've already answered this one. You've talked
24 about the need to defibrillate very quickly after
25 cardiac arrest, you've talked about that hopefully

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

6 **A.** Correct, mm-hm.

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

9 **A.** It is.

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

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

21 **THE CHAIR:** Thank you. That's helpful.

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

23 **THE CHAIR:** Five past 12.

24 **MS HARRIS:** Thank you.

25 **(11.49 am)**

1 (A short break)

2 (12.05 pm)

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

9 **A.** Yes, yes.

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

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

14 **THE CHAIR:** Is that available?

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

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

19 **A.** Very much so.

20 **THE CHAIR:** Very much so?

21 **A.** Yes.

22 **THE CHAIR:** Thank you.

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

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

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

6 **A.** Mm.

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

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

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

15 **A.** That's correct.

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

18 Again, not aspirational, would you agree?

19 **A.** I would hope not, yes.

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

22 So those might be aspirational aspects?

23 **A.** Correct.

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

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

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

6 **A.** It is.

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

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

10 This is the Quality Standards for Mental Health
11 Inpatient Care?

12 **A.** Correct, yes.

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

17 And you've just explained a bit about that.

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

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

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

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

7 **A.** I would hope not.

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

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

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

3 **Q.** So those are kind of geographical issues?

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

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

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

15 **Q.** All right. Thank you.

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

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

25 **A.** Correct.

1 Q. And that at 2:

2 "Every organisation must have an identified board

3 member who is responsible for resuscitation services.

4 This was required in England by Health Services Circular

5 2000/028," and that dates us back to the year 2000,

6 doesn't it?

7 A. That's correct.

8 Q. So this has been a governance requirement for some

9 considerable time?

10 A. Very much so.

11 Q. And it goes on, if we look at the bottom of point 2, to

12 say that's to ensure that a resuscitation policy is

13 agreed, implemented and regularly reviewed within the

14 clinical governance framework.

15 A. Correct.

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

17 "The resuscitation service structure must be part of

18 each responsible authority's management structure."

19 So therefore clinical governance, clinical risk,

20 quality improvement, education service structures.

21 A. Correct.

22 Q. And it says at 4 that it must include local

23 resuscitation experts.

24 A. *(The witness nodded)*.

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

1 intended by "local resuscitation experts"?

2 **A.** So a local resuscitation expert could be either

3 a resuscitation officer, so someone who has a clinical

4 interest and skill in resuscitation practice.

5 **Q.** Can I stop you? Because obviously the standards require

6 every organisation to have one. Do you mean a separate

7 one, or just -- can it be the same person within the --

8 **A.** It could be the same person within the organisation

9 -- (overspeaking) --

10 **Q.** Sorry, I interrupted you.

11 **A.** No, that's fine. It can also be a doctor who has

12 interest or training within resuscitation as well. So

13 someone who is familiar with resuscitation who has had

14 training in advanced level resuscitation, is familiar

15 with resuscitation governance.

16 **Q.** Looking at 5, it says that:

17 "The lead person responsible for the resuscitation

18 service structure must have an active and credible

19 involvement in resuscitation."

20 What do you mean by "credible involvement"?

21 **A.** So that's quite a broad term because actually what we

22 don't want people doing is resuscitating everybody,

23 every day, that type of thing. So when we talk about

24 someone who is credible in the field of resuscitation,

25 so they will be individuals who are trained to a high

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

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

8 **A.** Correct.

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

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

18 **A.** Correct.

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

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

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

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

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

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

14 A. Correct.

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

17 A. *(The witness nodded)*.

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

19 A. Oh absolutely, yes.

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

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

24 And:

25 "Preparing and implementing policies", again,

1 including those relating to prevention of cardiac
2 arrest.

3 **A.** Correct.

4 **Q.** And "recognising patients who are deteriorating."

5 **A.** Correct.

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

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

11 **A.** Correct.

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

13 **A.** Correct, yes.

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

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

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

25 What does that mean?

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

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

7 **A.** Essentially, yes.

8 **Q.** A doer?

9 **A.** Yes, absolutely.

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

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

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

1 education.

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

6 A. Yes, correct.

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

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

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

13 And that:

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

16 A. Correct.

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

19 A. Correct.

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

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

1 your second witness statement and you say this:

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

8 **A.** Correct.

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

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

13 **Q.** You say:

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

16 **A.** Correct.

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

18 **A.** Correct.

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

22 **A.** Correct.

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

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

3 **A.** Correct.

4 **Q.** Moving then to number 3, you say:

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

7 You've already given some evidence about that.

8 **A.** Mm-hm.

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

15 **A.** Correct.

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

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

21 **A.** Mm-hm.

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

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

3 **A.** Correct.

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

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

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

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

19 **A.** Correct.

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

24 **A.** Absolutely.

25 **Q.** And why is that?

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

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

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

14 "recognise cardiorespiratory arrest;
15 "summon help;
16 "start CPR;
17 "[and] attempt defibrillation if appropriate within
18 3 minutes of collapse using an automated external
19 defibrillator or manual defibrillator."

20 **A.** Correct.

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

25 **A.** Yes, correct.

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

6 **A.** Yes.

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

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

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

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

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

1 training required or not required for an AED?

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

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

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

11 "recognise cardiorespiratory arrest;
12 "summon help; [and]
13 "start CPR using chest compressions."

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

17 **A.** Yes, correct.

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

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

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

1 arrest?

2 **A.** They certainly might be in some organisations.

3 Particularly if an individual is -- we might use the

4 term being "specialled" so where they're being

5 one-to-one monitored so -- (overspeaking) --

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

7 **A.** Yes.

8 **Q.** Or somebody who is, for example, maybe in a ligature

9 risk or an overdose risk?

10 **A.** Absolutely.

11 **Q.** Okay. And are they drafted, then, these standards, on

12 the basis that HCAs are often responsible for checking

13 vital signs?

14 **A.** In most healthcare organisations, that role of checking

15 vital signs is often delegated to healthcare assistant

16 staff.

17 **Q.** And they're --

18 **A.** Not exclusively.

19 **Q.** Sorry, I spoke over you. You may need to give that

20 answer again.

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

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

23 Sorry, Chair, I interrupted you.

24 **THE CHAIR:** No, finish and --

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

1 emergency?

2 **A.** They can be, yes.

3 **THE CHAIR:** You've talked about the training that you would

4 expect people to have, in these circumstances. How long

5 would a training course that covers the things you've

6 recommended last? How long would that take?

7 **A.** As in the duration of the course --

8 **THE CHAIR:** Yes.

9 **A.** -- or in between training?

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

11 **A.** Sure.

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

13 **A.** So for -- I'll start with our ILS course because that's

14 very easy to do within the programme. That's a full-day

15 training.

16 **THE CHAIR:** Four days.

17 **A.** Full day. One full day.

18 **MS HARRIS:** So that's ILS?

19 **A.** That's ILS. We have a set programme for that which is

20 the national standard. And that can be split up between

21 e-learning which takes the theory away, and then half

22 a day practical. But the length of time spent on that

23 training is a day.

24 For basic level life support, that's very much -- it

25 depends on the organisation and how they've set their

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

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

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

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

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

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

9 **THE CHAIR:** Thank you.

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

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

19 **Q.** Right.

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

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

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

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

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

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

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

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

16 **A.** Sure.

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

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

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

1 **A.** Within their organisation, yes.

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

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

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

7 **A.** Absolutely.

8 **Q.** -- and what that might involve.

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

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

14 **A.** Correct.

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

21 **A.** Correct.

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

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

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

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

8 Q. All right, that's helpful. And at 15:
9 "All new members of staff must have training
10 resuscitation as part of their induction programmes.
11 Even those who have current training, require
12 resuscitation training on induction, to ensure they are
13 familiar with the local policies and equipment."

14 A. Correct.

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

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

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

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

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

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

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

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

16 "The same role-based approach applies to Standard
17 18, where healthcare assistants are expected to be
18 involved in responding to special circumstances, they
19 should receive training appropriate to responding to
20 those special circumstances in the same way."

21 **A.** Correct.

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

1 assistants?

2 **A.** Absolutely.

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

7 **A.** Correct.

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

10 **A.** Absolutely.

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

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

18 **A.** Absolutely.

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

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

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

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

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

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

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

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

18 **A.** I would certainly say so.

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

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

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

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

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

22 **A.** Correct.

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

1 support, and advanced life support training.

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

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

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

1 allows ventilation to be delivered much more effectively
2 and easier.

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

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

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

23 **A.** Yes.

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

1 "To train healthcare personnel in causes and
2 prevention of cardiopulmonary arrest. The ABCDE
3 approach [as you've said] initial resuscitation and
4 defibrillation, manual and/or AED and simple airway
5 management. To train healthcare personnel to manage
6 patients in cardiopulmonary arrest until the arrival of
7 the resuscitation team and to train healthcare personnel
8 to participate as members of the resuscitation team."
9 **A.** Correct.
10 **Q.** Is it that last point, then, that would include those
11 elements of leadership?
12 **A.** So the leadership element would come into that, that
13 second point until that arrival of the team --
14 **Q.** The management part?
15 **A.** The management.
16 **Q.** Okay.
17 **A.** But what we wouldn't want is for those individuals to --
18 you know, as the advance team arrives, sometimes what
19 you see happening in clinic environments is ward members
20 of staff might then go away and leave the cardiac arrest
21 management to the advanced team, whereas, actually,
22 there's no reason why they shouldn't stay and be part of
23 that team approach and managing that patient altogether.
24 **Q.** In light of your previous answers, there's no reason, is
25 there, that healthcare personnel should not include

1 healthcare assistants?

2 **A.** Absolutely no reason at all.

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

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

16 **Q.** I'm not going to ask us to jump to it but healthcare
17 assistants I think are listed in that list of --
18 -- (overspeaking) --

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

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

1 just confirm the position in relation to the paediatric
2 ILS regulations, and I think that is your exhibit
3 ABC 10, at page 1. And this -- these regulations,
4 actually, are a little earlier, aren't they, they're
5 2019 --

6 **A.** They are, yes.

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

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

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

15 **A.** Mm-hm.

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

22 So with emphasis, again, on prevention.

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

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

4 **A.** Correct.

5 **Q.** -- the EPALS course.

6 **A.** That's correct.

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

10 **A.** Absolutely.

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

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

21 **A.** Correct.

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

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

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

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

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

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

18 **A.** Correct.

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

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

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

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

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

21 **A.** Exactly.

22 **Q.** -- and were supported by those staff?

23 **A.** Exactly.

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

1 ambulance response?

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

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

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

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

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

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

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

22 **Q.** And --

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

24 **Q.** As a minimum standard?

25 **A.** As a minimum standard. But ultimately, and

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

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

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

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

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

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

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

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

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

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

8 **Q.** I think you know what Oxevision is.

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

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

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

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

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

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

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

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

25 And I can deal with this very quickly because

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

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

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

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

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

12 **A.** Correct.

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

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

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

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

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

22 **A.** Correct.

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

1 deterioration?

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

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

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

14 I think that's very emphatic.

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

16 **Q.** And 8:

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

21 **A.** Correct.

22 **Q.** And at 9:

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

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

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

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

9 **THE CHAIR:** 1.50. Thank you.

10 **(1.00 pm)**

11 **(The Short Adjournment).**

12 **(1.50 pm)**

13 **(Proceedings delayed)**

14 **(1.54 pm)**

15 **THE CHAIR:** Ms Harris.

16 **MS HARRIS:** Thank you, Chair.

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

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

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

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

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

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

18 **A.** Correct.

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

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

25 "... intravenous cannulation ... intraosseous access

1 ... drug administration ..."

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

7 **A.** Correct.

8 **Q.** -- if that makes sense.

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

12 **A.** Correct.

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

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

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

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

1 might be a special circumstance?

2 **A.** Yes, it would be.

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

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

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

25 **A.** It is indeed, please.

1 Q. It's about 50 --
2 A. 54 pages.
3 Q. 54 pages long? And it sets out, doesn't it, various
4 special circumstances, including asphyxia-induced
5 hypoxia, ligature, choking, suffocation -- I'm just
6 selecting a few examples.
7 A. Sure.
8 Q. It also includes electrolyte abnormalities about which
9 you gave evidence earlier, traumatic cardiac arrest from
10 significant blood loss, cardiac arrest from poisoning,
11 which would include overdose.
12 A. Mm-hm.
13 Q. Special environments which would have the section on
14 drowning, those kind of matters are covered in that
15 paper.
16 But it is, as you say, quite a dense paper.
17 As you've already outlined in the earlier part of
18 your evidence, emergencies arising in special
19 circumstances in mental health inpatient units require
20 special interventions sometimes.
21 A. *(The witness nodded)*.
22 Q. You're nodding. Is that a yes?
23 A. Correct, yes, sorry.
24 Q. We've already covered several times, if possible, as
25 soon as the deterioration is identified?

1 **A.** Correct.

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

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

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

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

24 **A.** Mm-hm.

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

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

6 **A.** Correct.

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

11 **A.** Correct.

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

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

23 **A.** Correct.

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

1 involved in restrictive interventions?

2 **A.** Correct.

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

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

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

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

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

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

22 **A.** We can certainly add it.

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

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

6 **A.** Sorry, could you say that again?

7 **Q.** Yes. I think I can see -- are there any local
8 circumstances that could override that requirement, that
9 minimum standard of ILS-trained staff then monitoring
10 ...

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

1 level of training, they really should follow it.

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

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

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

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

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

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

8 **A.** Yes, standardised level of skillset, yes.

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

14 **A.** Correct.

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

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

25 **A.** Correct.

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

4 A. Correct.

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

7 A. Correct.

8 Q. You received feedback?

9 A. Correct.

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

11 A. Correct.

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

14 A. Correct.

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

17 A. Correct.

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

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

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

25 A. Correct.

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

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

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

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

18 **A.** Mm-hm.

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

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

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

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

10 **A.** So they still do get face-to-face training,
11 -- (overspeaking) --

12 **Q.** Certainly for part of it --

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

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

1 by that?

2 **A.** -- (overspeaking) --

3 **Q.** Verification?

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

7 **Q.** And not doing somebody else?

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

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

13 **A.** They do a half day.

14 **THE CHAIR:** They do a half day?

15 **A.** Yeah.

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

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

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

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

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

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

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

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

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

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

24 **A.** Yes.

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

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

5 **A.** Yes.

6 **Q.** A chest pain?

7 **A.** Correct.

8 **Q.** A hypovolemia? Have I pronounced that correctly?

9 **A.** Yes.

10 **Q.** Anaphylaxis?

11 **A.** Correct.

12 **Q.** Asphyxiation following a ligature?

13 **A.** Yes.

14 **Q.** And a hyperglycaemia?

15 **A.** Correct.

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

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

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

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

1 there's a collapsed person what are you going to do?

2 You ask them to go up, confirm cardiac arrest, put out

3 a cardiac arrest call, start chest compressions,

4 ventilate the patient and use an AED. So it doesn't go

5 above and beyond managing that and having that decision

6 or thought-making process.

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

9 I think you have already touched on this as well.

10 Do you agree it's really important for staff that work

11 together to train together as a team if possible?

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

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

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

4 **A.** Correct.

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

9 **A.** Correct.

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

13 **A.** Okay.

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

19 **A.** Correct.

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

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

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

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

3 **A.** Yes.

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

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

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

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

1 and those --

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

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

9 **A.** That is correct.

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

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

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

18 **A.** Absolutely.

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

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

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

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

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

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

15 A. Correct.

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

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

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

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

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

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

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

19 **Q.** So day and night?

20 **A.** Day and night.

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

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

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

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

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

8 **A.** Correct.

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

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

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

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

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

5 **Q.** So kind of refresher update --

6 **A.** Absolutely.

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

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

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

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

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

11 And I think it also goes on to say that:

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

14 **A.** Correct.

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

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

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

23 **A.** Correct.

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

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

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

11 **A.** Absolutely.

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

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

15 **Q.** The number to call?

16 **A.** Correct.

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

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

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

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

1 needs to be plugged in which means you may not be able
2 to take it around with you. So not every device works
3 perfectly in that sort of sense. But as long as there
4 is a system and process, so that when an event happens,
5 there's no delay in getting that response to a --
6 particularly if it's a 999 response centre, that you are
7 able to give that correct information to the call
8 handler who can send the most appropriate response to
9 the individual.

10 **Q.** That's what I was going to ask. How can that be done if
11 the phone or the person on the phone isn't with the
12 patient?

13 **A.** Mobile phones aren't without their risks in mental
14 health hospitals and that's the challenge we have to
15 think about, the risk/benefit for -- if you're -- if
16 you've got a device with you which could then become
17 problematic for delivering patient care. It's all very
18 much down to that localised risk assessment.

19 Some organisations have emergency call bell buttons
20 which go straight through to an emergency service.
21 Others may have that 2222 system and strategically
22 placed phones within the vicinity. It's just about
23 having that knowledge and awareness of that process on
24 how quickly to get that response out --

25 **Q.** But you don't --

1 **A.** -- in a safe environment.

2 **Q.** But you don't think it is essential for a person to be
3 able to take instructions from, for example, the
4 Ambulance Services with the patient?

5 **A.** But again, they certainly can do, and depending on the
6 situation, they should do. But that's why you need
7 that -- you know, that ILS sort of level clinical
8 response so we can be maintaining elements of
9 resuscitation. The Ambulance Service will provide more
10 advanced level resuscitation, which may be out of the
11 skillset of the individuals to deliver. So the call
12 handler wouldn't be instructing people to do
13 advanced-level resuscitation over the phone, but as long
14 as that message goes to the call dispatch that there is
15 a cardiac arrest and therefore that that rapid response
16 ambulance can be sent to your location, that's the key
17 thing, but it's minimising that time from recognition to
18 placing that call.

19 **Q.** I understand.

20 **A.** That's where the gaps will need to be shortened.

21 **Q.** You've already given evidence that people should know,
22 and in fact you've suggested a huddle at the beginning
23 of a shift, that people know whose responsibility is
24 what, which presumably would include who is going to
25 call 999 or who is going to -- you know, which roles

1 people are going to assume. Should that also include
2 who is going to let the paramedics in, for example?

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

4 **Q.** Who is going to do the door, or who knows the door code?

5 **A.** Absolutely. And those types of things don't need to be
6 limited to clinical members of staff, that's how you can
7 incorporate ward clerks and ward administrators to help
8 guide and help support because in some of these areas,
9 particularly high, sort of, locked-down areas within
10 mental health hospitals it's really important that part
11 of the delay is not getting through the building to
12 provide that life-saving support.

13 **Q.** So there needs to be a process for that?

14 **A.** Yes.

15 **Q.** All right. Again, jumping to a slightly different
16 question and going to the equipment list, and this is at
17 page 4 of your ABC 6, there we are. So this is the list
18 of equipment suggested availability and this is in the
19 airways section, I think, for adults.

20 **A.** Correct.

21 **Q.** And it suggests that ligature cutters should be
22 immediately available on adult wards. As we can see,
23 it's the number 1. Before I ask you about ligature
24 cutters, why is there not a similar requirement for
25 paediatric CAMHS wards?

1 **A.** There should be, and that will be corrected.

2 **Q.** That will be corrected, did you say?

3 **A.** And it will be corrected.

4 **Q.** Does RCUK consider that all staff should carry ligature
5 cutters?

6 **A.** Again, it's that risk-benefit ratio in those areas where
7 it's higher risk, either having identified in a key
8 location, or key locations -- there should be more than
9 one so you're not traipsing around the clinical area
10 looking for clinical cutters -- or absolutely that it
11 might be seen as appropriate for individuals to carry
12 them as well. But it's that risk-benefit ratio of: is
13 it riskier holding a ligature cutter around in the areas
14 or not, essentially depending on the patient cohort.

15 **Q.** Are you able to give any information as to your view on
16 what would be a key location for ligature cutters?

17 **A.** It depends on the local environment. But you would want
18 it somewhere accessible and central and safe.

19 **Q.** A further question, and I think it's on page 14, please,
20 and this relates to drugs. This is where I think --
21 it's the -- maybe I've ... where are we? Let me start
22 by asking this question, and then we'll have a look at
23 the second part.

24 Naloxone is, I think, an accessible drug at the
25 moment.

1 **A.** Mm-hm.

2 **Q.** Would RCUK consider revising the requirement for it to
3 be accessible for it to be immediate on mental health
4 (unclear) --

5 **A.** So the thing with -- naloxone has a short drug life
6 anyway, so when you give to it a patient you're going to
7 need to give several and subsequent doses afterwards.
8 If -- so naloxone is also -- is a reversal agent for
9 opiates, so morphine-based drugs. The reason it's there
10 is because obviously it reduces your respiratory drive
11 by making your respiratory rate drop. You can
12 counteract that and manage that by good quality
13 ventilation before naloxone even comes on the scene.
14 But certainly that's why it's accessible rather than
15 immediate because your first action would always be to
16 ventilate that individual to give them those breaths.

17 **Q.** The part I wanted you to look at, sorry, on page 14, if
18 you have it in front of you, is about the storage of
19 drugs because you give a little bit of information about
20 that at paragraph 42 of your witness statement and it's
21 around keeping resuscitation drugs locked away. And we
22 look at, it says when we look at point 3, it says:

23 "When deciding how and where to store emergency
24 drugs, a local risk assessment is required to balance
25 the risk of access to drugs by patients and visitors

1 against the risk of a delay in access to emergency drugs
2 in an emergency."

3 That's probably self-explanatory. Sorry, it's now
4 my fault. I need to slow down again. Apologies.

5 I think you explain in your paragraph 42 that this
6 reflects a concern that arose, I think, some time ago --

7 **A.** Correct.

8 **Q.** -- when CQC inspectors advised that drugs on
9 resuscitation trolleys should be locked away.

10 **A.** Correct.

11 **Q.** And I think you responded to that, and now you suggest
12 a local risk assessment because it's important that key
13 drugs are in fact readily accessible and not locked
14 away?

15 **A.** That's correct.

16 **Q.** I think that can be taken down now. Thank you.

17 Just moving on now to some -- towards -- you'll be
18 relieved some of the ends of the questions. Can I just
19 ask you about the status of these standards and we
20 touched on this at the beginning.

21 As you explain in your witness statement, at
22 paragraph 38, RCUK do not undertake direct distribution
23 of these to NHS mental health trusts or to private
24 mental health inpatient providers, or indeed any sort of
25 NHS provider; is that right?

1 **A.** Yes, so at the time that these were written initially,
2 we had -- the organisation is small. We are a headcount
3 of 40, which is very small for the remit that we cover.
4 And obviously we're not a statutory, regulatory or
5 accrediting body. So historically our method of
6 communication would be with our core audience of
7 instructors who would predominantly then be
8 resuscitation officers or medics with that interest in
9 resuscitation. We have a lot more -- a better
10 communications and engagement team so that when we do
11 this, the next time around, so this year, we have a
12 greater sort of contact list of people within NHS
13 England and any other devolved nations who to contact.
14 We would certainly contact the Royal Colleges. We would
15 contact like the British National Formulary, the Medical
16 Health Regulatory Authority, so we've got a much, much
17 more bigger impact of people to contact to ensure these
18 get distributed within the organisation.

19 **Q.** So a much wider distribution for the --

20 **A.** Much, much wider.

21 **Q.** If they become the 2026 Quality Standards -- the 2026
22 Quality Standards.

23 We know, however, that you provide -- I don't know
24 if "advice" is the word you would use, but you've set
25 out in your witness statement at paragraph 78, and

1 you've been able to identify examples of when people
2 have contacted RCUK for advice on interpretation of
3 various guidance?

4 **A.** Correct, yes.

5 **Q.** If you are approached, or if you were to be approached,
6 by individual wards or institutions, would you provide
7 perhaps not training but training or advice on the
8 location and storage and contents of standard equipment,
9 for example?

10 **A.** So that's not something we'd be able to provide over the
11 phone, you really need to have a detailed assessment of
12 the environment. If we were to receive an enquiry like
13 that what I would recommend is actually liaising with
14 a local acute trust resuscitation team and asking one of
15 those resus officers to go down and have a look and walk
16 through the space with them so they can do that risk
17 assessment together.

18 **Q.** So RCUK wouldn't do it but you might make suggestions of
19 others where they could get the assistance?

20 **A.** Yes, correct.

21 **Q.** All right. So I think that perhaps answers my next
22 question. So you yourself wouldn't go to specific
23 wards -- as in you the organisation, not necessarily you
24 yourself -- to assess the requirement to have multiple
25 grab bags or particular equipment on that ward?

1 **A.** No, that's outside of our remit, unfortunately.

2 **Q.** All right. You also explain at paragraph 24 of your
3 witness statement that you don't mandate the
4 implementation of the standards?

5 **A.** Correct.

6 **Q.** And you don't operate any formal compliance or
7 accreditation or assurance process in relation to their
8 adoption?

9 **A.** Correct. We are a non-statutory, non-regulatory body.
10 So we have no jurisdiction in this field.

11 **Q.** So inspection and regulation of resuscitation and the
12 provision relating to resuscitation sits with those who
13 regulate healthcare more generally --

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

15 **Q.** -- so the CQC --

16 **A.** The CQC --

17 **Q.** -- NHS England, to a certain extent, and those that
18 regulate individuals, GMC, NMC, if you're dealing with
19 particular individuals' actions?

20 **A.** Correct.

21 **Q.** You make clear that whilst the CQC have reference to
22 RCUK standards, and we've seen an example of that, or
23 you've given evidence about an example of that, you
24 don't have any involvement in CQC inspections?

25 **A.** No, we have none at all.

1 **Q.** Not do you direct or inform CQC inspections?

2 **A.** We might get asked for our opinion on elements of what
3 an assessment may or may not require. I can't think of
4 any off my head, but it would be advice and guidance.
5 If they chose to take it up, it would be down to the
6 CQC.

7 **Q.** Okay, so they might ask you about what an inspection --
8 what might be required?

9 **A.** Correct.

10 **Q.** Are there circumstances in which they might come back to
11 you and say, "This is what we found, what do you think
12 about this?"

13 **A.** To my knowledge, that's historically never happened
14 within the organisation.

15 **Q.** Do you think there's a role for an independent body to
16 oversee the implementation of your standards?

17 **A.** I certainly do think there is an element for that.
18 Resuscitation is one of those elements within healthcare
19 which is so important, vital, recognising my own bias as
20 a resuscitation specialist, but actually it can often be
21 almost a, you know, a secondary thought in certainly
22 it's another thing we have to do in terms of training
23 but, actually, if we want to make that change and
24 increase survival, then having some form of monitoring
25 system would be much more beneficial above and beyond

1 what is sort of standard auditing at the moment.

2 **Q.** Similarly, then -- and we've already seen and you've
3 given evidence about the fact that RCUK recognises
4 challenges with the implementations of the standards in
5 mental health inpatient settings. Would you consider
6 there's a place for additional guidance and support for
7 mental health inpatient settings, as to how to implement
8 your standards?

9 **A.** Certainly, and that's something we can work with our
10 community of practice to help give options and
11 suggestions to individuals. But if there is a great and
12 global area or challenge, then this is something that
13 NHS England should be looking to help support and reduce
14 that sort of inequality.

15 **Q.** I suspect we'll be asked to slow down again in
16 a moment -- no, it's my fault, so I'll go through the
17 other questions slowly.

18 In your view, what is the best way that a Trust
19 could be monitored regarding implementation, compliance,
20 accreditation? Both internally and externally?

21 **A.** Currently I think that needs to sit with the CQC or NHS
22 England.

23 **Q.** I know you've indicated in evidence that it hasn't
24 happened historically, but would you consider -- and
25 you've just told us you're a small number, 40 -- but

1 would RCUK consider, if asked, providing representatives
2 to join CQC on visits or inspections or to provide
3 specific recommendations?

4 **A.** We would be more than happy to have conversations with
5 them to help guide and advise. Within that organisation
6 of 40, I have a clinical team of about six, so it's --
7 that would be a very difficult task for us to go and
8 assess or go along with them to assess. A part of their
9 overarching assessment, because it is one little
10 section, although albeit a very, very important, about
11 the whole governance they're looking at for a hospital
12 or clinical area. But we can certainly have a
13 conversation about what a good assessment looks like and
14 what should be happening.

15 **Q.** And given the small number, I may know the answer to
16 this next question, but do you consider it would be
17 helpful if you did have some form of statutory power to
18 ensure compliance with the guidance and the standards?

19 **A.** I would love that ability, but it's probably not within
20 my gift to say, yes, or no without the trustees saying
21 that, but I can certainly say that as we are the expert
22 body in resuscitation within the UK, we would be ideally
23 placed to help provide that level of assurance.

24 **Q.** In terms of -- yes -- in terms of compliance, your
25 standards record as a "must", and we've been through

1 this, action that healthcare staff receive resuscitation
2 training at regular intervals. We've been through that.

3 Again, turning that on your head, if staff who are
4 working in -- or who staff -- sorry, working in mental
5 health inpatient units who are not up to date with their
6 training remain on the wards, if that makes sense,
7 whether that be ILS or BLS, would you consider that
8 a breach of your standards?

9 **A.** Certainly we would want enough training on that area to
10 make sure it's safe for patient care.

11 **Q.** That was my next question.

12 **A.** And that's the key thing. It's about safety.

13 **Q.** Because it would create a risk to public safety,
14 wouldn't it, in your view?

15 **A.** Exactly. And the kind of example I would give there is
16 our certificates are dated. They're valid for a year.
17 And someone who is two days out of that validation date
18 suddenly wouldn't lose knowledge so there's that
19 mitigation sort of risk whereas someone who may not have
20 had training for five years, that would be a much
21 greater concern, but it is about being overarchingly
22 maintaining that patient safety and being able to
23 provide that appropriate response.

24 **Q.** And finding the balance between the need for compliance
25 with the mandatory resuscitation training, and you've

1 already given evidence about this, with the need to
2 ensure there is sufficient staffing levels?

3 **A.** Correct.

4 **Q.** Even if those staff may potentially be out of date on
5 their training?

6 **A.** I would -- well, the date element is really key.
7 Because you can be out of date one day post or you can
8 be out of date, as I say, five years, and that would be
9 a much, much greater concern.

10 **Q.** Would you consider issuing further guidance for Trusts
11 that disregard or that they don't use non-compliant
12 staff?

13 **A.** That's a difficult question to answer because, again,
14 it's about one element of their role against their whole
15 role within that department. And by taking away
16 somebody, you might then cause other issues and
17 a clinical risk within that environment.

18 **Q.** Do you provide any guidance on staffing levels and staff
19 allocation?

20 **A.** We don't, that's outside of our remit.

21 **Q.** Would you consider agency staff generally undesirable
22 because of the risks around the training and the risks
23 around the fact they haven't been training or haven't
24 done simulations with the team? Sorry, that was
25 probably two questions in one.

1 **A.** Again, it's a difficult question to answer because
2 I don't think -- I can't remember the word you used for
3 the beginning part of that question, sorry, but I don't
4 think agency staff are undesirable, again, because
5 resuscitation is only one part of their role whereas,
6 actually, the needs of the environment can be quite
7 great depending on what's needed in that ward area and
8 therefore they do serve a benefit, you know, agency
9 staff keep the NHS afloat in a lot of clinical areas and
10 they're very much considered as part of the team.

11 We know that teamwork works better in these sorts of
12 skills and drills as we talked about when you're using
13 the same people so they get used to the processes, and
14 they can be a challenge if you have an outsider within
15 that or even a newly employed member within that area,
16 who is not familiar with those sorts of skills and
17 drills or the procedures. But that's about making sure
18 that the induction process to that area is more -- is
19 robust.

20 **Q.** I'm going to finish with just a couple of separate
21 topics and the first is the question of data collection.
22 I think, if we, with reference to paragraph 114 of your
23 statement, it's right that RCUK do not undertake
24 monitoring of individual cardiac arrest incidents?

25 **A.** Sorry, say that again, sorry.

1 Q. That you don't take individual monitoring of individual
2 cardiac arrest incidents?

3 A. Correct.

4 Q. But there are two bodies that do?

5 A. Correct.

6 Q. The National Cardiac Arrest Audit and the
7 Out-of-hospital Cardiac Arrest Outcomes Registry?

8 A. Correct.

9 Q. And you've noted, I think, in your paragraph 135,
10 a limitation in the availability of national data
11 specifically relating to resuscitation events within
12 standalone mental health inpatient environments?

13 A. That is correct.

14 Q. Because there's no body that's -- with a remit for
15 collating or analysing that data.

16 A. There's no body but there's also challenges in, if
17 I look at the National Cardiac Arrest Audit, their
18 criteria for entry on to the audit criteria, mental
19 health hospitals, unless they're part of an acute
20 hospital site, they may not get entry on to the
21 register. So there does need to be a specific way of
22 gathering and collecting information from this patient
23 cohort, certainly.

24 Q. I mean, the long and short of it is that at the moment
25 the result -- the trends and outcomes of cardiac arrests

1 in mental health inpatient units cannot easily be
2 analysed?

3 **A.** That's correct.

4 **Q.** And they can't be compared, really, with either the
5 OHCAO Registry or the NCAA Registry?

6 **A.** Correct.

7 **Q.** Okay. Audit and review. I won't ask that it be put up
8 for speed purposes, but section 12 of the Quality
9 Standards relates to audit and reporting after a CPR
10 event.

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

12 **Q.** And standard 2 provides that:

13 "All CPR attempts must be reviewed."

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

15 **Q.** "When appropriate a root cause analysis must be
16 undertaken and the action plan implemented. A suggested
17 guide for reviewing cardiac arrests is available in the
18 supporting tools below."

19 Now, can you confirm that the supporting tool in
20 fact is the tool that refers on the --

21 **A.** Correct.

22 **Q.** -- that appears on the next page?

23 And that if the answer to any of the questions in
24 that supporting tool raises a concern, the tool
25 recommends a full root cause analysis and action plan.

1 **A.** Correct.

2 **Q.** None of the questions expressly state or suggest that
3 immediately following the event, an accurate and
4 detailed record should be made of the timings of key
5 events such as when the patient was found, when the
6 emergency alarm was activated, when an AED was applied,
7 et cetera. Do you have detailed guidance on what
8 information should be recorded immediately after event?

9 **A.** There should be evidence about what to document during
10 a cardiac arrest which goes through those processes.
11 Because that forms part of your requirements as
12 a healthcare professional for documenting -- or the
13 legal requirement for documenting the care you give
14 during an event. So there are elements within the
15 Quality Standards which say about the location, time,
16 onset of rhythm, what drugs were given, CPR started, all
17 those types of things and along with any other pertinent
18 medical history.

19 **Q.** They don't reference what I'm going to call preservation
20 of evidence, or of items. So CCTV, other recordings,
21 retention of the ligature.

22 **A.** No.

23 **Q.** Do you think they should?

24 **A.** The -- that's a good question. If it's there and it's
25 relevant to the patient's medical records, absolutely.

1 Certainly the preservation of the knot of a ligature is
2 often quite important, but there's no reason, as long as
3 it, you know, it fits within the requirements of GDPR in
4 that sort of sense, you know, you're not monitoring
5 other patients, but there's no reason why it can't be
6 put into a medical note as a reference.

7 **Q.** And do you think guidance might be of assistance in that
8 regard?

9 **A.** It could be. It's outside of our sort of scope of
10 practice to say what should or shouldn't in that sort of
11 sense, but it certainly could be looked into.

12 **Q.** Have you considered developing specific quality
13 standards or guidelines for auditing resuscitation
14 attempts?

15 **A.** We've -- we have some guidance within the Quality
16 Standards but we don't have a set national standard for
17 the requirements for an audit. That very much sits
18 either with the National Cardiac Arrest Audit or the
19 Out-of-Hospital Cardiac Arrest Audit, but they do follow
20 a set template called the Utstein template or formula
21 which looks at the, you know, the rhythm, you know, if
22 you got return to spontaneous circulation, survival to
23 discharge, and those types of things. So there are sort
24 of recommendations in other documentation.

25 **Q.** In terms of review and audit, can I just ask about what

1 you would expect to happen immediately after a cardiac
2 arrest on a mental health inpatient ward. Are you aware
3 of the concept of a hot debrief?

4 **A.** Hot and cold debriefing, yes.

5 **Q.** Can you explain in a sentence what a hot debrief is?

6 **A.** So a hot debrief is one that's done directly after the
7 event. It's a touch base just either to have a quick
8 lessons learned about what's happened, to look at what's
9 going to happen next, restocking of the trolley, you
10 know, these types of things that need to happen
11 immediately. That then feeds into the cold debrief
12 which often usually happens afterwards and is much more
13 structured and organised, and that's where you start
14 looking at the detailed root cause analysis about what
15 was going on with the patient, were there signs of
16 deterioration? Were there, sort of, organisational or
17 was it healthcare-related instances which may have
18 contributed to the cardiac arrest that we know of?

19 So we look to identify where errors may have
20 happened to try and reduce them but also to look for
21 areas of good practice to reinforce those going forward.

22 **Q.** That's kind of a wider ward-level debrief?

23 **A.** Yeah, much more. Much more in-depth looking at the ward
24 and procedures.

25 **Q.** Do you then consider that any learning from cardiac

1 arrest events should be disseminated to all the staff
2 at --

3 **A.** Absolutely.

4 **Q.** Do you have any opinion or views as to the best way of
5 sharing learning in that sense?

6 **A.** It very much depends, again, on the organisation. Very
7 acutely aware that if people just send constant emails
8 about learning, they may or may not get read. So it
9 depends on what works well for that organisation. Do
10 they have regular team huddles? Do they have ward-based
11 team meetings where information and learning can be
12 shared? It kind of depends on the communication system
13 that works better for that hospital.

14 **Q.** Have you ever considered recommending that
15 organisational audits are shared with you, RCUK, so that
16 you contract national learning from cardiac arrest
17 incidents on mental health inpatient wards?

18 **A.** Not something we've considered. But again, we don't
19 collect data on, you know, those sorts of granular stuff
20 from individual organisations. We look at sort of
21 wider, published data, but if there were a national
22 audit set up, then that would be something we'd be
23 really keen to look into.

24 **Q.** Just then coming to the end of the questions I have to
25 ask you, you've already given evidence that the Quality

1 Standards are being reviewed this year?

2 **A.** Correct.

3 **Q.** You've already alluded to changes and matters that are
4 going to be addressed as part of that process. How
5 dramatically do you expect those standards to change,
6 then, when they're reviewed?

7 **A.** A good question. The -- when we -- as an example, when
8 we update our clinical guidelines, we give organisations
9 up to a year to get them embedded, generally. That's
10 our recommendation. We'd probably follow suit with
11 clinical Quality Standards. The reason being if there's
12 a change in policy, that needs to be learnt and
13 disseminated and education needs to happen across an
14 organisation because if we change a document, and an
15 organisation changes, we need to make sure that people
16 on the shop floor, so in those wards and clinical areas,
17 know what's happened, and what's changed and what's why.
18 So we need to give time and flex for that to happen but
19 I would certainly expect it to change within a year.

20 **Q.** Within a year. At paragraph 134 of your witness
21 statement, and you've alluded to this, as well, as we've
22 gone through your evidence, you've set out that RCUK
23 recommends that the ongoing NHS England review of
24 statutory and mandatory training requirements should
25 consider ILS training as a minimum standard within

1 inpatient mental health facilities proportionate to
2 local risk assessment and service configuration.

3 **A.** Correct.

4 **Q.** Why do you consider it's important that the NHS England
5 review considers this change in minimum standards
6 specifically?

7 **A.** So the NHS review, NHS England review, they're looking
8 at mandatory training across the board and part of that
9 is also looking at resuscitation training. And what we
10 want to ensure that quality isn't dropped, and it
11 doesn't become an exercise where everyone then just
12 learns about basic level life support but we want to
13 ensure that, you know, safety is paramount within the
14 workforce. So we want to ensure that clinicians have
15 that understanding of recognition of deteriorating
16 patient. We want them to be able to provide
17 good-quality or high-quality CPR and safe
18 defibrillation.

19 ILS, for us as an organisation, really is that
20 standard about how you manage the event locally to help
21 support the team before the more advanced team arrive,
22 and taking elements of that away, would actually
23 possibly compromise patient care. Certainly when we
24 look at all the stuff we've talked about today,
25 particularly when you look at tranquilisation and stuff,

1 that's the element, the standard we would want to
2 maintain and deliver.

3 **Q.** And would that include healthcare assistants, then, in
4 terms of a recommendation that all clinical staff or
5 frontline staff are provided with that ILS training?

6 **A.** If it's appropriate for their clinical role, absolutely.

7 **THE CHAIR:** If it's appropriate for?

8 **A.** Their clinical role.

9 **THE CHAIR:** I'm just a bit -- I'm struggling a bit as to
10 where you land on all of this. Because earlier you had
11 implied that you weren't actually pressing for ILS for
12 all healthcare assistants, other than those with an
13 interface with patients. In a mental health setting,
14 can you envisage -- can you actually envisage that there
15 wouldn't be a necessity for all healthcare assistants,
16 given what you've told us, to be trained to ILS
17 standards?

18 **A.** As I say, it very much depends on what their clinical
19 role is within that organisation, because what we
20 certainly understand is that the role of the healthcare
21 assistant can be very varied depending on where they
22 work and what their role is and what they're doing.
23 Certainly if there's an expectation for them to be
24 involved with managing or supporting a deteriorating
25 patient or even the people recognising that

1 deterioration has happened because they are the only
2 person looking after that individual whilst being
3 supported by the team, then absolutely certainly.

4 If there is a broader requirement that actually says
5 for the safety element for all patients that it should
6 be a global, everyone should have ILS, we'd be very,
7 very supportive of that, but we recognise that not every
8 healthcare assistant works in the same sort of way
9 across the organisations depending where they -- what
10 their clinical role is.

11 **THE CHAIR:** Okay, thank you.

12 **A.** But what I wouldn't want to do is disadvantage patient
13 care by saying that everyone needs training which could
14 also then become a bottleneck into training, but also by
15 not allowing people to access training who should be --
16 or should be, if that makes sense.

17 **MS HARRIS:** It does, but could I pick up and ask this, then:
18 would you say that everybody needs ILS training if they
19 are potentially a first responder?

20 **A.** Yes. That is a very reasonable request, yes.

21 **Q.** And could you make that recommendation even if
22 NHS England didn't?

23 **A.** We certainly would do. Our position wouldn't change,
24 you know, in that sense we will happily make
25 recommendations to training, to practice, to clinical

1 guidelines, even if there were changes within NHS
2 England which may go against that sort of
3 recommendation. But we're working with them to help
4 guide and advise and support so hopefully that wouldn't
5 be the situation.

6 **MS HARRIS:** Thank you very much, Mr Benson Clarke. That's
7 all my questions -- unless, Chair, you have anything
8 else --

9 **THE CHAIR:** I haven't.

10 **MS HARRIS:** -- you would like to ask?

11 What happens now is we have a 10-minute break to see
12 if there are any other questions from any others that
13 have arisen during the course of your evidence. And if
14 there are, we will come back. And if there aren't, we
15 won't. So I will say very much for helping us today.

16 **THE CHAIR:** I'd like to reiterate those thanks. Thank you
17 very much.

18 **THE WITNESS:** Thank you very much.

19 **THE CHAIR:** Thank you.

20 **(3.00 pm)**

21 **(A short break)**

22 **(3.15 pm)**

23 **THE CHAIR:** Thank you Ms Harris.

24 **MS HARRIS:** Thank you, Chair.

25 Thank you, Mr Benson Clarke. Two short matters.

1 The first matter is returning to your evidence about
2 skin colour or darker skin colours, and pallor and
3 petechial markings being a poor indicator or not being
4 a reliable indicator in persons of darker skin tones.

5 In terms of your current training materials, do any
6 of those training materials make those limitations
7 clear?

8 **A.** It's within our course manuals that there are
9 limitations. We go into quite some detail. The
10 challenge within course materials is that a lot of the
11 mannequins are historic and they are very
12 Caucasian-looking. Manufacturers are bringing our more
13 different-coloured mannequins to reflect proper skin
14 tones, so essentially the scenarios become quite generic
15 in that sort of sense because it's -- it's disrespectful
16 and a little bit discoherent to say that: I want you to
17 imagine that this white mannequin in front of you is
18 a different shade than what we would like it to be, and
19 recognising that actually that does patients a massive
20 disservice. So once the equipment matches up with the
21 requirements, we will certainly be able to do that.

22 **Q.** You've already indicated you're moving away from that in
23 any event --

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

25 **Q.** -- and, I think you indicated that future materials are

1 likely to be updated or future standards are likely to
2 be updated?

3 **A.** Absolutely. Much more reinforcement of that as a sign
4 that people need to be much, much more acutely aware of.

5 **Q.** And is there any more that should be done before
6 updating those materials?

7 **A.** As I say, it's within our course manuals which every
8 candidate who is on a course gets and as we go through
9 those detailed assessments, we talk about differences
10 within skin tone. Anaphylaxis is a great example where
11 you might get hives and flushing on the skin. Well,
12 that is not going to be present. So we talk about how
13 to spot different signs and symptoms to confirm your
14 diagnosis.

15 **Q.** Okay.

16 Slightly separate topic. The standards do not
17 mandate that a doctor on call or, indeed, any healthcare
18 professional on a ward should hold the ALS
19 qualification, but appears to assume a prompt response
20 by ambulance crewed with a paramedic, and we've already
21 heard or you've given a lot of evidence about how,
22 particularly, given the geographical location of mental
23 health inpatient care, the urgent -- prompt response,
24 apologies, or the expert help is likely to be
25 paramedics, ambulance service, or perhaps

1 a resuscitation team if collocated.

2 Do you have any concerns about the fact that the
3 standards don't mandate that the doctor on call should
4 hold an ALS qualification, or do you think, in the
5 circumstances, and given the particular circumstances of
6 mental health inpatient unit, that at least someone on
7 duty should have the ALS qualification which allows for
8 advanced airway management, for example, in case there
9 is a delay in the ambulance or designated resuscitation
10 personnel attending?

11 **A.** So what we do say, within the Quality Standards, it's
12 within the training -- yeah, training starts at
13 section 3.21, that members of mental health
14 resuscitation teams that have specific involvement in
15 resuscitation, particularly team leaders, require
16 a level of training above and beyond provided by local
17 ROs. These people should be encouraged to attend
18 a nationally recognised course such as advanced life
19 support.

20 So we do make the provision that if you're going to
21 be the team leader of a cardiac arrest and you've got
22 that advanced level or an expectation of advanced level
23 skills such as like being a doctor then you certainly
24 should have that ALS-level training.

25 **Q.** But that's a slightly different question, isn't it, than

1 this one, which is: do you think that a person with that
2 level of training should -- there should always be a
3 person --

4 **A.** Oh sorry --

5 **Q.** Sorry, I may have asked it badly -- that there should at
6 least be somebody on duty on the ward or in that mental
7 health inpatient setting who has that level of
8 qualification, given the challenges in getting expert
9 help in?

10 **A.** Certainly there should be someone, if you're having
11 a cardiac arrest team, for the hospital, then you should
12 have someone with that level of qualification.

13 **Q.** Again, I don't think that's the question. The question
14 is: given that in mental health inpatient care you are
15 more often than not, or certainly very often, relying on
16 a 999 telephone call or a team coming in from another
17 location, in those circumstances, do you consider that
18 there should be one person on duty in the unit who has
19 got that advance level training?

20 **A.** When you say "unit", do you mean --

21 **Q.** The mental health inpatient unit --

22 **A.** -- the ward or the hospital?

23 **Q.** Well, if it's -- if it's -- it's different, isn't it,
24 because you're talking about a hospital, I suppose, if
25 they're collocated.

1 **A.** Or --

2 **Q.** I'm asking you -- if it's a mental health inpatient
3 unit, which is not collocated --

4 **A.** Yeah.

5 **Q.** -- with an acute clinical setting and therefore there
6 may be a delay in the expert team arriving, in those
7 circumstances, what would RCUK's view be on whether
8 there should be a person on that unit on duty as part of
9 the staffing rota, with that ALS training?

10 **A.** So sorry, my clarifying point was that they're often not
11 isolated wards when they're in their own mental health
12 facility, you might have several wards together, and
13 it's whether or not you're saying they should have one
14 person on every shift in the ward or within the building
15 at a time, sorry --

16 **Q.** Within the building. It's my fault.

17 **A.** Within the building. So certainly I would say that
18 would be one of our highly recommended elements that the
19 medical cover certainly could do and should do,
20 recognising that within their training they would have
21 gone through acute care, an element within and therefore
22 that would be an appropriate level for them.

23 **MS HARRIS:** Thank you. Those are my additional matters.

24 Chair, did you have any --

25 **THE CHAIR:** No, thank you very much indeed.

1 **MS HARRIS:** I'm asked now if we can have a break until 3.40,
2 at which point the evidence of Beverly Switzer will be
3 played.

4 **THE CHAIR:** Thank you very much indeed.

5 **(3.22 pm)**

6 **(A short break)**

7 **(3.46 pm)**

8 **THE CHAIR:** Good afternoon.

9 **MR GLANVILLE:** Good afternoon. Chair, this afternoon we are
10 playing the evidence of Beverly Switzer, a member of
11 staff at EPUT. Ms Switzer has given oral evidence to
12 the Inquiry by way of a pre-recorded session, which you
13 granted on the basis of special measures.

14 Please could we play the video.

15 **(Pre-recorded evidence of Beverly Switzer)**

16 **MS ONABANJO:** Could you read the words of the affirmation.

17 **BEVERLEY SWITZER (affirmed)**

18 **Questioned by MS ONABANJO**

19 **MS ONABANJO:** Thank you.

20 Could I remind you to please keep the pace slow so
21 that the stenographer can transcribe the proceedings.
22 Thank you.

23 Can you state your full name for the record, please.

24 **A.** Beverly Susan Switzer.

25 **Q.** And you have provided one witness statement to the

1 Inquiry, dated 7 June 2026; is that correct?

2 A. Correct.

3 Q. And you have a copy of that statement in front of you?

4 A. Correct.

5 Q. And the final page of that statement, at page 8, bears

6 your signature, and a statement of truth?

7 A. No signature.

8 Q. Your signature has been redacted.

9 A. Okay, thank you.

10 Q. But you confirm that that is your signature -- that that

11 is your statement?

12 A. Yes.

13 Q. Have you had an opportunity to read it recently?

14 A. Not recently.

15 Q. Do you confirm that the contents of the statement are

16 true to the best of your knowledge and belief?

17 A. To my belief, yes.

18 Q. And are you content for that statement to stand as your

19 evidence to the Inquiry?

20 A. Sorry?

21 Q. Are you content for the statement to stand as your

22 evidence to the Inquiry?

23 A. Yes.

24 Q. Thank you.

25 I will start by asking you questions about your

1 qualifications and your experience. You say at
2 paragraph 2 of your witness statement that you currently
3 work within EPUT Dementia Services?

4 **A.** Correct.

5 **Q.** Is that correct? And at paragraph 5 you say that you
6 started working at EPUT Community Dementia Services in
7 2022; is that correct?

8 **A.** Yes.

9 **Q.** Thank you.

10 Do you recall what month you began working at that
11 service?

12 **A.** To be honest, no. I keep thinking, was it the August or
13 was it the February? Around that time. I think it
14 might have been the February, March time.

15 **Q.** Thank you.

16 What is your role? What is your current role within
17 EPUT Community Dementia Services?

18 **A.** I am a healthcare assistant as well as, now, being a --
19 apprentice nursing associate.

20 **Q.** And as a healthcare assistant, what kind of tasks do you
21 undertake in your role?

22 **A.** I generally do the initial memory monitoring, and that
23 is monitoring medication that patients have been put on
24 after having a diagnosis of dementia. It's also to see
25 how they're doing, how the families are doing, whether

1 they need extra support with OT referrals, Adult Social
2 Care referrals, if they're having any side effects with
3 their medication, if there's any behavioural issues that
4 we can refer to the dementia services, the DST office,
5 or even the Intensive Support Team, and I also do ECGs.

6 **Q.** And when you say the "DST office", what is --

7 **A.** Dementia Support Team.

8 **Q.** Thank you.

9 Prior to your role, your current role, you worked at
10 the Peter Bruff Ward, didn't you?

11 **A.** Correct.

12 **Q.** And you worked there -- you began working there in
13 August 2020?

14 **A.** Correct.

15 **Q.** What was your role there?

16 **A.** Healthcare assistant.

17 **Q.** And at that ward, what types of tasks did you undertake
18 as a healthcare assistant?

19 **A.** Physical observations, level 1s, 2s, and 3s. Obviously
20 engaging with patients, supporting them if they need any
21 support with personal care, being a voice for them if
22 they needed to speak up but didn't feel like they could.

23 **Q.** Thank you.

24 The focus of my questions today would be about your
25 time at the Peter Bruff Ward. Before I move on to my

1 next set of questions, I'll just like to remind you
2 again to keep the pace slow for the benefit of the
3 stenographer. Thank you.

4 Prior to working on the Peter Bruff Ward, I note
5 from paragraph 3 of your statement that you say you were
6 a Senior Healthcare Assistant at Cambian Fairview, which
7 is now Cygnet Care; is that right?

8 **A.** Correct.

9 **Q.** I note that you were a Senior Healthcare Assistant
10 there. Did you have experience prior to working in that
11 role?

12 **A.** In -- what, within Cambian?

13 **Q.** Within healthcare.

14 **A.** Yes. I've been doing healthcare since 1997, and that
15 was with mainly learning disabilities, autism. And --

16 **Q.** And was that, similarly, as a healthcare assistant?

17 **A.** Yes.

18 **Q.** Thank you. And so you have substantial experience as
19 a healthcare assistant?

20 **A.** Yes.

21 **Q.** Thank you.

22 Turning now to the Peter Bruff Ward. What type of
23 ward was it? Was it an acute ward, an inpatient ward?
24 And what types of patients did you see on that ward?

25 **A.** It was -- when I first started there, it was an

1 assessment ward. It was originally designed as an
2 assessment ward. So patients would come in, they'd be
3 assessed, and then -- as to whether they were to go home
4 with treatment or whether they were to be forwarded on
5 to a different ward for longer-term care.

6 **Q.** And were these both male and female patients?

7 **A.** Male and female, yes.

8 **Q.** And do you remember what the size of the ward was? How
9 many beds were on the ward?

10 **A.** I think it's 17 or 18-bedded ward. And we also had,
11 like, an isolation bit as well. Like, it's not -- it's
12 like a -- the only way I can describe it is like
13 a seclusion bit, where someone who -- sorry, someone
14 that was -- the people that I saw going there, that were
15 violent, aggressive, and things like that.

16 **Q.** You've mentioned that it was designed to be an
17 assessment ward?

18 **A.** Yes.

19 **Q.** And you say at paragraph 6 of your witness statement
20 that:

21 "... due to a lack of available beds on ...
22 longer stay wards ... patients would be there for longer
23 than ... planned."

24 **A.** Yes.

25 **Q.** In your experience, how long were patients typically

1 admitted onto the ward?

2 **A.** It could -- it varied from patient to patient. I knew
3 of patients that had been there for a few weeks; I knew
4 patients that had been there for a few months. The
5 longest patient I can recall is nine months.

6 **Q.** In your experience, if it was functioning as an
7 assessment unit as designed, how long would you have
8 expected patients to remain on the ward?

9 **A.** This is my own personal preference, I must add, but you
10 would expect a week, sort of, like, seven days, because
11 then a bed may have become available for them to go
12 into, or they're getting the right treatment into place
13 for them to be able to return to their own home.

14 **Q.** What impact did these extended stays by patients have on
15 the ward, in terms of patient care and, for example, the
16 availability of therapeutic activities for them and
17 planning discharge?

18 **A.** Once again, it's individualised, isn't it, to each
19 patient, I believe. I've only ever worked on the --
20 Peter Bruff. I've never worked on any of the
21 longer-term wards. So I don't know what benefits they
22 would get on the longer-term wards. I can only go by my
23 experience, so I honestly couldn't answer that.

24 **Q.** Thank you.

25 the Inquiry has heard evidence from Zoe Bunting,

1 and she was the Ward Manager at the Peter Bruff Unit
2 from November 2020 and she became Acting Manager --
3 Acting Matron, I apologise, in 2022, and so is it
4 correct that she was the Ward Matron, or Ward Manager,
5 or Acting Matron, for the majority of the period that
6 you were working on the Peter Bruff Ward?

7 **A.** Yes.

8 **Q.** Thank you.

9 I will now ask you some questions about therapeutic
10 activities and care planning.

11 At paragraph 8 of your witness statement, you say
12 there were OT activities, so occupational therapy
13 activities, throughout the week. Can you describe the
14 range of activities that were available to patients on
15 the ward.

16 **A.** It would be things to engage them, like ping pong ball.
17 They'd be doing that -- arts and crafts in -- I'd say
18 mainly it was around the arts and crafts more so than
19 anything.

20 **Q.** And how frequently were these activities available for
21 patients to access?

22 **A.** They were -- there was -- I can recall there used to be
23 an activity list, weekly activity list, put up on the
24 board, Monday to Friday, but there was times, you know,
25 if the occupational therapist was off sick, these

1 activities wouldn't happen.

2 **Q.** Yes, and the Inquiry has in fact heard evidence from
3 Zoe Bunting to say that the activity timetable was
4 impacted by the availability of occupational therapy
5 staff.

6 What impact did the non-delivery of therapeutic
7 activities have on the patients on the ward?

8 **A.** Individualised, once again. You know, it's -- you know,
9 with some, we'd try and find something else for them to
10 do. You know, they would -- there's people that would
11 purchase their own diamond art. So, you know, us, as
12 healthcare assistants, if we could, we'd engage with
13 them with playing cards. You know, inviting them to do
14 their diamond art within the communal area. And trying
15 to, you know -- obviously they were upset at the fact
16 that what they were expecting wasn't happening, but it
17 was obviously out of our control, so we'd try, as
18 healthcare assistants, to put something else in place.
19 But obviously with shortage of staff and everything,
20 it's not always possible to give them that engagement in
21 that way. That's why the occupational therapist people
22 used to come in, to be able to that.

23 **Q.** Zoe Bunting has told the Inquiry that she noted
24 a significantly improved atmosphere on the ward when the
25 activity programme was fulfilled. Is that --

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

2 **Q.** -- consistent with your experience?

3 **A.** Yes, because it gave them something to look forward to.

4 **Q.** Thank you.

5 Turning now to care plans. You say at paragraph 21
6 of your witness statement that care plans were
7 "person centred".

8 The Inquiry has heard evidence that, in practice,
9 care plans were sometimes completed without input from
10 patients or from their families, sometimes because of
11 staffing pressures. Were you aware that sometimes it
12 was not possible to involve patients and their families
13 in care planning?

14 **A.** If the patient wasn't engaging, because sometimes you
15 get patients that would come in onto the ward and they
16 didn't want to engage, so then it became traditional
17 planning. But obviously when they're on the ward, we
18 would -- if there was -- you know, if they were -- they
19 had a decision whether to take any medication that was
20 prescribed for them, it was their choice to say, "No,
21 I don't want it", but I was never involved in any of the
22 planning at all. It was just we were able to read up
23 the care plans once they were in place.

24 **Q.** You refer to "traditional planning". What do you mean
25 by that?

1 **A.** Traditional -- there's two types of care planning.
2 You've got person-centred and you've got traditional,
3 which is what the professionals do. They come in:
4 Right, this person needs that, they need that, they need
5 that. So that that is traditional.

6 Person-centred is where the person is the one that
7 puts their input as well. Everybody is involved.

8 **Q.** Are you aware of circumstances where the care planning
9 wasn't -- the care planning wasn't person centred as
10 a result of factors other than that the patient
11 themselves weren't engaging? So, for example, were
12 there circumstances where traditional care planning had
13 to be undertaken because of pressures on staff?

14 **A.** I can't answer that one because I never was involved
15 with the actual care planning.

16 **Q.** Thank you.

17 You say that care plans were updated by nursing
18 staff, and you've just told me that you weren't involved
19 in that. What arrangements were made to ensure that
20 you, as a healthcare assistant, knew about changes to
21 risk assessments, for example, or updates to the care
22 plan?

23 **A.** Handovers. Handovers. Or if you was on shift and
24 something happened where a risk assessment had to be
25 altered, we would be told.

1 Q. And so, when you say, at paragraph 22 of your statement,
2 that "Any changes or concerns regarding a patient's care
3 plan being updated were always handed over from shift to
4 shift" --

5 A. Yes.

6 Q. -- is that what you mean?

7 A. Yes.

8 Q. That updates and anything you needed to know, as
9 a healthcare assistant, regarding the care to be
10 provided to a patient would be told to you at handover?

11 A. At handover, yes.

12 Q. You also say that care plans were "easily accessed" via
13 the records system on the ward. In practice, did you
14 have time to review patient care plans?

15 A. Not always, no.

16 Q. And how often would you review a patient's care plan in
17 full?

18 A. Me personally, if a patient -- a new patient came on,
19 I would look at their care plan when it was all up on
20 the system and obviously just to see for myself. But to
21 look at it again, with updates, I would say I wouldn't
22 look for updates, I was -- they were handed over.

23 Q. And in terms of not looking for updates, is the reason
24 why you wouldn't look for updates that you would expect
25 that any updates would be provided to you verbally, or

1 were there other factors, such as not having the time to
2 read updates to the care plans?

3 **A.** Sometimes it was not having the time to actually sit
4 there and read the updates. But generally, it was
5 because it was handed -- you know, it would be handed
6 over from shift to shift.

7 **Q.** And how -- in your experience, how full were those
8 handovers from shift to shift? Did you -- were you able
9 to get all of the information? Did you -- in your
10 experience, did you get all of the information that you
11 required in relation to the updates that may have been
12 made to a patient's care plan?

13 **A.** I'll be totally honest -- yeah, the handovers was half
14 an hour long, and I do personally feel sometimes that
15 wasn't long enough to get a full spec of what had
16 happened from the previous shift or from the previous
17 few days. Because you'd be more mindful that the
18 previous shift were waiting to go, so it's like
19 sometimes it could have been -- I feel it could have
20 been a bit rushed.

21 **Q.** And were other matters discussed at those handovers
22 other than changes to care plans?

23 **A.** It was about how the patient's presentation had been,
24 you know, how they'd been within the last 24 hours,
25 generally. Or if there was something important that we

1 still needed to know on a daily -- that was left on the
2 handover, or we were advised, you know, to have a look
3 at anything that we needed to look at. But that was
4 generally -- would be for the nurses on shift more than
5 the HCAs.

6 Q. And in relation to observations, did you rely on the
7 information from these handovers or would you use --
8 would you go to the care plans as part of your
9 observations?

10 A. What do you mean, sorry?

11 Q. So, in conducting observations, for example, would you
12 look to care plans or would you rely on the information
13 that you obtained from handovers?

14 A. Me personally, would rely on information at handovers.

15 Q. Thank you.

16 I will now turn to asking you about safety on the
17 ward. You have explained at paragraph 20 of your
18 statement that you "had no concerns" about patients
19 feeling safe, because no safety concerns were raised
20 with you.

21 Were you aware of any formal processes, for example
22 patient meetings, community meetings, through which
23 patients were encouraged to raise their concerns about
24 safety on the ward?

25 A. There was -- I don't know whether it was daily or

1 whether it was weekly, but there used to be what they
2 called patient huddles, where patients could get
3 together and talk about any concerns that they had, you
4 know, quite freely.

5 And, you know, if patients came up to us with
6 concerns themselves, individually, then we would either
7 ask them -- or make them feel comfortable to address
8 them to the Ward Manager and -- you know, this is me,
9 personal, I would advise them, you know, if they want me
10 to support them, I'll come in there with them. But I've
11 never had any patient say that they didn't feel safe.

12 **Q.** And how frequently did the patient huddles take place?

13 **A.** I can't recall if it was daily or weekly.

14 **Q.** Who organised them?

15 **A.** The Ward Manager.

16 **Q.** And how well do you think that forum worked, in terms of
17 patients raising their concerns and those concerns being
18 addressed?

19 **A.** Ooh, I've ... there was never anybody come back to me to
20 say "Well, I don't think anything's going to be done
21 about that."

22 The Ward Manager would always -- everything would be
23 written down and she would investigate, you know, if it
24 was little things, and like -- generally it was about
25 food, and stuff like that, you know, they're not getting

1 enough food choices, and -- that's from what I can
2 recall.

3 **Q.** Thank you. And I'm only asking about your personal
4 experience.

5 **A.** Okay.

6 **Q.** You say at paragraph 35 of your statement that:

7 "A patient's threats to self-harm were always
8 treated seriously ..."

9 How frequently did you observe patients threatening
10 self-harm?

11 **A.** Depending on what patients were in. You know, it's --
12 once again -- you could -- I would say weekly you'd have
13 someone that was threatening. So it's about giving them
14 the support, to be there with them, you know, to try and
15 get them out of that mindset by getting them to express
16 why they're feeling like it, and escalating it even
17 further, like to the nurses, to making sure that they
18 were aware.

19 **Q.** And you've said that -- you've just said that you would
20 get other staff members involved, and in your statement
21 you do say that if you felt you couldn't confidently
22 manage a situation, you would get another member of
23 staff to take over. What would happen in a situation
24 where the ward was short staffed? How would that
25 situation be dealt with?

1 **A.** You'd obviously, if the patient was feeling that way,
2 we'd have to keep that patient safe, and it was about
3 making sure you knew where they were. They would
4 sometimes be -- if they were feeling that way and we
5 didn't have the -- it's horrible to say, but if we
6 didn't have the staff available to give that time, then
7 they may have been moved up an observation level. So,
8 instead of being checked once in an hour, they were
9 checked four times in an hour.

10 **Q.** Thank you.

11 I now want to ask you some questions about sexual
12 safety. Do you remember there being any incidents of
13 sexual safety on the ward, either involving patients or
14 involving staff?

15 **A.** No.

16 **Q.** And do you remember whether you had any training in
17 relation to sexual safety?

18 **A.** We do, yeah, we do have training around sexual safety
19 and, you know, raising alarms and whether we feel
20 uncomfortable, reporting any concerns and everything.
21 Whether it be patient, staff, patient on patient, staff
22 to patient, and vice versa, we were always told to
23 report it. But I've never experienced anything.

24 **Q.** And in your experience, did you understand the processes
25 for reporting sexual safety issues?

1 **A.** Yeah.

2 **Q.** Thank you.

3 I will now ask you some questions about staffing on
4 the ward.

5 At paragraph 24 of your statement, you say that
6 staffing levels were adequate, but you also note, in the
7 context of carrying out observations, that sometimes
8 staff could be stretched. You recall missing breaks,
9 and there were occasions on which management could not
10 secure bank or agency staff to provide additional
11 support. And you say that:

12 "This would cause burn out for some staff resulting
13 in absents. I have known staff turn over to be quite
14 regular on the ward myself only being there for 2 years
15 before moving on."

16 How frequently would you say you missed breaks as
17 a result of staffing pressures?

18 **A.** Not regularly missed. We would -- it wouldn't be, like,
19 once a week or twice a week, anything like that. It
20 would be on the rare -- it was a rare occasion that we'd
21 miss breaks, but there were times where we did miss
22 breaks because, you know, staff had come in and they'd
23 gone home sick. And at the site we had what was called
24 a site buddy, which is an extra member of staff for
25 where they were needed. They could have been put onto

1 another -- one of the wards, because there was only ever
2 one site buddy, so it was a case of: we'll continue
3 doing the obs. And we just looked after each other when
4 we were still there.

5 Q. When you say that the turnover was quite regular, how
6 frequently would you say staff turned over?

7 A. When I started there, it was like -- about one, two
8 members of staff would leave a month. And then you'd
9 get new staff members. And then there -- I think there
10 was an occasion there was, like, four members of staff
11 were leaving in the space of a couple of months, or less
12 than a couple of months.

13 Q. And did these staff leaving create unfilled vacancies?

14 A. Normally the vacancies were put out if -- if they
15 were -- there was -- no, I know of one staff member that
16 was sick, and was long-term sick, and their vacancy, as
17 far as I'm aware, I don't believe was filled. So,
18 because they're still ongoing sick, even though the
19 shift would -- that they would have been on was filled,
20 it wasn't a case of it was a permanent member of staff.

21 Q. Thank you.

22 You refer to staff experiencing burnout. Did you
23 experience burnout?

24 A. Yes.

25 Q. You also refer at paragraph 35 of your statement to

1 suffering from compassion fatigue. Was that compassion
2 fatigue and burnout part of the reason, or the reason,
3 that you decided to leave inpatient work?

4 **A.** Yes.

5 **Q.** And were there any steps, any actions, that the Trust
6 could have taken to mitigate burnout or compassion
7 fatigue?

8 **A.** I was being burnt out because of doing long days. It
9 wasn't just about the ward; it was about my home life as
10 well. So it -- one was going into the other. I had
11 support where my home life was, through my -- I was
12 seeing my Ward Manager. And it was like -- I'm just
13 going to have to be -- it was like work and home life
14 were very similar, is the way I can put it. So I wasn't
15 able to leave my work at work and my home life at home,
16 because it was too similar, two similar things.

17 **Q.** But in terms of the compassion fatigue, is there
18 anything that the Trust could have done, any steps that
19 could have been taken to improve that situation for you?

20 **A.** I don't know if there could have been.

21 **Q.** You refer to the long shifts and you make reference to
22 this in your witness statement as well, to
23 12-and-a-half-hour shifts, and you say sometimes there
24 is insufficient time to decompress between shifts, and
25 this has an impact on staff.

1 What impact did these long shifts have on staff
2 performance, and how did that translate into impact on
3 patient care?

4 **A.** It could be, like, if you're doing it two long days in
5 a row and you've not had time to decompress from one
6 shift, and you've had a busy shift the day before, then
7 you go in to do another busy shift the following day,
8 it -- it just wears you out. So the -- you know -- it
9 was wearing me out, but I wouldn't let it impact how
10 I cared for the people on the ward.

11 **Q.** Thank you.

12 When I started the questions in this section,
13 I noted that in your statement you started off by saying
14 the staffing levels were adequate, but then we've just
15 talked about some of the pressures on staff --

16 **A.** Yeah.

17 **Q.** -- and some of the difficulties with staff. And
18 Zoe Bunting, who was your manager, who has also told the
19 Inquiry that managing staffing levels has always been
20 a challenge, and she said, for example, that staffing
21 constraints had a direct impact on the ability to
22 deliver observations as prescribed, and they also had an
23 impact on other areas, for example the extent to which
24 care planning could be collaborative and the extent to
25 which engagement with families could be done adequately.

1 Is that consistent with your experience?

2 **A.** I would agree with that.

3 **Q.** Thank you.

4 I will now ask you some questions about the training
5 that you received. I'll come on later to training about
6 observations, but for now, focusing on paragraph 28 of
7 your statement, where you say that NHS bank staff
8 received the same training as permanent staff, but
9 agency staff did not.

10 Do you know how the Trust ensured that agency staff
11 were nevertheless conversant with the Trust's policies
12 and procedures, and the specific policies and procedures
13 for the ward, before they came to work on the ward?

14 **A.** I'm not aware of ...

15 **Q.** Did you observe any differences in understanding, in the
16 level of understanding of policies and procedures
17 between permanent staff and bank staff on the one hand,
18 those who had Trust training, and agency staff on the
19 other hand?

20 **A.** Are you on about the difference in the training?

21 **Q.** Did you observe any difference in understanding? Was it
22 your experience that there was a better understanding of
23 policies and procedures by -- that permanent staff and
24 bank staff had a better understanding than agency staff,
25 who had not received training?

1 **A.** I wouldn't feel there was much different, but obviously
2 they don't -- I don't know what the agency staff's
3 training are. All I know is they're not trained by
4 the NHS.

5 **Q.** Thank you.

6 You explain at paragraph 27 of your statement that
7 you received basic life support training. And you
8 considered that the training was adequate. But you do
9 say that it did not prepare you for the initial shock of
10 finding someone unresponsive.

11 The Inquiry has heard evidence from another witness
12 who said that none of the training courses involved any
13 practical scenario training. Do you think that basic
14 life support training which includes a practical
15 scenario would have helped?

16 **A.** When I've done -- I've done -- with the NHS, I've done
17 the enhanced one that -- basic life support. So
18 obviously I've had that extra bit of training to what
19 the normal training, baseline training is. And I think
20 everyone should have it. Everyone should have that
21 extra bit of training, to be honest.

22 **Q.** The Immediate Life Support Training; is that what you
23 mean?

24 **A.** (No audible answer).

25 **Q.** But in terms of dealing with the shock of a live

1 situation, is there anything that you think could be
2 done to mitigate that?

3 **A.** I honestly don't know. Obviously because we use the
4 Annies, which is the dummies, then it's -- you know,
5 people are sitting there: it's not a real person.

6 **Q.** Thank you.

7 **A.** So it's -- so, you know, you can't do CPR on a real live
8 person, can you? So I don't think there is any
9 preparation out there, unless the instructor is really
10 hard on the trainees and, say, make it into, in inverted
11 brackets, a real-life situation kind of thing. Do you
12 know what I'm trying to say?

13 **Q.** What I understand you to be saying is that it is
14 difficult to replicate --

15 **A.** Yes.

16 **Q.** -- the circumstances of a real-life scenario.

17 **A.** Yes.

18 **Q.** Thank you.

19 We've now been going for 30 minutes, and we --
20 we can take a break if you would like to?

21 **A.** I'm fine.

22 **Q.** You're fine to carry on?

23 I'll now turn to asking you questions about
24 therapeutic observations and engagement.

25 You explain at paragraph 11 of your witness

1 statement, on page 2, that you only ever used three
2 levels of observations on the ward. So, level 1 is once
3 an hour check; level 2 is four checks within an hour,
4 and also knowing where the patient is; and level 3
5 observations is always within eyesight; is that correct?

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

7 **Q.** Do you know what level 4 observations are?

8 **A.** Level 4 observations are where you're next to them.

9 **Q.** Yes, so within an arm's length --

10 **A.** Arm's length, yes.

11 **Q.** In practice, did you have sufficient time to engage with
12 patients while carrying out observations?

13 **A.** If you was on a level 3 with someone, yes, because
14 you're -- you know, generally, if you was on that
15 level 3, you'd engage with that person. Level 2s,
16 you're going round -- obviously level 2 is -- whoever
17 was doing level 2s did the level 1s as well. So you're
18 going round just seeing where people are.

19 Some people would come up and talk to you while
20 you're doing that observation, so -- and you try and
21 engage with them but you knew that you had to make sure
22 everybody else was in a safe place, everyone else was
23 there.

24 **Q.** And so you would not necessarily engage with patients if
25 you were carrying out level 1 or level 2 observations?

1 **A.** No, you'd try not to, because you was looking -- you was
2 trying to be aware of where 17, 18 patients were. But
3 when you was on level 3, you was able to, because it's
4 more of a one-to-one.

5 **Q.** Thank you.

6 You explain that when you started off on Peter Bruff
7 Ward, recording of observations used to be paper --

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

9 **Q.** -- and that this resulted in the timing of checks being
10 estimated. Can you explain why paper records resulted
11 in estimation of the timing of checks?

12 **A.** Because we weren't wearing watches and things like that,
13 you know, and we couldn't -- we'd just, "Oh, it must
14 have been two minutes later."

15 You'd get distracted by other patients. As I was
16 saying a bit before, someone would come and ask you
17 a question or they wanted to engage with you.

18 So it just wasn't accurate timing because you didn't
19 have the watches on you to be able to go: right, okay,
20 and write it down.

21 **Q.** And when would the time be recorded? Would it be whilst
22 you were carrying out --

23 **A.** Yeah.

24 **Q.** -- the observations? But what you are saying is you
25 didn't --

1 **A.** We'd have -- we'd have a board, write it as we were
2 going along, once we'd seen that person.

3 **Q.** And in your experience, was this the practice on the
4 ward: that the times would be recorded in this way,
5 would be estimated in this way?

6 **A.** Generally, yes.

7 **Q.** Did you have any concerns about the reliability of times
8 that were recorded in this way?

9 **A.** Sometimes it wasn't accurate.

10 **Q.** And so you would accept that, for example, estimating
11 times could affect subsequent investigations into -- if
12 an incident occurred, in terms of establishing exactly
13 when the patient was last observed?

14 **A.** Yes.

15 **Q.** Thank you.

16 You explain at paragraph 12 of your statement that
17 you sometimes experienced barriers to completing
18 observations. And you give an example of an alarm going
19 off, or another patient needing support. You then say
20 that some changes were made in 2021, which meant that
21 you would not need to attend any alarms unless it was
22 you that raised it. Prior to these changes being made
23 in 2021, how often were you diverted from observations?

24 **A.** I would say daily, with the patients -- you know,
25 with -- like I've expressed earlier, with the patients

1 wanting to come up and engage with you, delaying the
2 check on the next person.

3 **Q.** And would you be pulled off one-to-one engagement by
4 these distractions?

5 **A.** If you was on a level 3, no. You stayed with your
6 person.

7 **Q.** But level 1 and level 2 --

8 **A.** Level 1 and level 2, you could be, obviously,
9 distracted.

10 **Q.** Why were changes made in 2021 which resulted in you not
11 needing to go away, for example, to respond to an alarm?

12 **A.** I don't know why. I can only guess. And it possibly
13 could have been due to the incident that happened on the
14 ward.

15 **Q.** And is the incident you're referring to the death of
16 Adam Steel?

17 **A.** Yes.

18 **Q.** And how were you informed of the changes to the way that
19 observations were to be carried out after the incident?

20 **A.** I believe that we were just told that it was -- we were
21 going to go to, like, a pad version, and it was -- the
22 Ward Manager told everyone that whoever's on level 1s
23 and level 2s, to redirect people to another staff
24 member.

25 **Q.** And so that electronic tablets were introduced?

1 **A.** Yeah.

2 **Q.** And was this at the same time that Oxevision was
3 introduced?

4 **A.** Oxevision was already there when I started.

5 **Q.** When you started?

6 **A.** Yeah.

7 **Q.** Thank you.

8 **A.** And obviously -- sorry, I missed the Oxevision part.
9 With Oxevision, when I came on shift, I always used to
10 use it just to check in the morning, just to check where
11 everybody was. And it was stopped us doing that, we had
12 to go and do a visual check, because sometimes we'd look
13 through people's doors but we had to, after the
14 incident, open the person's doors and check for
15 breathing.

16 **Q.** Thank you. And I will return to Oxevision and the
17 changes after Adam Steel's death. I will return to
18 those in detail shortly.

19 In terms of staffing pressures and observations, did
20 you witness staff falling asleep or becoming disengaged
21 during observations?

22 **A.** Not falling asleep, but you would see, you know,
23 someone's doing their observation and they're -- you
24 know, they're in the dining room and they're checking
25 who's in there, and someone's gone up to speak to them.

1 So that's -- generally, because we were doing other
2 stuff, we weren't watching who was doing the
3 observations, if you know what I'm trying to ... or am
4 I mishearing?

5 **Q.** No, no. My question was: did you witness staff not
6 being able to carry out observations adequately because
7 of the pressures on their time?

8 **A.** I can only say what was on my time. And sometimes, you
9 know, there was times where you were trying to get the
10 four in the hour, and you've just spent 15 minutes with
11 someone else because the -- within them four checks in
12 the hour, it wasn't at set times. So -- because
13 otherwise the patients would get used to -- "Oh, right,
14 15 minutes, they'll be back." So it was a case of you
15 could do five minutes apart and then leave it for
16 15 minutes. But you'd gauge what the ward environment
17 and the individuals were like.

18 **Q.** Thank you.

19 I will now ask you questions about the training you
20 received on observations. And if I take you to
21 paragraph 13 of your statement, you say that:

22 "The training I recall was from ... staff that knew
23 the system."

24 Your reference to "the system" there, are you
25 talking about the Oxevision system?

1 **A.** Yes.

2 **Q.** Okay. So I will leave the Oxevision system for the
3 moment, and ask you questions about training on
4 observations in general.

5 Did you undertake any training on observations
6 before you started working at EPUT?

7 **A.** I cannot recall taking any.

8 **Q.** And what about training on observations at any point in
9 your career?

10 **A.** I can't recall any. It was from -- learning from
11 staff-to-staff, from what I can recall.

12 **Q.** And is that the same in relation to how to engage with
13 patients? Did you receive any training in relation to
14 that?

15 **A.** To engagement?

16 **Q.** Yes.

17 **A.** Um ... I don't know if it was -- if it was before that,
18 but I -- the only things I'm thinking about is, like,
19 open questions, closed questions, and ...

20 **Q.** And in terms of that, where did you receive that
21 training?

22 **A.** That would have been with EPUT.

23 **Q.** With EPUT.

24 Were you required to complete an observations
25 competency checklist when you started at Peter Bruff

1 Ward?

2 **A.** I can't recall.

3 **Q.** Thank you.

4 You say that you were informed that the policy for

5 engagement and observations could be found on the

6 intranet as well as being in a folder on the ward. You

7 say you don't recall any training on it, other than to

8 read it. Was reading the policy mandatory?

9 **A.** I don't recall if it was -- you know, all policies and

10 that are -- I don't know about reading the policy, we

11 get told -- I was told to read up on all the policies,

12 and we're shown where the folder is. We get told it's

13 on the intranet. And we do spend whatever time, you

14 know, within the first week we're shadowing, so we do go

15 through the folder.

16 **Q.** So, do you recall reading the policy?

17 **A.** I don't recall reading it.

18 **Q.** Do you recall whether anybody checked, any manager

19 checked, whether you had read the policy?

20 **A.** No.

21 **Q.** Would more formal training on observations and

22 engagement have been -- would that have been useful to

23 you in carrying out and understanding the purpose of

24 observations?

25 **A.** I think it would have been beneficial.

1 **Q.** Thank you.

2 I will now ask you some questions about Oxevision.

3 So I've taken you to paragraph 13 already, where you say
4 the training "was from other staff that knew the
5 system". You say you can't recall whether there was
6 online training. You say that you were able to advise
7 and train new staff members when they were shadowing
8 you.

9 You also say at paragraph 15 that you had no
10 specific training for Oxevision other than being shown
11 how it works. And you say that:

12 "... a better explanation with training at the time
13 would have been more beneficial."

14 Would it be correct, therefore, to say that the
15 training that you received on Oxevision was informal?

16 **A.** Was in fault?

17 **Q.** Informal.

18 **A.** Informal. It was from another staff member.

19 **Q.** And how was it delivered? Was there a specific time
20 allotted for that training or --

21 **A.** It was whoever you were shadowing, and you was obviously
22 shown around the ward, shown where everything was,
23 fire points, and you was then shown the Oxevision and
24 just told how it works. And then shown, obviously, "You
25 press ..." and then what -- you press "Vitals" and then

1 you could -- things would come up and be recorded.

2 **Q.** And so the people who you were shadowing would show you

3 how the system worked. And who would that be,

4 typically?

5 **A.** Another HCA.

6 **Q.** Another healthcare assistant.

7 And how did the managers on the ward, for example

8 the Ward Manager, satisfy themselves that you were

9 competent in operating the system?

10 **A.** They didn't, that I recall.

11 **Q.** Do you recall ever being given a copy of the Oxevision

12 Standard Operating Procedure?

13 **A.** No.

14 **Q.** Do you recall ever being told about or given any

15 training informally, or guidance, about how the

16 procedures would be -- the procedures in the SOP would

17 be implemented, and how they would be updated?

18 **A.** No.

19 **Q.** You mentioned giving patients leaflets about Oxevision.

20 So, apart from those leaflets, did you see any written

21 information about Oxevision and how it functions and how

22 it's supposed to be used?

23 **A.** I can't recall, no. Just the leaflets that we used to

24 hand to the patients to make them aware that it was

25 there.

1 **Q.** And when you say that it would have been -- a better
2 explanation with training would have been beneficial, at
3 the time that you were being shown how Oxevision worked,
4 did you have concerns about the training that you had
5 received in relation to it?

6 **A.** Not at the time.

7 **Q.** In terms of using Oxevision, what was your understanding
8 of the purpose and how it was to be used?

9 **A.** It was there -- it alerted you when someone came out of
10 their bedroom. It let you know (sic) whether someone
11 was in the room, whether the room was empty. And we
12 would use it just for a quick visual check, especially
13 if we had concerns about whether -- a patient's mental
14 state. So it would be like an extra, that you would use
15 it against the four other checks.

16 **Q.** So if somebody was on level 2 observations --

17 **A.** Yeah.

18 **Q.** -- you're saying that the check via Oxevision was an
19 extra check --

20 **A.** Should have been an extra check. But I know that some
21 people used it as one of their checks.

22 **Q.** And to what extent did people use it as one of the
23 checks? Was this widespread, in your experience, on the
24 ward? Or was it a few people that used it as one of the
25 four checks?

1 **A.** I don't know if it was widespread or not. But I know,
2 you know -- and I put my hand up, myself included -- had
3 used it a couple of times as a check.

4 **Q.** Can you talk us through how Oxevision and the electronic
5 pad that you used with it, how that is used to carry out
6 observations? If you would walk us through how you
7 would use the system to carry out -- in the course of an
8 observation.

9 **A.** The pad wasn't the -- the Oxe pad -- you know, we had
10 the Oxevision on the screen, and the pad was separate.
11 The pad would give your level 1s and 2s and it was like
12 your paperwork on a pad. So I don't -- I can't recall
13 if that was connected to the Oxevision.

14 **Q.** So if you were using the Oxevision system, in connection
15 with an observation, how would you use the Oxevision
16 system? What would you do?

17 Could you take us through the steps of how you would
18 use the system.

19 **A.** You would press on the room number.

20 **Q.** And where would you press on the room number?

21 **A.** On the screen.

22 **Q.** And where is this screen?

23 **A.** In the office.

24 **Q.** In the office.

25 **A.** You'd see where the person -- if the person was in the

1 room or not. You could see if they were moving. There
2 is a bit on there that you could press "Vitals", and it
3 would tell you their pulse rate, and I can't remember
4 what else. I think there was two things it would tell
5 you. Breath rate. I think it's pulse and breath rate.
6 Then it'd be after, I think it was, like,
7 10 or 15 seconds, it would go off.

8 **Q.** So you could use the Oxevision system remotely from the
9 office to check on vital signs, the pulse rates and the
10 breath rate, and you could also use it remotely to
11 observe a patient?

12 **A.** Yeah.

13 **Q.** And you've already said that sometimes, if a patient who
14 was on level 2 observations, for example, that remote
15 observation could count as one of the four observations
16 within an hour?

17 **A.** Yeah.

18 **MS ONABANJO:** I think it's a convenient time to take
19 a break.

20 **(A short break)**

21 **MS ONABANJO:** When you were giving your answer in relation
22 to the way in which you conduct level 2 observations,
23 you explained that you might not engage individually
24 with patients because you try to be aware of -- you
25 would be trying to be aware of 17 or 18 patients.

1 Does that mean that one person would have been
2 responsible for, for example, conducting level 2
3 observations in relation to 17 or 18 patients?

4 **A.** Yes, and you did that for an hour. Sometimes,
5 obviously, you'd end up going on and doing it for
6 two hours.

7 **Q.** So there were times where the entire unit was on level 2
8 observations and it was the responsibility of one person
9 to conduct those observations?

10 **A.** More so on the level 2s, yes.

11 **Q.** Thank you.

12 In terms of the accuracy of time recording of -- on
13 paper, you explain that one of the reasons why time
14 can't be recorded accurately was because healthcare
15 assistants weren't wearing watches. But could that have
16 been remedied by wearing a watch? Would that have then
17 ensured that you were then able to record time
18 accurately?

19 **A.** For me it would have been. I'd be able to look right at
20 the time. Or even more clocks.

21 **Q.** More clocks in the unit?

22 **A.** More clocks within the unit.

23 **Q.** Within the unit. Thank you.

24 Then could you tell the Inquiry whether you are
25 aware of Oxeobs? Oxeobs, whether you're aware of what

1 Oxeobs is.

2 **A.** Oxeobs?

3 **Q.** Yes.

4 **A.** I just believe it's the Oxehealth obs, or --

5 **Q.** And what is your understanding of what that is?

6 **A.** I'd have to -- I'll have to say no.

7 **Q.** My question was whether you're aware of the -- a device,

8 an electronic device, that was connected to the

9 Oxevision system --

10 **A.** Oh, the hand one, yes.

11 **Q.** Yes -- that was used to take observations?

12 **A.** We never used to take that round with us. That

13 was -- you know, someone would have it.

14 **Q.** And so the only way that you would conduct observations

15 using the Oxevision system was, as you've described

16 previously, from the --

17 **A.** Either on the little small thing or in the office on

18 the ...

19 **Q.** So, on the little small thing, could you have used the

20 little small thing in the way that you could have used

21 the screen in the office?

22 **A.** Yes, you could do.

23 **Q.** And were you, as a healthcare assistant, able to use the

24 device in that way?

25 **A.** I could use it in that way if I wanted, but for level 2

1 obs, we used to just walk round.

2 I'm getting confused, sorry.

3 **Q.** In the course of your evidence earlier you were

4 explaining that you -- the handheld devices weren't used

5 to carry out observations. I'm just trying to

6 understand what the nature of -- what the type of the

7 handheld devices that you had, what it was and what it

8 could do, and how you used it.

9 **A.** When we had Oxe -- just the Oxevision, before it went

10 from the paper to the tablets, it's -- the Oxe one and

11 the new one were two separate things. So the hand

12 tablet for the Oxevision is the same as on the screen.

13 **Q.** The same as on the screen in the office?

14 **A.** Yes.

15 **Q.** Then what was the change?

16 **A.** The change was we had tablets come in where you had to

17 record level 2 obs and level 1 obs of, like, where they

18 were. And there was bits in there that you could put

19 "in bedroom", sort of like "sitting in lounge", "awake",

20 "asleep", and things like that. You had to put in what

21 the person was doing when you did that check.

22 **Q.** And you would move around with that --

23 **A.** Yes.

24 **Q.** -- with that tablet?

25 **A.** Yeah, you was not able to visually see them on that

1 tablet.

2 Q. Thank you.

3 I will now ask you some questions about Adam Steel's
4 case.

5 In the statement that you provided to the inquest
6 into his death, that is exhibited to your statement to
7 the Inquiry, you explained that you used the -- that you
8 conducted a preliminary level 2 observation.

9 A. *(The witness nodded)*.

10 Q. What did you mean by preliminary level 2 observation?

11 A. When I used to go in, as I've said earlier, in the
12 morning, that was a thing that I did: that I would check
13 the Oxehealth to see where everybody was, to see whether
14 they were asleep, awake. Just for my own peace of mind.

15 Q. And this was the check in the office that you --

16 A. That was the check I did on the monitor in the office.

17 Q. Did that constitute one of the four levels --

18 A. On that day I put it down as one of the four, because
19 I was then given the level 2s.

20 Q. Thank you.

21 I will now ask you questions about learnings from
22 the death of Adam Steel. You say that following the
23 death -- at paragraph 34 of your statement:

24 "You were informed that Oxevision was NOT to be used
25 as a level 2 check and all checks had to be visual even

1 if it meant opening a patient's door and ... waking them
2 up."

3 How was that learning communicated to you?

4 **A.** Team meetings.

5 **Q.** And are you aware whether that learning was shared just
6 at your ward level or whether it was Trust-wide?

7 **A.** I don't know if it was Trust-wide but I knew it was on
8 our ward.

9 **Q.** And did this information impact the way in which staff
10 conducted observations in practice?

11 **A.** As in?

12 **Q.** Did -- in your experience, did staff comply with that --

13 **A.** Yeah.

14 **Q.** -- direction?

15 Zoe Bunting has given evidence to the Inquiry to say
16 that she personally issued reminders of face-to-face
17 checks being required for level 1 and level 2
18 observations.

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

20 **Q.** Were those reminders given after the death of
21 Adam Steel?

22 **A.** Yes.

23 **Q.** Thank you.

24 I will now ask you about the extent to which
25 patients consented to the use of Oxevision. At

1 paragraph 16 of your statement you say that:

2 "Some patients did not like the idea that, of
3 Oxevision being used and would cover up the camera with
4 stickers or paper."

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

6 **Q.** Was it your understanding that those patients weren't
7 consenting to the use of Oxevision?

8 **A.** Some of them, yes, I would agree, they didn't -- it was
9 like they did not want to be -- they didn't feel
10 comfortable. And I would explain to them again that it
11 was there not to spy on them or, you know, to watch
12 them; it was there to check that they were safe.

13 **Q.** And what process was followed if a patient insisted that
14 they did not want to be observed using the Oxevision
15 system, whether they said it in words or by their
16 actions they demonstrated that they did not want to be
17 observed?

18 **A.** We would just report it, like, escalate it to -- as an
19 HCA, we'd escalate it to the nurse in charge. And then
20 I don't know where -- to be honest, I don't know where
21 it went from there.

22 **Q.** And so you don't know action would then be taken --

23 **A.** No.

24 **Q.** -- as a result?

25 You describe the fact that patients could be

1 observed from the stations --

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

3 **Q.** -- and you could go into the live feed of them in the
4 bedroom. To what extent were patients aware of the fact
5 that they could be observed at any time when the
6 Oxevision system was on in their bedrooms?

7 **A.** They were informed upon entrance to the -- once they
8 came onto the ward.

9 **Q.** And how were they informed?

10 **A.** We'd verbally tell them, and there was leaflets that we
11 gave.

12 **Q.** And do you recall what information was contained in the
13 leaflets that they were provided with?

14 **A.** Not the exact information, but it was around of how --
15 that it was there and how it worked.

16 **Q.** Thank you.

17 I will now ask you about the response to
18 investigations in general, and the support that you were
19 provided. You have said at paragraph 36 of your
20 statement that you considered the investigation
21 following Adam Steel's death to have been timely and
22 professional.

23 Were you given an opportunity to contribute to that
24 investigation and to the recommendations arising from
25 it?

1 **A.** Not with recommendations arising from it, but obviously
2 contributing the fact of witness statements, and
3 obviously speaking with the police.

4 **Q.** Were you informed of how the recommendations that flowed
5 from -- apart from the one that we've discussed, were
6 you informed of how any other learnings from that
7 incident, how the compliance were to be monitored, and
8 how -- any steps that would be taken in relation to the
9 learnings from that incident?

10 **A.** No.

11 **Q.** You describe in your statement going into shock after
12 finding Mr Steel deceased. Following that incident, was
13 there a formal debrief undertaken?

14 **A.** I cannot recall a formal debrief, because we continued
15 with the rest of the day. Obviously, Mr Steel was found
16 first thing in the morning, and we continued with the
17 shift. And it was just supporting each other as a team.
18 So if we needed time out, we could. Zoe said if we
19 needed to speak to her, we could. And being able to
20 take a step back throughout the day when we needed to.

21 **Q.** And how would you describe the adequacy of the support
22 that you were provided with in that process?

23 **A.** As a team, we supported each other good, then.

24 **Q.** You describe the communication and leadership on the
25 Peter Bruff Ward as "positive", and you say that the

1 learning incidents were shared. What was it that
2 contributed to the positive leadership in the ward at
3 the time?

4 **A.** Can you rephrase that for me?

5 **Q.** In what way do you consider that the leadership was
6 positive? How did that manifest, and in what way did
7 you feel the benefits of positive leadership on the
8 ward?

9 **A.** On that day?

10 **Q.** Not on that day, just generally.

11 **A.** The leadership I class as the nurses in charge. And
12 whilst I worked there, the nurses in charge, in my
13 opinion, were good nurses. They supported their staff
14 as well as they could.

15 **Q.** And you do say in your statement that Ward Managers were
16 visible --

17 **A.** Yes.

18 **Q.** -- that daily huddles took place at which concerns could
19 be raised, and they shared new practices.

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

21 **Q.** Do you know whether there were any steps to record
22 actions arising from those huddles, and to monitor what
23 steps were taken in relation to actions raised -- in
24 relation to concerns raised at those huddles?

25 **A.** Obviously the huddles were recorded, and then it would

1 be the Ward Manager that would escalate any concerns or
2 anything else. As to how -- what the process was after
3 that, I wouldn't know.

4 **Q.** Thank you.

5 And finally, coming on to your recommendations. You
6 have -- you suggest that the Inquiry should consider
7 crisis services beyond inpatient wards, and you refer to
8 an occasion where a Crisis Team describes and cites
9 suicidal behaviour as "attention seeking". Was this in
10 any way related -- did this circumstance arise out of
11 your employment with EPUT?

12 **A.** It's through -- it was whilst I was working for EPUT,
13 and it was personal circumstances that made me see the
14 parent side, and what a family member struggles -- can
15 struggle with to actually get the support from the
16 mental health services -- not just wards, but even the
17 Crisis line, to begin with.

18 **MS ONABANJO:** Thank you.

19 Those are all the questions that I have for you.

20 Thank you.

21 **(Pre-recorded evidence of Beverly Switzer concludes)**

22 **THE CHAIR:** Mr Glanville?

23 **MR GLANVILLE:** Chair, that concludes the evidence for today.

24 We will continue the evidence tomorrow at 10.00 am when
25 will hear evidence from two comparator trusts on their

1 use of Oxevision, namely Tees, Esk and Wear Valleys NHS
2 Foundation Trust and Leicestershire Partnership NHS
3 Trust.

4 **THE CHAIR:** Thank you very much. Tomorrow morning at 10.00.

5 **(5.02 pm)**

6 **(The hearing adjourned until 10.00 am the following day)**

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