Thursday, 9 July 2026

(10.00 am)

(Proceedings delayed)

(10.06 am)

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Good morning, Chair.

This morning the Inquiry will hear from Ms Dawn Low, the undercover reporter from the Dispatches documentary Hospital Undercover: Are Our Wards Safe?

She will be giving evidence about her observations whilst working under cover as a healthcare assistant during a two-month period between 5 April and to the 8 June 2022.

She will talk about her experiences whilst working shifts at the Willow Ward, Rochford Hospital, the Mental Health Urgent Care Department in Basildon Hospital, the Cherrydown Ward in Basildon Mental Health Unit, and the Galleywood Ward at the Linden Centre.

This afternoon we will hear from Mr Ian Arthur. He is a Registered Mental Health Nurse and is currently seconded to the Mid and South Essex NHS Foundation Trust working as the Integrated Discharge Hub Mental Health Lead.

His previous experience includes working at various managerial levels on older adult wards, dementia care

wards, during various periods from 2018 to October 2023. He was also responsible for the Peter Bruff Unit.

Before we hear any evidence, and as with previous days, Chair, there may be aspects of today's evidence that are difficult to listen to. And for some it may not be possible to sit through the sessions. Anyone in the Inquiry room should feel free to leave at any time.

May I take this opportunity to remind those engaging with the Inquiry that emotional support is available to anyone who requires it. Present here again today, as with other days, are members of our emotional support staff from Hestia, an experienced provider of emotional support at these types of hearings. They are currently in this room and can be identified by their orange-coloured scarves.

There is a private room downstairs where anyone who needs emotional support can talk to Hestia support staff.

If you prefer, you can talk to a member of the Inquiry Team and we will put you in touch with the emotional support staff. We are all wearing purple-coloured lanyards.

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

@lampardinquiry.org.uk. The "Support" tab is near the top right-hand corner. We want everyone engaging with this Inquiry, in whatever way, to feel safe and supported.

Thank you, Chair, we are ready to hear from our first witness this morning who is already sitting here. Could I ask that the witness be sworn, please.

DAWN LOW (sworn)

Questioned by MS MALHOTRA

MS MALHOTRA: Thank you. You've provided a witness statement to the Inquiry dated 28 May of this year.

Have you had an opportunity to read it recently?

A. Yes, I have.

Q. And do you have any corrections you wish to make to your statement?

A. Yes, I do.

Q. What are those corrections, please?

A. I would just like to correct two of the dates contained within my statement. Shift 11 should read "A shift on Cherrydown Ward on 28 May 2022", and my last shift at Willow Ward was on 9 June 2022, rather than the 8th.

Q. Thank you very much. Aside from those corrections, can you confirm that the contents of your statement are true?

A. Yes, they are.

Q. Now, you were the undercover reporter in the Channel 4 Dispatches documentary produced by Harbar 8, called Hospital Undercover: Are Our Wards Safe; is that right?

A. That's correct.

Q. And the documentary aired on 10 October 2022; is that correct?

A. That's correct.

Q. And you undertook shifts as an undercover Bank healthcare assistant during a two-month period which you've now corrected, 5 April 2022 to 9 June 2022; is that right?

A. That's right.

Q. You worked a total of 13 shifts across four wards, nine shifts at the Willow Ward in Rochford Hospital, one shift at the Mental Health Urgent Care Department in Basildon Hospital, two shifts at the Cherrydown Ward in Basildon Mental Health Unit and one shift at the Galleywood Ward, Linden Centre; is that correct?

A. That's correct.

Q. And from your witness statement, we can see that you worked on the Willow Ward on the following dates: so the first shift was on 5 April, the second shift was on 6 April, third shift on the 12th, the fourth shift on the 16th, the fifth shift on the 19th, the sixth shift on the 20th, shift 7 was on the 25th, shift 8 was on the

27 April -- those were all April 2022 -- with the last shift that you've just mentioned, 9 June 2022; is that right?

A. That's right.

Q. You worked, as we say, one shift on the Mental Health Urgent Care Department on 17 May 2022; does that sound right to you?

A. Yes.

Q. And just about the Mental Health Urgent Care Department, was there a specific name of the ward, or can you give us any information about what that was?

A. I'm not -- I can't remember whether it had a name. It may well have done but I can't remember that.

Q. What type of unit was it, the Urgent Care Department?

A. From memory it was a ward where, if someone had been sectioned by the hospital or by other agencies, they would go on to that ward where they would be assessed.

Q. So an assessment, an assessment unit?

A. I believe so, yes.

Q. Then one shift on Cherrydown Ward on 20 May 2022; is that right?

A. That's correct.

Q. And then a second shift, can you recall when that shift was?

A. That was 28 May.

Q. And then again, 2022?

A. 2022, sorry, yes.

Q. And then one shift on the Galleywood Ward on 1 June 2022; is that so?

A. That's correct, yes.

Q. So a total of 13 shifts. I'd like to ask you about the length of those shifts. Each shift was 12.5 hours; is that right?

A. That's correct, yes.

Q. So were all the 13 shifts that you worked 12.5 hours?

A. Yes, they were.

Q. So by my calculation that's 162.5 hours working within the mental health, the four wards that you've -- we've already mentioned at EPUT; does that sound right to you?

A. That sounds about right, yes.

Q. Prior to working as a healthcare assistant for those 13 shifts, did you have any experience of working in healthcare?

A. No, I didn't.

Q. Have you gained any experience of working in healthcare since?

A. No, I haven't.

Q. Do you have any clinical, nursing or mental health professional background?

A. No, I don't.

Q. Is the extent of your experience working in mental health for those 13 shifts?

A. That is correct, yes.

Q. And so that's the prism within which we view your evidence; would that be right?

A. That's correct, yes.

Q. What's your motivation for giving evidence to this Inquiry today?

A. I think it's important. One of the reasons I worked undercover within EPUT was to hopefully get this Inquiry on to a statutory footing, and I think it's important to bring to life my experiences whilst working within those wards. Obviously I wasn't -- I was independent, if you like, of the Trust and I just think I think it's important to bring to life my experiences.

Q. You say in your witness statement, I wonder if we could have this up on the screen, please, page 22, paragraph 72:

"During my time with EPUT I would say it was one of the most difficult jobs I have ever done. There is no consistency across the wards, a severe lack of leadership and support for the staff members and an environment that is absolute chaos. I would say that for things to improve significantly there needs to be an overhaul of the way the wards are run."

Does that fairly summarise your experience across the 13 shifts on those four wards?

A. Yes, it does. That is my opinion, obviously based on the 13 shifts working on those wards.

THE CHAIR: Can I ask you, before you took up the role of working as an HCA, had you been aware of the issues with EPUT and the calls for a statutory Inquiry?

A. Yes, I was.

THE CHAIR: Thank you.

MS MALHOTRA: Thank you.

I have a number of topics that I would like to explore with you this morning. One of those is your recruitment experience to become a healthcare assistant. Perhaps if we could have up page 1, paragraph 4 of your statement, please. You describe here in your witness statement it being a lengthy, "a lengthy and frustrating one."

You go on to say:

"It was extremely difficult to make contact with the recruitment department, the phone was rarely answered, but when it was, I was told on more than one occasion that staff were working from home. I was instructed to communicate via email, it [could] take days for me to receive a response to email enquiries. I had to send numerous follow up emails to prompt a response."

Can you remember when you first made contact?

A. I can't remember the date of when I first made contact but it would have been around probably the beginning of September. I can't remember the exact date.

Q. And who did you contact? For example, was it EPUT directly, or was it to an agency?

A. No, it was EPUT directly.

Q. Approximately how many times did you need to telephone or email?

A. It was a daily thing, because obviously I was keen to become a bank staff member, so it was a daily thing to the point that on one occasion, and I can't remember the date, I actually drove to the recruitment centre in Grays and there was a notice -- hoping to speak to somebody, but there was no one there, there was a notice on the door saying for enquiries to ring the number I'd been calling and getting no response.

Emails would take days to answer. It was a frustrating process.

Q. And you tell us in your statement, we can see it there on the screen, on 10 September 2021 you completed an application form which required you to fill out your personal details, work history, and provide details of your previous employment.

Presumably you didn't provide any details of past

employment in healthcare, because you didn't have any. Is that right?

A. I didn't have any experience. However, I was -- I had applied to become a Covid vaccinator but never actually performed the role because -- I did the training for that but there was never any shifts available so I didn't actually put my training as a Covid vaccinator into practice.

Q. And when you applied to be a healthcare assistant, what information were you given about the role before you submitted your application form?

A. I really can't remember.

Q. To help jog your memory maybe, was there a job description with the experience, qualities and characteristics that were expected of a healthcare assistant?

A. I can't remember.

Q. Were you given any indication of what wards you would be working on?

A. No.

Q. Were you given any indication of being confined to particular wards?

A. No, my understanding, the role I applied for was a Bank healthcare assistant within the mental health wards, within Essex Partnership Trust. So I was aware of what

wards were within that area, and the mental health wards, not normal, you know, medical wards. They were mental health environment.

Q. Were you aware of any restrictions on working on particular wards?

A. No.

Q. You say you completed a New Starter Pack -- we can see that, for those following your statement, at page 2, paragraph 4 -- a New Starter Pack which required proof of address and identity. As far as you can recall, there was no eligibility criteria apart from having the Covid-19 vaccination and completing a DBS check. Was there anything in that starter pack, to the best of your recollection, about the characteristics or qualities, job description, or any restrictions on working on particular wards?

A. Not that I can remember.

Q. Do you know if a DBS check was undertaken?

A. I assume so. Again, I can't remember. It was four and a half years ago. And I had had a DBS check done for the Covid vaccinator role, like I said, that I'd never actually got to perform, so whether or not that kind of encapsulated that time frame, I couldn't be sure.

Q. And you say at page 2, paragraph 4:

"There was no interview process."

And three months later in December 2021, you were told that you were successful; is that right?

A. That's correct, yes.

Q. You were offered the role of a bank healthcare assistant, did this mean that you were employed by EPUT or via an agency?

A. Via EPUT.

Q. And would you describe the recruitment process as robust?

A. I would have thought that an interview, at the very least, whether that was an online interview via Teams or some conversation, would have taken place. But there was nothing of that nature. It was literally my application form, and then I was offered the job.

Q. I'd like to ask you next about training. You explain that before you were allowed to work on the wards, you had to complete a series of online and in-person mandatory training courses, and the courses had to be completed within seven days of receiving, was it a link, in order to undertake the courses?

A. That's right. It was called a training tracker. And you had seven days from receipt of the training tracker to complete the 20 online courses, some of which were quite lengthy courses.

Q. And you say in your statement at page 2, paragraph 5,

that you had to chase the training tracker by sending numerous emails and making numerous phone calls on almost a daily basis to prompt the tracker to be sent.

When you say "numerous emails and phone calls on almost a daily basis", can you help us with how many that might have been?

A. Well, it would have been a phone call or an email a day, because obviously I was a keen -- I was aware that in order to get on the TASI course, which was the five-day in-person course, I needed to complete the online training before I was allocated a slot on the five-day course. So I was keen to get those under my belt so that I could then book myself on for the TASI course.

Q. So was this chasing emails as you describe, or calls, over the course of a week or weeks or months? Can you help us at all?

A. Well, it was from the day that I found out that I'd been accepted, which I can't remember the date of that, that I'd got the job to actually receiving the email. So, you know, most of January I was chasing that because I was keen to complete them, like I say, so that I could then book myself on the TASI course.

Q. So I think, if it helps you at all, you were told that you were successful in December 2021 and then you were sent the information, the training tracker, on

24 January 2022 --

A. Mm-hm.

Q. -- based on what you say in your statement.

A. *(The witness nodded)*.

Q. So would it have been for most of January, or --

A. Yes, it was for the -- from, you know, 1 January or 2 January. Obviously the Bank Holiday up until receiving it, I was chasing it daily.

Q. And once you did receive that information, you received 20 online training courses which you completed; is that right?

A. That's correct.

Q. And we can see a list of those at page 2 to 3, paragraph 6 of your witness statement. Can you recall how long each of those training courses were?

A. They all varied, from I think somewhere, 30 minutes long, to an hour-and-a-half, two hours. But there was on some of them, not necessarily all of them, there was like a test at the end that you had to get a passmark on but I couldn't tell you which ones the test applied to. So obviously you had to complete that and pass it, or redo it again if you failed it.

Q. So some of them were assessed, not all of them?

A. Some of them, yeah, from memory, some were assessed, not all.

Q. I'll return to that in a moment. Just help us with whether they were NHS-branded online training courses or EPUT training courses?

A. I can't remember that.

Q. What was the format of the training, to the best of your recollection? So for example, was it reading a text or watching a video and then answering some questions?

A. So, they were reading texts. There would be short videos on some of them. And then, at the end of the course on some of them there would be a knowledge checker, presumably to make sure that you've taken on board the lesson that you've just read. So it was a mix and match of, like I say, text and videos and pictures of, you know, items. For example, the ligature cutters, there would be photographs of the different ligature cutters, from memory.

Q. We'll come on to that in a moment. You may not be able to recall, appreciating it was some time ago now, but the training that we can see, I think it's at page 2, of dementia awareness. Can you help us with what that covered?

A. I really can't remember, I'm sorry.

Q. Can you recall whether you thought at the time it was a helpful course, or not?

A. I did think it was helpful. I mean it kind of explains

dementia. I have experience of dementia in my private life, but it obviously puts it -- it educates you more on actually how behaviours can differ with the different degrees of dementia.

Q. The Inquiry heard some evidence yesterday about diabetes and you undertook Diabetes Level 1 training. Can you help us at all, to the best of your recollection, what that training covered?

A. I can't. I'm not trying to be obstructive; I really just can't remember what the content of that was.

Q. Can you remember thinking at the time if it was a helpful course?

A. I remember thinking it was helpful, but I can't remember exactly the content of the course.

Q. And what about the Mental Health Act for non-registered staff? Can you recall anything about that?

A. I think that was legislation based, and that's all I could say about that. I can't really remember any other of the content, just more the legislation to do with the powers to section someone.

Q. I see.

A. But as to any more detail, I couldn't be specific.

Q. And then we can see at page 3, again paragraph 6 of your witness statement, reference to engagement and supportive observation. Was that therapeutic engagement

and supportive observation, or was it as per your witness statement, engagement and supportive observation?

A. I believe it was as my statement: Engagement and Supportive Observation. That was the title of the course.

Q. So it didn't include the word "therapeutic engagement"?

A. Not from memory, no.

Q. What were you told about the purpose of observations during that course? Can you remember?

A. No, I can't remember.

Q. Was it explained how observations should be undertaken?

A. I really can't remember.

Q. Did it say anything about how observations should be recorded?

A. I can't remember that either.

Q. Did the course provide you with any specific training on how to engage with patients during observations?

A. I don't think -- I can't remember whether that course covered it, but it was covered, I believe, during the TASI training, the five-day course that I did in person.

Q. We'll come on to the TASI training in a moment. Can you recall if it included -- and you may not be able to remember on that, and that's absolutely fine -- whether there was anything about engaging patients safely, who

were on one-to-one observations?

A. I really can't remember.

Q. What did you understand "therapeutic engagement" to mean, following this course?

A. I can't specifically say what I remember from doing this -- that particular course. But at what point I thought this, it could have been after I completed the TASI training or it could have been after I completed that course, combined with the TASI training. But my idea of it was to supervise, to engage with, and observe and prevent any self-harm to any of the patients. What I saw when I worked on the wards was not that. It was members of staff just sitting, not engaging with patients, which, for me, I found quite different because if -- that's not how it should have been done, but equally, how would anyone feel if someone was just sat staring at them for hours on end without engaging or interacting with them?

Q. So was there a disconnect between what you understood would happen and what you observed when you were on the wards?

A. Absolutely, yes.

THE CHAIR: To be clear, you considered, after your training, that you would be interacting with patients?

A. That's correct, yes.

MS MALHOTRA: Now, you say that that wasn't what you observed. Was that across all the 13 shifts, all members of staff that you observed, or are we talking about a small selection?

A. I would say that it's not -- it wasn't all the members of staff. But I would say that across the 13 shifts I did, I did see, on every shift, members of staff not engaging with patients. As my statement says, I saw members of staff fall asleep, members of staff using their mobile phones, members of staff talking amongst themselves in another language, which was upsetting to the patient that they were supposed to be observing. And I know it was my training, but also I think it's commonsense that if you're sitting, looking after somebody basically, to put it bluntly, then why would you not want to engage with that person?

Q. Well, we'll come back to the observations that you observed on the ward. I wonder if, just going back to the training for a moment, whether the course that you undertook -- so part of the online course, the Engagement and Supportive Observation -- whether that included anything on policy documents, supportive observations and therapeutic engagement or any sort of standard operating procedures, anything like that?

A. I don't recall being shown anything like that.

Q. What about the Oxevision system? Was that covered in the online courses?

A. No.

Q. You then mention "Make every contact count Physical Health Screening". Can you help us whether that training included how to identify whether a patient's physical health was deteriorating?

A. I can't remember, I'm sorry.

Q. And I think it probably follows from that that you -- that you're not able to say what signs, whether the training included signs to look out for, to identify if a patient was deteriorating?

A. I can't say whether that training specifically included that, no.

Q. And if I was to mention National Early Warning Score 2, does that ring any bells from that initial online training?

A. No. I've heard it, but not from the training.

Q. You say you've heard of it. Is that from subsequent training that you attended?

A. No, I heard people talking about that when I was on the ward but it didn't mean anything to me.

Q. When you say you heard people talking about it, was that other healthcare assistants or nursing staff or doctors?

A. I can't remember who, it was staff members. Whether it

was a -- probably not a doctor, because I don't think I had any interactions with a doctor, so it was either a nurse or a healthcare assistant.

Q. But that didn't sort of register with you, you didn't understand the significance of that?

A. No.

Q. Okay. I want to look at the Prevention of Suicide by Ligature training. Can you recall whether this training included how to respond to a ligature incident?

A. I can't remember.

Q. And Safeguarding Adults and Children Level 2, including Mental Capacity, Deprivation of Liberty, and Prevent. Can you recall whether you were given any information about safeguarding in that course?

A. There was, there was information on safeguarding, yes. As to the extent of it, I can't recall that.

Q. Okay. Well, let's see if we can help jog your memory at all. Did the training include how to recognise signs that a patient might be exploited or abused?

A. I can't remember, I really can't. This makes me sounds really like I'm not being helpful at all at the moment but I am trying to be.

Q. Can you remember whether the training included sexual safety risks that a patient might face?

A. I really can't tell you what that training, what it

contained. The only thing I do remember about it is to do with the DoLS and that's something that registers, and that's the Deprivation of Liberty. So that's the only thing I can really remember from that.

Q. Is there anything specific that you can remember, or --

A. Just that that could be something that is implemented with a patient, but as to the -- I can't tell you what was in the training.

Q. And so you mentioned earlier there was also the Suicide Awareness Course. Just out of completeness, can you remember anything about what that course covered?

A. I can't remember the detail of it. Obviously, working in the environment I was about to work in, it would, I suppose, the title says it all, but I can't remember the content.

Q. Okay. Now, you mentioned earlier that the courses were assessed. Can you recall how they were assessed?

A. Those online courses, you were given questions, obviously from the content of the training and then answer the questions, and then it would be marked at the end, and then, if you didn't get the correct score then you had to re-sit the test until you passed it.

Q. Do you know what the passmark was?

A. I can't -- it was around 80% but I think it differed on each of the courses.

Q. So they were all assessed or some of them were assessed?
A. Some of them were assessed, yeah, but can't tell you which ones.
Q. And did you feel that these online courses prepared you well for working as a healthcare assistant on a mental health ward?
A. I think they were quite comprehensive, but at the time I was undertaking the training, I really wasn't aware of what kind of would be expected of me when I went to work on the wards. I think that was kind of made clearer when I completed the TASI course.
Q. Just before we come on to the TASI course, you did also attend three in-person courses that you talk about in your statement. Page 3, paragraph 7, for those following: Moving and Handling Face-to-Face training, Grab Bag training, and Basic Life Support training.

Were all of those three courses, were they assessed, can you remember?
A. I think if you just completed them to an adequate standard then you were, you know, you had completed them. I'm not aware of any assessed per se but I think it was just a case of, obviously, if you were not paying attention or you weren't performing the basic life support correctly, I mean I don't know what would have happened. Probably you wouldn't have passed it, but I

can't be sure.

Q. Okay. So they -- you had to pass them adequately. Do you know how that was measured?

A. No.

Q. Okay. And were they theory or practical based?

A. They were practical based. They were in-person in Rochford Hospital, like the training unit there.

Q. And was it an external provider or EPUT employees who undertook --

A. I believe it was EPUT employees.

Q. Would you know if they were members of the clinical staff?

A. I have no idea.

Q. Would you be able to help us with their role or their seniority?

A. I have no idea.

Q. And did you feel that the course, for example, Moving and Handling, prepared you well for moving and handling patients whilst working as a healthcare assistant on a mental health ward?

A. The Moving and Handling was, I believe, more geared towards if you were working with elderly or physically disabled people because it was how to use the chairs that put people into the bath and get people out of bed and out of chairs, which obviously may happen on the

mental health ward, but I didn't experience that, so it was useful.

Q. I'd like to ask you next about the Grab Bag training. Can you remember whether you did the Grab Bag training first before the Basic Life Support training or was it as per your statement, the Basic Life Support training was the last one?

A. I believe the Basic Life Support training was the last one.

Q. Okay. So the Grab Bag training contained, you say in your statement, this is page 3, paragraph 7, contained ligature cutters, other items that might be needed in an emergency, and the training focused on the training of oxygen and CPR and the use of defibrillator. Was the training specific to working on a mental health ward?

A. I think it was.

Q. Was it explained in what instances or scenarios a grab bag would be required?

A. It -- well, because the grab bag contained ligature cutters, then my understanding is that grab bag was for the mental health wards for if anybody attempted to ligature.

Q. And do you remember whether the bag included equipment that could be inserted into a patient's airway to help with their breathing?

A. I can't remember whether that was in the grab bag or whether that would have been in a first aid kit, no.

Q. What about equipment such as a suction machine or a device that could be used to remove items from a patient's mouth? Can you recall that?

A. I can't recall that but it may well have included that.

Q. Were you given training on how to use each item in the grab bag?

A. I was given training on how to use the ligature cutters. As for the airway suction thing, if there was one, indeed one in there, I can't remember being trained on that.

Q. Just help us, then, if this was practical or theory based. What I mean by that is did you actually practise using the items, say for the moving and handling, you said that it was practical. Does that mean that you practised the techniques and the trainer was there to sort of help you?

A. I don't remember the Grab Bag training being practical. It may have been, but I don't remember that. And the reason I say that is the ligature cutters are one-use only so I only imagine if they went through the training and were using a ligature knife on -- to practise on, they have to be discarded after a use so I don't remember it. It might have been demonstrated but I

really can't remember.

Q. Okay. Can I ask, did the training include CPR training?

A. Yes.

Q. Did it include the use of oxygen cylinders?

A. Yes, it did.

Q. Use of defibrillators?

A. Yes.

Q. And was that practised on a dummy, for example?

A. Yes, it was. It was, yes.

Q. And was that delivered by EPUT staff or an external provider? Can you remember?

A. I believe it was EPUT staff.

Q. And did you feel that the course prepared you well for identifying when a grab bag would be required and how to use the contents of it?

A. I believe so, yes.

Q. And was your technique that you used observed, and were you given any feedback?

A. Not that I recall, no.

Q. And at the end of the four-hour training session, how confident were you with using the emergency medical equipment?

A. I felt quite confident.

Q. And then finally, the in-person Basic Life Support training. You say at -- this is page 3, paragraph 7:

"The training included the use of defibrillators." Was this different to the Grab Bag training?

A. Yes, I think the Basic Life Support training also included use of defibrillators. I suspect the Basic Life Support training is given to all EPUT staff, healthcare assistants, but obviously the grab bag, like I said earlier, is probably more for the mental health wards so it was covered in both sessions.

Q. Again, was this a practical course? Did you practise on a dummy, for example?

A. Yes.

Q. Were you given feedback on your technique?

A. I just remember them walking round while we were practising the CPR on the dummy and the use of the defibrillators. Obviously they've got training ones to practise on.

Q. Did it include specific scenarios for a mental health unit such as a ligature emergency or an overdose?

A. Not as far as I remember, no.

Q. And was it assessed?

A. Well, like I say, I think there's -- members of staff were walking round and checking that you were doing it correctly. But there wasn't, as far as I'm aware, an assessment, per se.

Q. Can you recall what checks you were told to make on an

unresponsive patient before starting CPR?

A. Well, it was the Dr ABC, which is the mnemonic used, so yeah, I mean there is a set procedure to go through.

Q. So following the Basic Life Support training, did you feel confident in assisting a patient who needed resuscitation if this was the only training that you'd received?

A. I did, yes.

Q. On reflection, do you consider the three in-person training courses equipped you for the risks and the circumstances that you might encounter in your role?

A. I think it went some way towards it. Whether it's -- whether it was a hundred per cent adequate, it's hard to say. But I certainly felt confident that I would be able to use the ligature cutters and also perform CPR and use a defibrillator. But it's quite subjective. I've done first aid training in my private life, so it was kind of something that kind of was just a refresher for myself. Whether or not other people would be that confident, I couldn't say.

Q. Okay.

And you mention at paragraph 7, we can see here, page 3 a Fire Web Video via Teams. Can you just explain what that was, if you can remember.

A. From memory, that was to do with how, like, the

evacuation procedure, and explaining to leave your personal belongings, and each -- obviously each ward, familiarise yourself with the emergency evacuation procedure on each of the wards when you go to work on them because they're different on each ward but apart from that, no, I can't remember anything else.

Q. You then, after completing the online courses, doing the three in-person training sessions, you then undertook the Therapeutic and Safe Intervention training known as TASI, which you mention at paragraph 8, page 3 of your statement. It was over five days, delivered by NHS employees.

Do you know if that was EPUT staff?

A. Whether they were EPUT or had come from another Trust, I'm not sure, but they were certainly NHS employees.

Q. Okay. And you mention at paragraph 8, it covered communication skills, holding techniques when required to move patients and the use of force, and you say it was interactive. Can you help us with what you mean by interactive? Is that there were role-play scenarios?

A. There were role-play scenarios where we take it in turns to be the patient and then the other members of the course would practise techniques on us as individuals and on some occasions on the trainers, as well.

Q. And you say at paragraph 8 it was a good course that

covered many aspects of the role. What other aspects, if you can remember, did it cover?

A. There was lots of -- I can't be specific on what other things it covered, but it was a very good course. And the other thing I got from the course was being able to listen to people who were working on other wards within EPUT, listening to the experiences of the trainers, who were experienced mental health workers, healthcare assistants, and also listening to the various anecdotes and stories of situations that had happened, the experiences of these people which bring the training more into life, and you can understand why the training is -- was as comprehensive as it was, because of the different situations that had arisen over the years.

Q. So can you help us with whether that was an assessed course?

A. Yes, it was assessed.

Q. Was there feedback from trainers?

A. Yes. We had to complete -- every day, we had to complete a sheet of -- a booklet, and there were, during the week, at the end of every day I think you had to write up your thoughts. From memory, there were certain questions on parts of the course, and then at the end there was a final assessment. It was a given, you know, that you'd complete the course, and that was that.

Q. Okay. Is there anything in the training that would have better prepared you for your role?

A. I can't think of anything. I did think it was very comprehensive. Short of actually performing the role, I thought it really gave you the skills to be able to deal with de-escalation, deal with somebody who may be ligaturing or self-harming in some way. I did think it was a good course.

Q. You mentioned conversations. I just want to ask you a bit about those conversations before we take a break. You say -- this is at page 3, paragraph 8 -- there were conversations during the training between the students and the staff on how under-resourced EPUT is. Could you give any more context for that conversation? For example, can you recall how that topic came up? What was said, who was saying it?

A. So the course had members of staff on there who, like I say, were working across various EPUT wards. There was a guy on the course who worked for the health and safety part of EPUT, and he said that he had to attend the course because they have to go in to all the wards every six months to look out for ligature points. And obviously if they're working on the wards something might happen and they might need to use some of the techniques that we were trained.

But the sense I got from everyone, including the trainers, was that EPUT was under-resourced, there weren't enough EPUT healthcare assistants, and the reliance was very much on the agency staff, which I found to be true when I went to work on the wards.

It was a topic of conversation that was mentioned on a daily basis.

Q. You say -- and we can see this at paragraph 8 -- that all of them apart from one of the people being trained had been working on various mental health wards prior to completing the training. Can you explain what you mean by that?

A. So when I was given the role of the bank healthcare assistant, I was told that I wasn't allowed to work on any of the wards until I'd completed the online training, the three face-to-face trainings, the Grab Bag, Basic Life Support, and the TASI training. However, there was a girl, a healthcare assistant, who was on the TASI training who was working on Willow Ward, and she'd been working on Willow Ward some months, and was on the same TASI course as me. So she'd been allowed to work on the ward without completing the TASI course. And that was, you know, I think I was the only person who wasn't actually working. The rest of them were working on wards within EPUT, yet they were just

doing the TASI training that I was doing.

Q. So was it your impression from conversations that you had with them that that was the first time that they were undertaking the TASI course?

A. It was the first time. You know, they were new employees. New-ish employees.

Q. So you heard directly from them that they had been working on wards without the training?

A. Yes, and one of the girls, one of the healthcare assistants that was on my TASI training, was working on Willow Ward, and I subsequently worked with her after the TASI training on Willow Ward. There were -- there was another healthcare assistant who was working on Willow Ward who had previously been on another mental health ward, and she hadn't completed the TASI training.

Q. And you mentioned agency staff, agency healthcare assistants, before. Can you help us with, in your experience, whether agency healthcare assistants had undertaken the TASI course or the online -- the 20 online courses and the three in-person courses that you attended? Would they have done the same training?

A. No, I know that they hadn't done the same training, because whilst I was waiting to hear back from EPUT between September and December, I had made enquiries to work potentially as an agency member of staff. And that

required a -- something called, I think it was a PMVA course, and a couple of online courses that you had to pay for yourself.

Now, I actually did the PMVA course, which was a two-day course, and didn't even, you know, didn't have half the things in it that the TASI course had. That was a course that, apparently, to work as an agency member of staff on a mental health ward, had to be completed.

Then the other issue, then, for me, trying to get employed as an agency member of staff, was I had to have experience of working on a mental health ward, which obviously I didn't have, but there's going to be a first time for everybody, so it was PMVA and then experience of working on the mental health ward were the criteria there.

Q. And you mention, paragraph 8 again:

"... it was mentioned that some of the techniques used by the agency staff are not correct, specifically the fact that the use of force that they adopt on the legs by grabbing the ankles is not correct and can be dangerous to the staff and to patients."

Was that said in the context of a particular incident that was referred to, or was it a general comment? Can you help us?

A. From memory, it was a general comment. But having experienced the training on the PMVA course which, like I say, was two days, I saw, you know, a completely different model of techniques, if you like, that were being taught to the healthcare assistants, the agency healthcare assistants.

Q. I see. Help us, then, about the incorrect techniques that you heard about during the TASI course, whether anything was said about actions taken to address any of those concerns that were mentioned?

A. No, I don't remember any conversations on actions, because, in -- you know, as I was later to find out, the wards are heavily reliant on the agency staff. Without them, then the wards just wouldn't be able to function.

Q. I'd like to just ask you, at paragraph 9, page 4, about Datix. You say that there were conversations that:

"... it [appeared] not to be completed when it should be. The use of the Datix appeared to be sporadic and inconsistent."

Can you help us within the context for how that conversation came about?

A. Sorry, was that the TASI --

Q. Yes, during the TASI.

A. I think that it was trying to educate us on the fact that Datix needs to be completed, and it currently isn't

being completed correctly. And I knew, from research that I'd done prior to going in to the TASI environment, that this was something that was criticised. I don't know whether it was by the CQC, but it -- there was a big void where the Datix wasn't being completed at all, or correctly, or didn't have enough information in it. And that was borne out in the training, the TASI training, that they said it's not being utilised correctly and that was my observation when I went to work on the wards.

Q. We'll come on to that, but just in terms of the TASI training, had you received training on serious incident reporting and use of the Datix system?

A. No. I think they -- from memory, it was very much -- once you get to your place of work you'll be shown how to complete this. You needed to have an NHS account to complete it. And it was very much left to, I think left to the individual wards to ensure that they trained you on it, or ...

Q. I see. And did you have any awareness of whose responsibility it would be to complete a Datix?

A. I was under the impression that it was the person that had utilised -- had applied the intervention. That it was their responsibility.

Q. Okay. Do you think the training could have been

improved by the inclusion of Datix and record-keeping and how to access a computer system?

A. I don't think that the TASI training was the forum for that, because the TASI training was very much geared towards safely intervening, physically intervening, should the necessity arise. The Datix was more of an administration role that I think could have been covered in one of the other online courses, or potentially, you know, one of the face-to-face courses.

So yeah, I don't think the TASI training would have been the right forum for that.

Q. And you mention absconsion was covered. Do you know whether -- were you told about what you should do in the event of absconsion?

A. There was mention of the absconsion. If they leave the grounds of the hospital, you're not to pursue them. That was touched on. And then I obviously, as my statement goes on to explain, I actually experienced that on one of my shifts, someone absconding, and was again told that I wasn't allowed to pursue them out side the perimeter of -- well, of the ward area, really.

Q. Not even to keep them within eyesight, for example?

A. That's right.

Q. And what reason were you given for that?

A. A health and safety reason, I think.

Q. And you mentioned earlier about ligatures and was the risk of ligatures discussed, how risk is mitigated?

A. Yes.

Q. Were risk items identified in the course?

A. As far as I remember, they were.

Q. Was de-escalation discussed?

A. Yes, it was.

Q. Was there anything in the training about treating patients with dignity and respect?

A. Yes, they were -- the trainers were very, in my opinion, were very good. They were, you know, we're dealing with individual -- with human beings here that need to be dealt with with courtesy and respect, and I think that came across in the training. And the de-escalation was, you know, they made it quite clear that de-escalation should be the primary way of dealing with a patient, and use of force is the last, you know, last, you know, last response. It's about talking, communicating to individuals, rather than laying hands on to try and deal with the situation in front of you.

Q. What about desensitisation of staff? Can you remember that being mentioned?

A. I don't remember that being mentioned.

Q. What about compassion fatigue? Was that something that was mentioned?

A. That term doesn't resonate.

Q. Okay. And what about caring for those using substances, illicit or otherwise?

A. I don't remember that.

Q. And what about caring for those diagnosed with emotionally unstable personality disorder or borderline personality disorders; was anything discussed about that?

A. I think the behaviours that may be demonstrated was discussed. But I don't -- it's not something that comes -- springs to mind.

Q. What about neurodiversity, such as those with autism or learning difficulties? Did the training touch upon that?

A. I can't remember that it did, no.

Q. What about caring with those with comorbidities such as diabetes or heart conditions, can you remember that being touched on?

A. No, I can't.

Q. What about anything said about allied health professionals, say physiotherapists, speech and language team, occupational therapists?

A. No.

Q. Was anything said about when to escalate any concerns about a patient?

A. I think that was discussed, regarding kind of the chain of command, really. The healthcare assistants are the bottom rung of the ladder, and obviously you've got the nurses and doctors above you. I think, obviously, it was explained that should you have any concerns with a patient, you need to escalate those concerns, not just ignore them or keep them to yourself.

Q. So was it clear to you, or was it explained to you how they should be escalated, where it should be documented, for example?

A. I can't remember that -- specifically that it was explained to me, or documented, but I just think it would -- should I say, it's common sense that if you've got an issue, you take it to someone who's got some -- got more experience than yourself, but I don't really remember them focusing on that specifically.

Q. And at paragraph 10, this is page 4 of your statement, you say that the training wasn't required to be undertaken by agency staff. Based on your experience, did you consider that it would be helpful for agency staff to have undertaken that training?

A. 100 per cent, yes.

MS MALHOTRA: Thank you very much. I've got no further questions for you now, we're going to take a break for 15 minutes.

THE CHAIR: Fifteen minutes.

(11.13 am)

(A short break)

(11.35 am)

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Thank you, Chair.

I'd like to ask you about your first shift on the Willow Ward. You describe it, for those following your witness statement, page 5, paragraph 14. Just for reminding everyone, Willow Ward in Rochford Hospital, a female-only ward with a capacity, you say, of 19-20 patients. Your first shift was on 5 April 2022.

Did you pick this ward or was it assigned to you?

A. No, I picked it.

Q. Was there a particular reason that you picked it?

A. I think it was because it was the first available shift. So as a bank staff member, basically, I would go on to an app or a website, and there would be -- shifts would be basically published for where they needed vacancies filled. So as a member of bank staff that was a zero hours contract so you didn't have to work if you didn't want to. So, from memory, that was the first available shift that I could take after I'd completed my TASI training.

Q. I'd like to ask you about some aspects of that first

shift and how that translated into what you saw later throughout the nine shifts that you undertook at the Willow Ward. Starting with briefings, please. For those following your statement page 5, paragraph 12.

You say:

"... there was no briefing on emergency procedures, nor was there any information on what to do if a patient was deteriorating or in cardiac arrest."

Was this the case for all 13 shifts that you undertook?

A. Sorry, there was a briefing at the start of every shift but at no time was it mentioned about a patient, if they were deteriorating, or in cardiac arrest.

Q. And so emergency -- including emergency procedures?

A. Yes.

Q. So was that the same for all 13 shifts across the four wards?

A. Yes, it was.

Q. When you started on the Willow Ward, help us with whether you were shown where the grab bag was?

A. I was, yes.

Q. You were shown where the ligature cutters were?

A. Yes, I was.

Q. Were you shown where the automated external defibrillator was, the AED?

A. Yes, I was.
Q. Were you told how to raise the alarm in an emergency?
A. Yes, I was.
Q. Were you given a personal alarm?
A. I can't remember whether I was given a personal alarm to start with because the alarms, the pin alarms were attached to keys, and there weren't enough sets of keys to go round so that each member of staff could have a set of keys, and the keys had the pin alarm on. Whether or not I was given that on my first shift, I don't know. And the keys used to get handed around because there weren't enough sets of keys.
Q. I just want to explore that a little bit with you. So the personal alarm was a pin alarm; is that right?
A. Yes.
Q. And that was attached to the keys?
A. That's correct.
Q. So if you didn't have a set of keys, you didn't have a personal alarm; is that right?
A. That's correct, that's correct, yes.
Q. So how would you, in those circumstances, raise an alarm?
A. Well, you'd have to shout and hope someone heard you.
Q. You talk about there being a lack of keys that were available. There weren't enough to go round I think you

say.

A. Mm-hm.

Q. What, in practice, what sort of impact did that have, leaving aside the pin alarm?

A. It was very frustrating. You needed the keys to get into certain areas of the ward and also they had a pin alarm on them which, like you've just alluded to, if something happens, how are you supposed to alert anyone? Unless there's someone else in the corridor in the part of the ward that you're on that has a pin alarm you're literally going to have to shout or run and get help.

Q. What about where the grab bag was kept? Would you need a set of keys to get to the grab bag?

A. I don't think, no -- no, you didn't. But the grab bag was in the office, which was as you came in to the ward, you know, Willow Ward was quite a big ward. You've got to go through a few sets of doors, depending on which side of the ward you're on. So it's not to hand, you know, if you've got an emergency, you had to run and get it.

Q. So the keys weren't for internal doors, then, they --

A. The keys were for internal doors.

Q. But it would have affected getting the grab bag, for example?

A. I don't think so but I wouldn't like to say a hundred

per cent whether that office was locked or not. It might have needed a key to get in there but I really can't remember, to be honest with you. It was -- as you walked -- as you went into the ward, it was where the head of the shift would sit, which I, you know, I didn't really go in there unless of course I did on one occasion, to get the grab bag.

Q. You can't remember needing the keys?

A. I don't -- I didn't need the keys. I know I didn't need the keys.

Q. You didn't need the keys. Okay.

What about body-worn camera? Did you have that?

A. No.

Q. Was that in use in the ward, can you remember?

A. Not from memory, no.

Q. Were you told when and how to call an ambulance?

A. No.

Q. So you weren't shown the phone, for example, where you could call for an ambulance?

A. I was aware -- there was a phone in the office that I just mentioned where the grab bag was, and there was a phone in the other office but the other office that had the nurse in it, you needed a key to get in there.

Q. I see. So the nursing office, you needed a key to get in?

A. Yes.
Q. There was a phone in there?
A. Yeah.
Q. And I think you say in your statement a computer, that would be in the nursing office, would it?
A. That was in -- there was a computer in the nurses' office. There was a computer in the other office by the doors where the grab bag was but that had the head doctor, nurse, whatever that was on duty, and you definitely needed a key to get in to there, because I, on occasion, needed to go in there to speak to someone, and you needed a key to get in there, which was frustrating.
Q. So that was the office, the nurses office, but there was another office where you didn't need a key where the grab bag was?
A. I can't be sure whether you needed a key or not, but the only reason I say that is the day that I went in -- the only time I ever went into that office was the day I needed to get the grab bag when the healthcare assistant had taken the wrong ligature cutter and I didn't need a key to get in there.
Q. Okay.
A. But having said that, the head medical practitioner had left the office to -- because I passed him on the way to

get the grab bag, he'd left that office he'd been sitting. So presumably he didn't lock it. You know, on thinking about I --

THE CHAIR: So did you, you went to get the grab bag from the head medical practitioner's office, not the other office?

A. That's correct.

THE CHAIR: And was there a grab bag in the other office?

A. Not that I'm aware of, no.

THE CHAIR: And you are certain that the place where you got the grab bag from, you got into without a key? And can you be certain that you would, in other circumstances, not have been able to get into that office?

A. I can't be certain, but thinking about it now, the staff members would lock themselves in the offices to stop the patients from going in there. The only time I needed to go in to the office when the -- with the grab bag was the time that the alarm had been raised, and I actually remember passing the head medical practitioner on his way to the room that the incident was happening on. I went past him as I was going back to his office. So he would presumably have left the door open, but I'd never really thought about it, to be honest.

MS MALHOTRA: Okay.

And just on emergency procedures, were you told how

to direct and attend an ambulance crew to the scene of an emergency, for example?

A. No.

Q. Were you told where the fire exits were?

A. Yes.

Q. In terms of the briefing that you received on that first day on 5 April, would you say it was a helpful induction or a helpful briefing?

A. Yes, it was.

Q. Did it prepare you for the shift ahead?

A. Well, I felt that I'd familiarised myself with the layout of the ward. Whether it had prepared me for what was to unfold I'm not really sure but at least I knew where the grab bag was because I needed, as my statement suggests, I needed to go and get the grab bag after the wrong ligature cutter was taken to the room, so had I not been giving that induction, I would have not known where it was.

Q. So is that why you say it was a helpful induction?

A. Yes.

Q. Because you knew where the grab bag was?

A. Yes.

Q. So I wonder whether, we can see for those following your statement, page 5, paragraph 14, there was a briefing by the nurse on duty where information from the previous

shift was relayed. Can you recall the level of detail that was provided?

A. So the -- generally, when the -- when we had the briefings at the start of the shift, it wouldn't take the patients patient-by-patient and give you a rundown. It was very much: patient in room 5 has done this; patient in room 6 has done that. It would only be a general synopsis of the evening's events.

Q. I see. So would there be a discussion about a patient's symptoms or their needs?

A. If something had happened overnight, there may be a conversation. They may say "One of the patients has got to go here", or "Got to go to, say, Basildon Hospital". "A patient has got an appointment at Southend Hospital, there will be an ambulance coming to collect them at such and such a time."

But there was no -- this is the thing that I found the most frustrating, was you're there to care for 19 to 20 ladies, and you know nothing about them until you're told to go -- in my case, in my first shift, I was told to go and sit on a one-to-one with a patient. No one asked me if I knew what I was doing.

No one told me anything about the patient. I was just given a room number and told to go round there. "You need to get round there because the night duty

needs to get home". That's really the level of information, if you like, that I was given.

Q. So can I take it from what you're saying, then, that you weren't told about risks or triggers --

A. That's correct.

Q. -- for each patient? Any information about safeguarding risks? Was that shared?

A. No.

Q. What was your understanding of the importance or the relevance of staff knowing about individual patient risk profile before conducting observations?

A. It's fundamental to your engagement with the patient, in my opinion. There were a couple of incidents that highlighted how important these things are. The assumption was that if you were -- on my part, was that if I was going on a one-to-one or a two-to-one, that was because that patient was at risk of self-harm. No other risk. And as my statement points out, there were several incidents where I found out more from the patients than I did from the staff. And I had to go about it in a very gentle way, because, you know, I was concerned that by, for want of a better word, questioning someone on their -- on why they were there, might trigger them. But you need to understand the person to be able to engage with them and support them

in that hour, or however long, you're sat with them.

Q. So you tell us that you were put on one-to-one observations with a patient at risk of self-harm. If that information wasn't given to you at the briefing, how did you know that that patient was at risk of self-harm?

A. Well, it was an assumption, really. The assumption being that -- throughout the training, the training suggested that people that were put on one-to-one or two-to-one observations were put on those observations because they were a risk to themselves.

Q. You say and perhaps we could bring this up, pages 7 to 8, paragraph 20, you describe a situation here where:

"I was on a two-to-one with a patient who [you were] attempting to talk to, it had not been brought to [your] attention that [the patient] was in fact deaf ..."

How did that make you feel, undertaking observations on a patient with whom you had no idea that they were deaf?

A. Well, I just -- I could not believe that I had not been told this. The patient was asleep for much of my interaction but when she was awake, I was trying to engage with her and I think it was the next time I was on shift, I'd spent a couple of hours with her and it was the next time I was on shift someone said -- I think

I was trying to talk to her and someone said, "I don't know why you're bothering, she's deaf", or words to that effect.

THE CHAIR: This person was on a two-to-one, so you sat with somebody else. Did they not say to you "This person is deaf"?

A. No.

THE CHAIR: While you were trying to talk to them?

A. No, it was on my second day of being on Willow Ward and being with the patient did someone say to me that she was deaf.

THE CHAIR: Did the person you were sitting with try --

A. I've got no idea.

THE CHAIR: -- try to talk to her?

A. No, and I don't know if they knew that she was deaf either.

MS MALHOTRA: They were the one that told you, though, were they?

A. So my first shift on Willow Ward I was sat with the patient at least for an hour, if not two. And then -- and I tried to talk to her. And she wasn't responding to me, fine, you know. And then on the second day, the second time I sat with her, or the second day I was working with her, the person I was sitting with said to me straight away she's -- "Don't

you know, she's deaf?"

Well, no, I didn't know that.

Q. Was this a one-off in your ward, in your shift on the Willow Ward? So the absence of sharing individual risk triggers, symptoms, care needs, and safeguarding? Was that a one-off?

A. No, it wasn't. There were other instances that information wasn't shared.

Q. What other instances?

A. Okay, so one of the patients that apparently suffered from anorexia but that was never, never communicated, and I'd been sitting with her on one-to-ones for quite some time now, and I think there's footage of her being triggered by other members of staff that were making references to dieting.

There was another at the end of the day that I was working with and I, you know, I tried to engage with the patients and talk to them and make them feel, you know, make them feel valued, try and strike up a conversation. And one of the patients I was speaking to, I was talking to her about her family members, and I said words to the effect of "Have you got any siblings?"

And she said, "I have", and said, "But I don't see them" because basically she'd been sexually abused by this family member.

So, had I known that that's part of her history, you know, I wouldn't have gone anywhere near that subject, but having to find out this information from the patients when you're trying to engage with them isn't good for the patients if you're triggering them by bringing things into a conversation that can trigger them.

Q. And so, just to be clear, then, the sort of absence of sharing of information about individual patients, was that your experience on your shift at the Mental Health Urgent Care Department?

A. Yes, it was my experience on all the wards.

Q. All wards. I want to ask you next about handovers. Perhaps we can pull up page 9, paragraph 26 of your statement. You say here that there was no arrangement for handovers to staff. There was also no time to familiarise yourself with patient records as they were computerised.

And then at paragraph 39 and paragraph 40, so 13 of your statement, this is against a background of a patient on the Willow Ward who ligatured on your first day, you say here that the nurse on duty stated during the handover that she had forgotten to complete the risk assessment for this change in frequency of observations.

And then at paragraph 40, also on the Willow Ward,

your seventh shift on 25 April, you say that at handover you found out that that same patient had attempted to ligature again on 23 April 2022.

I just wonder if you can help us with whether there were handovers or not?

A. So when I mention handovers, I mean the handover from the night duty shift to the day shift. I only ever did the day shifts. So the handover, from my -- what I'm meaning to say there is the briefing before the shift or when you went to take over from a -- from somebody sitting on a one-to-one observation, you know, there was no communication, as in "Oh, this -- she's tried to do this" or "She's tried to do that". There was just no flow of information. It was just hand you the sheet of paper and then off you go.

Sorry, I don't know if I've made that -- if that was very clear, what I've just said there.

Q. So I think what you're saying is that there were handovers but they didn't provide you with information about the individual patients?

A. No. So the -- if you like, the briefings in the morning where the night duty would have handed over to the dayshift nurse, she would then brief us on what had gone on in the evening. There was nothing specific to a patient that -- unless something had happened.

So what I'm trying to explain is if you've got ten members of staff that come in to work, have all those ten members of staff worked on that ward before? Because there may be an assumption that all the members of staff know all the patients because they're in there every day. I wasn't in there every day and nor were some of the agency workers.

So from my point of view, each patient should have been spoken about, so that throughout the shift, we're all interacting with them on different levels, so we all need to understand what the patient needs and that was never done.

THE CHAIR: Was the briefing conducted by the head nurse in charge of your shift?

A. Usually, yes.

THE CHAIR: So that -- so you did not hear whatever was said between the night shift and the day shift?

A. No.

THE CHAIR: How long did those briefings last?

A. Usually about 10 to 15 minutes.

THE CHAIR: Thank you.

MS MALHOTRA: I want to move on to ask you about technology. Were you aware of any technology being used to assist patient observations?

A. I know that they had -- not that it assists it, but they

had CCTV on the wards. And they also had some monitoring -- sorry, my screen has just gone off -- I can't remember the name of it, there was a monitoring device which I hadn't been trained on and wasn't aware of until a few shifts into working on Willow Ward, where they had a monitor in the nurses' office that used to bleep, and it was something to do with if there was no movement on a mattress in one of the rooms, that's what I was told. But I was never trained on it and that's my basic knowledge on it.

Q. Have you heard of Oxevision or --

A. That's it, Oxevision.

Q. -- or Oxehealth?

A. That's it, yeah, sorry, that was the name of it.

Q. So you weren't trained on Oxevision?

A. No, I wasn't. And the monitor and all the -- I don't know, whatever kind of monitored it, was in the nurses' office that you needed keys to get into.

Q. So was it the case that you were asked about whether you had done Oxevision or Oxehealth training by the nurse in charge on your first day at the Willow Ward?

A. No, I wasn't asked because I didn't even know it existed.

Q. It was a few shifts later that you learned of it?

A. I think I just asked one of the healthcare assistants

"What's that all about?" Because it was making a noise, bleeping. Otherwise I would have just thought it was a CCTV monitor but it constantly made noises in the office.

Q. So if it was constantly making noises in the office, it was an alarm, was it?

A. Yeah, it was like -- it was a bleeping noise. I don't -- I really don't know how it worked. It wasn't a very loud alarm, but if you were in that office, you could hear it bleeping almost constantly making a noise. But I have absolutely no idea how it worked.

Q. So when you heard this bleeping that you've described, what were the other staff members around you doing in response to the bleeping?

A. I think they were just carrying on and ignoring it. I didn't even -- it was -- the noise was constant, so there was no -- there was no reference to "The Oxevision's activated, we need to go and check on the patient" because, like I say, I wasn't even aware of its existence until some shifts later.

THE CHAIR: You said it was in an office that needed locking, was it in the -- the computer system. Was it not in the main nursing station --

A. Yeah, it was in the --

THE CHAIR: -- which you've already told us didn't need

a key?

A. No, it was in the -- there may well have been one where the grab bag was, I don't know, a monitor, but in the nursing station where the nurse and the health -- head healthcare assistant were based, it was in there.

THE CHAIR: And that didn't need a key.

A. That needed a key to get in there. That's the one that needed a key, definitely, but I can't speak about the other one.

MS MALHOTRA: So did you see any members of staff using the Oxevision system at all, or using it to undertake observations, for example?

A. I wouldn't know what using it -- what that would entail. So I can't -- I can't really comment.

Q. I'd like to ask you on a similar theme about therapeutic observations. You've done the training, you've now done your first shift on the Willow Ward. What was your understanding of therapeutic engagement?

A. My understanding -- from my, I suppose, from my training and how I am, I was never given any advice on how to do it, but from -- my impression was that you are there to supervise, communicate, engage with, a patient. And if necessary, intervene should they try and do something that may harm themselves.

So I would always try and strike up a conversation

with them. Just, you know, make them feel that they weren't just being stared at. Because that's what I witnessed, was some of the healthcare assistants, the agency staff, just sat there staring at the person and not even talking to them. That's -- that can't be right.

Q. And so before you started undertaking observations, so thinking about that first shift on the Willow Ward on 5 April, was there any process or an opportunity for you to shadow staff before undertaking observations?

A. No.

Q. Were you shown a copy of the Therapeutic Engagement and Supportive Observation policy by staff on the Willow Ward when you started?

A. No, I wasn't, and I wasn't even asked if I was aware of my responsibilities. Bearing in mind the first shift on Willow Ward was the first time that I'd met -- I'd been in that ward. It was my first shift as a healthcare assistant and it was actually myself that said to them "This is my first shift. Can someone show me round?"

Had I not said that, you know, I don't imagine it would have happened. But equally, at no time did anyone check that I was proficient or I understood my responsibilities and my role as a healthcare assistant on a one-to-one observation.

Q. But you did attend the TASI training, which you say was very good and helpful?

A. I did, yes, yeah.

Q. So did you feel that that prepared you well, then, to undertake the observations that you were asked to do on the Willow Ward on 5 April?

A. I absolutely agree that it prepared me for my role, and particularly the one-to-ones. However, my concern, which was borne out with what I witnessed, was that agency staff who hadn't had that training properly did not understand their role on the one-to-one observations, because of their behaviour. And I think it's -- you know, it was mentioned on one of the briefings on Willow Ward after some time, it was pointed out to staff members that they shouldn't be using their mobile phones, and they shouldn't be falling asleep.

Q. So just putting to one side the other staff and just going back to what you say about undertaking observations, I just wonder if it's helpful, you say that you didn't understand what was required of you. You didn't understand what was required for the observations, the engagement.

A. What, I didn't understand?

Q. Yes, is that what you were saying, that you didn't understand what --

A. No, I understood what was required of me. But my concern was that the agency staff didn't understand what their role was. You know, for me, performing that role was -- you've got to be on heightened alert. You know, you're there to make sure that somebody doesn't hurt themselves, and that -- the seriousness of the role I don't think was taken into account by the agency staff. And I don't want to say all the agency staff, but as a generalisation, you know, potentially if you don't -- if you're not observant and you're not engaging and you're not switched on when you're performing this role, something serious will happen, as it did.

THE CHAIR: You told us that the agency staff -- that you had tried to apply to be an agency staff?

A. *(The witness nodded)*.

THE CHAIR: -- and were not able to do so because you have not got previous mental health experience.

A. Yes.

THE CHAIR: So they would have had previous mental health care experience.

A. Mm-hm.

THE CHAIR: And you still think that they did not understand the seriousness of what they were doing, or do you think they just were choosing not to do the job as they should?

A. Um --

THE CHAIR: You may not know because you may not have talked about it.

A. Yeah, I'm not sure and I was at a bit of a loss as to how -- firstly there's going to be a first time for everybody getting -- going to -- like it was for my first time, there's got to be a first time before you work on a mental health ward, and I was unsure how these agency staff had managed to work on there, because there has to be a first time. And it never became clear to me how they were allowed to work on there, what experience they'd had previously.

I did try and kind of speak to a few of them, but I couldn't really get to the bottom of it.

MS MALHOTRA: I just wonder if I could invite you to have a look at page 8 of your witness statement, paragraph 22. You say there, the second sentence -- or the second line on paragraph 22:

"I was not given any instruction on this and was just handed a sheet of paper with the names and room numbers, I had to seek clarification on what I was supposed to be doing."

I just wonder whether, did your training not help you with what you were supposed to be doing?

A. No, there was focus on the one-to-one observations which

are the highest risk, two-to-one observations, but it was never mentioned about the checks up to five times an hour. So I remember being on my first shift, being told "You're doing these checks", and I was like "Well, I don't -- what have I got to do with these checks?" Because it had never been explained to me.

Q. So did you consider it appropriate that you were assigned one-to-one observations with a patient at risk of self-harm on your first day?

A. I don't think it was wrong for them to do that, but if you're -- you're reliant -- as a medical professional in that environment, my opinion is that you need to know who you have working with you on that 12.5-hour shift. You need to know the skillset and you need to know that, you know, you're putting somebody's life in the hands of a healthcare assistant, potentially.

So I was quite surprised that the head for the shift that particular day didn't really know the staff that they were deploying to perform these roles.

Q. I wonder whether we could just turn, then, to your evidence you said earlier before the break, and you didn't observe engagement with patients and other staff, carers that were there. That was your experience.

You say in your statement at paragraph 27 -- we can take you to it if you would like, but you say there

that:

"... their communication style at times combative and unhelpful."

I just wonder whether you can help us with any specific examples of that?

A. Sorry, could I just --

Q. Yes. Paragraph 27. It's page 9. Towards -- three lines up from the bottom.

A. Yeah, thank you. Yeah. I've got it now. Thank you.

Q. Can you give us some examples of --

A. Generally, my experience of this was there would be patients that would sometimes become difficult to manage, and I witnessed on several occasions the style of communication used by some of the staff members to be very dismissive, unhelpful, and lacking empathy. And at times, I would go as far as to say quite aggressive and confrontational.

To kind of explain what I'm trying to say is, I did get the sense quite often, on probably all of the wards, that the patients were treated more like children than adults who just needed a bit of understanding and a little bit of empathy and a little bit care. And quite often, because of the, you know, because of the pressures of a lack of staff, if there was an incident that had gone on, obviously that takes a lot of

resources away to deal with that particular incident. But from my point of view, you know, these ladies just needed a bit of help and a little bit understanding and a little bit empathy and yes, you know, at times they needed to be dealt with in a robust way because there are rules and there are ways to behave and conduct yourself, and at times I just think that the communication style and the behaviours of some of the staff just made situations escalate, when that didn't need to happen.

Q. You've already spoken about staff falling asleep whilst undertaking observations of a patient. Did you observe that staff member falling asleep? We can look at paragraph 52, for example of your witness statement, which I think is page 16.

Paragraph 52, page 16, at the bottom of that page. Thank you.

"The HCA I was working with fell asleep ..."

And then it goes on:

"... only a few hours after the patient she was observing made a ligature attempt. I challenged the healthcare assistant and told her she couldn't sleep but the healthcare assistant said it was okay because the patient was asleep.

"The HCA [the healthcare assistant] said she was

tired and had a headache, having been up since 5 am to travel from Stratford ..."

And then you started your shift at 7 am but weren't allocated a break until 4 pm.

I just want to ask you about the breaks. Were you given breaks during your 12-and-a-half-hour shift?

A. You were given, I think it was either 30 minutes or a 45-minute break.

THE CHAIR: Just one?

A. Mm-hm.

MS MALHOTRA: How often did managers check whether the staff on observations were awake and alert?

A. I personally didn't have any manager come and check on me, or the senior healthcare assistant check on me. And I have to say that if you are doing the one-to-one or the two-to-one observations properly, it's probably one of the most emotionally draining things you can do, to think that you are the person that can stop the person you're watching from, you know, harming themselves or trying to take their own life.

I can't explain how hard that is. And on my first shift, I think I did, for the whole shift, I did constant one-to-one observations. So I was going from one patient to another patient to another patient to -- for a whole hour, and then you -- you've got to kind of,

you know -- well, I was talking to them, engaging with them, trying to, you know, "Let's go for a -- something to eat. Let's go out in the fresh air."

Because, you know, you want to make that time for them as pleasurable as possible, I suppose. But, I have to say, it is the most exhausting time. I can't put it into words. Because you are focused 100 per cent on that -- every time they move, or every time they want to get up, you're, you know -- or I was -- following them, should be following them, to make sure that they're not going to do anything to themselves because within the flat -- in the blink of an eye, they could have picked something up and tried to tie it round their neck, which happened. Or if they, as happened, go into the bathroom and they're not followed into the bathroom, that's because they know that if they've got a male member of staff they're unlikely to follow them in there, and if they want to do something to themselves, that's when they're going to do -- when you take your eye off them, which, you know, it just can't happen.

Q. And so with this incident with the staff member falling asleep, I think it was a healthcare assistant that fell asleep --

A. Yes.

Q. -- was that a one-off incident or did you see that

happen more than once?

A. No, I saw that regularly. I was working during the day so it wasn't even nights.

Q. How often would you say? Every shift, or --

A. I think -- I remember it happening several times on Willow Ward and it happened when I was on Cherrydown. I don't recall it happening in the Linden Centre but I was only in there for one shift and I spent most of my shift there with the lady who had attempted to abscond. But, you know, one shift I came in to Willow Ward, and one of the patients had actually caught the healthcare assistant who was watching her asleep and videoed him asleep. And then went -- came out of her room, walked round the healthcare assistant, and went and told the nurse that the healthcare assistant that was supposed to be watching her was asleep.

Q. And did anything happen as a result of that incident, or this incident?

A. Sorry, the incident that I --

Q. So the incident where, on Willow Ward, where you observed the healthcare assistant falling asleep during the observations, and the --

A. No. The one involving the healthcare assistant that I was with when she fell asleep, I -- obviously I woke her up, and said she shouldn't be sleeping, and then she

didn't do it again, with me, anyway. The guy that was -- the healthcare assistant that was on the one-to-one with the patient who videoed him, I don't know who he was and I think they sent him home that night. But whether he -- what happened to him, I've got no idea.

THE CHAIR: Did you observe that incident?

A. I didn't observe the one with the male healthcare assistant but the girl that took the video of him showed me the video when I was on a one-to-one with her, and told me that -- about what had happened.

MS MALHOTRA: You talk about staff shortages, that there was a reliance on agency staff. When you say that, in your statement you say at page 9, paragraph 24, that the senior staff on duty were aware of this, do you mean the nurse in charge or someone more senior than that, such as a Ward Manager?

A. Sorry, could I just look at the statement on that?

Q. Yes. Sorry, and it's four lines up from the bottom:

"The senior staff on duty were aware of this, and I witnessed the perpetrators being told not to fall asleep. As far as I am aware they [were] told not to come back to the ward, but this is something I heard via one of the [healthcare assistants]. I don't know if anything further happened to them."

When you say senior staff on duty, can you help us with who you were referring to?

A. So there was a -- the healthcare assistants and then there was a nurse, and then there was another medical practitioner and I can't remember what title they had. They were the senior member of staff on duty, and they were aware of the -- obviously of the guy that had fallen asleep and they'd taken a video, the patient had taken a video of him, because she went round and showed them and they escalated that. And on one of the briefings, we were told not to fall asleep, and not to use your mobile phone while you're on a one-to-one. Because obviously if you're on your phone, you're not observing the patient.

But as to who the senior -- what level or grade they were, they were the senior member of staff on duty. I don't -- one above a nurse, I suppose, whatever that grade is.

Q. And you say that you -- and this is at paragraph 38 of your statement, so that's page 12. Again, this is on the Willow Ward. This was concerns that you had expressed about a patient, the patient who had ligatured on the first day on the Willow Ward --

A. Mm.

Q. -- had been taken off her one-to-one observations; do

you see that?

A. Yes.

Q. Was there any process or opportunity for providing feedback for the patients that you were observing at the end of your shift?

A. Sorry, for me to provide feedback to?

Q. Yes, to another member of staff.

A. Well, there wasn't like a debrief or anything like that, but on that particular occasion, you know, if I witnessed something I wasn't happy with, I would take it to either one of the more senior healthcare assistants or the nurse. On this occasion, I spoke to the nurse and said that she was still, you know, that particular patient was still feeling suicidal and she still nothing -- she still was no longer on one-to-ones.

But then later on, a few days later, she tried to ligature, I believe, from my statement, again.

Q. You say here at paragraph 38 that there was a stool and some curtain hooks that had been left in this same patient's room and the patient had informed you that she could use those to harm herself. You removed those items from the room and spoke to the nurse about it. Help us understand whether any of the ligature attempts that you witnessed or were involved in during your shifts, did you observe any patient's room being

searched afterwards and items being removed, for example?

A. I did on one occasion, and -- but I can't remember the circumstances. I think it might have been the girl that -- the patient that tried to ligature with her bra. I think it might have been that. But there were things, I suppose, it's a balancing act, isn't it? At the end of the day, the room that the patient is in is their home, for all intents and purposes. And everyday garments can be used as ligatures. So there's a balance between kind of taking everything out of their room and making them think that they're in a prison cell, and balancing that with trying to keep them safe. So it's a difficult one.

But yes, rooms were -- a room was searched when the lady had tied her bra around her neck and I think that was taken out of the room, but any item of clothing can be used as a ligature. A pair of trousers, you know, tights, bras, jumpers, scarves, anything like that.

Q. But so far as you were aware, you did observe there being searches of rooms?

A. Yeah, on at least one occasion I did.

Q. I want to ask you about recording of observations. You talk about observation logs in your statement. Did you see other staff complete observation logs? Did you

complete observation logs?

A. So there was like a clipboard when you went to take over from the observations, the one-to-ones or the two-to-ones. And that would have -- the way it was supposed to be completed would be kind of a running dialogue, I suppose, of things that the patient does. So patient goes to have something to eat, patient goes to the garden. And any behaviours that may assist somebody taking over on the next stint that might assist them in looking after that patient. But there was very little information on there, to be honest with you.

Q. So you say, and perhaps we can bring this up, page 6, paragraph 15, that each patient on these close proximity observations has a handover sheet that is supposed to complete the forms during the observations but it was clear, due to the lack of detail, that these were not completed correctly.

Are these handover sheets the same as observation logs or is that something different?

A. No that's the same thing.

Q. The same thing.

A. Yeah.

Q. And what information was incorrect? Why do you say that?

A. I wouldn't necessarily say it was incorrect but it was

incomplete. There wasn't the right sort of information, you know, the information on that sheet is supposed to assist in whoever else takes over from you to understand a little bit about what's happening with the patient. So, for example, if the patient is in bed all day and not got out of bed and generally, I suppose, if they're somebody who doesn't behave like that, that might highlight some risk to the patients.

But if it's not documented, or they went for something to eat or they went to the garden, were on the phone, seem upbeat, all that kind of information helps the person that's coming to take over understand the patient at that particular time, which can obviously change, but it helps you build a picture of how that person is feeling on that particular day.

So I just don't think the information was detailed enough to assist.

Q. And you describe an instance of a healthcare assistant showing you how to copy and paste from the night duty entry, which led to the observation levels being recorded inaccurately.

That's at page 15, paragraph 49 of your statement. How common was copy and paste recordkeeping, in your experience?

A. This was to do with the Mobius system, I think. And

I asked if someone would show me. So it was at the end of my shift, and I said to one of the healthcare assistants "Can you show me how this works?"

And she was -- I logged on to it to see if I could get on to it and then she was showing me how you create -- how you update some information on there. So she copied and pasted from the previous entry, and then pasted it on to my entry and when I was reading it for -- to see what it said, the observation levels, she hadn't changed them. And I'm aware from, whether it was from CQC or other agencies that have highlighted that copying and pasting from other -- previous records was a common practice and shouldn't be done. But I did -- obviously that happened while I was there.

Q. Was that a one-off or did you see it occur more than once?

A. That was a one-off because I don't remember going back on to the system because I had to literally badger someone to let me into the office that had a key. There was one computer in there that I could use and then I had to log on to it, you know, at the end of my 12-and-a-half-hour shift, to then be able to see what this system did. Because there was no time during the day, because we were all constantly on one-to-one observations getting moved around, to actually go and

complete anything if it needed doing, any paperwork or administration.

MS MALHOTRA: I think we're going to take a short break now, Chair, if we can return at 12.50.

(12.34 pm)

(A short break).

(12.50 pm)

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Thank you.

Perhaps I could ask for page 6, paragraph 17 of your witness statement to be brought up on screen, just to orientate you here and to provide you with the context.

You describe, at paragraph 17, page 6, the ligature attempt by a patient on your first shift at the Willow Ward, and I just want to ask you a bit about that incident.

You mentioned earlier that you didn't see any doctor on the Willow Ward that day. What about afterwards?

A. No, I don't recall seeing a doctor. That was my first shift.

I think the only time I -- I saw a doctor once, and he was in a -- in an office with someone, I don't recall seeing a doctor at all.

Q. So just in your experience, then, on the Willow Ward, how often did doctors come on to the wards?

A. I want to say twice a week, but that's not because I saw that, observed that. It was just something that was said to me when I questioned how often the patients would see a doctor.

Q. How visible were Ward Managers or Matrons on the ward, on Willow Ward, for example?

A. They were -- they would work in the office that the grab bag was in. They would do the handover in the morning or the briefing in the morning, and then, I don't really remember having much of an interaction with them, to be honest.

Q. At, again, page 6, paragraph 17, you describe here that same patient with a second ligature attempt on the same day. Was it your understanding that the patient was able to ligature because the male healthcare assistant allowed her to go into the bathroom unobserved? Was that your understanding?

A. Yeah, absolutely. Yes.

Q. Were you aware of any guidance or practice about male staff observing female patients in bathrooms or private spaces?

A. I was aware that after the incident, the nurse was talking to one of the other healthcare assistants and saying he should have called for another member of staff, a female, to come while the patient went into the

bathroom. Which is easy to do -- easy to say, but not as easy to do, because how would he have communicated that to somebody? Because he's sat in the room with them. You know, there was nobody really to communicate with, unless somebody happened to walk past him.

Q. So there weren't radios, for example?

A. I think there were radios but I was never given a radio. I mean, when you were on one-to-one observation, there was no way of you, you know, communicating with anyone. If the patient wanted something, then you'd have to wait for someone to walk past you and ask for that to happen, or, kind of, ask the patient to come with you, if it was, you know, if that was appropriate.

And if it was an emergency, then you, if you had a pin alarm then you'd activate the pin alarm. But like I previously said, not everybody had those.

Q. And so after the first ligature attempt that you describe, was there any debrief amongst staff about what had happened?

A. So the ligature attempt that I witnessed was the second ligature attempt that day of the same patient. So the first ligature attempt that day, I didn't witness that because I was on a one-to-one observation.

The second ligature attempt no, there was no debrief. There was no -- there was just a heated

exchange between the nurse and the healthcare assistant and the patient, actually, as well, because the healthcare assistant who was the healthcare assistant that had shown me around the building or around the ward on my first shift and was the one who showed me where the ligature cutters was -- sorry, were housed, and actually said to me "If you're going to take the ligature cutters, take the whole bag, not just one."

And when it came to it, she went to get the ligature cutters, took one ligature cutter and it was the wrong one, which is why I then went to get the grab bag with them all in it.

But there was no debrief. There was no debrief after any of the incidents that I was party to.

Q. So I don't know whether you're able to help us with this, because as you describe, there wasn't a debrief afterwards, but were you able to get a sense of why the healthcare assistant hadn't followed her own instructions about getting all the ligature cutters?

A. I've no idea.

Q. Was there any change in practice after this incident?

A. Not that I'm aware of, no.

Q. I'd like to ask you next about therapy and what activities, if any, did you observe patients undertaking whilst on the Willow Ward or in any of the other wards

that you worked at?

A. There was some kind of craft activity that I was never involved in, but there would be -- a couple of times on Willow Ward there was a room that was assigned for kind of social gatherings, if you like, and there was, like, some sort of craft event where they would round up some of the patients and take them in there and I'm not really sure what they were doing, some painting or something like that. I'm not -- that's the only thing that I was ever aware of.

Q. Did you see any patients taking part in those activities, the crafts, for example?

A. I was aware that there were people in there but, to be honest, I didn't pay much attention because I was always busy looking after patients on one-to-ones or doing the rounds. But I did struggle to think that, you know, day in, day out, patients were just -- they were either in their room or in the garden. There was a telly in the main lounge area, but there was nothing to stimulate them. They were kind of just wandering around chatting to one another. There was no interventions, there was no activities for them. It just seemed to be from breakfast to lunch to dinner to bed. That's how it appeared to me.

Q. You just touched upon the staffing and the pressures

that staff could be under whilst undertaking one-to-one observations, not being able to leave the patient. I wonder if we could just explore that a little bit more.

Did you observe, in your time working undercover as a healthcare assistant, sufficient numbers of staff on duty to respond to an emergency?

A. Certainly not on Willow Ward, no. When I worked on Cherrydown, I would say that they had quite a number of staff there, and this was the kind of, the feeling I was getting from working on other wards: that people didn't want to work on Willow Ward. Hence --

Q. Why was that? What was the difference that you were able to observe between the shift that you did at Cherrydown and the shifts that you did on the Willow Ward?

A. The difference, the main difference being the fact that there were a lot of one-to-ones at Willow Ward. And because there were less staff at Willow Ward, that meant that you were on one-to-ones for 12 hours because there was less staff there. So it was a self-perpetuating kind of failure really, because if -- basically, if the staff weren't happy they could go somewhere else. That was the beauty of working as an agency worker, I suppose, they could pick and choose -- as could I as a bank worker, I could pick and choose where I worked.

Q. So there was less staff. That was the main difference?
A. That was the main difference. There was less staff, and from working on other wards, there were more people on one-to-ones at Willow Ward. So the staff didn't want to go to Willow Ward because they were on one-to-ones constantly for 12 hours.
Q. You discuss the capacity at the Willow Ward in particular. Can you help us, from what you observed, whether the difficulties with staffing pressures impacted or drove reductions in observations at all?
A. I believe they did.
Q. Why do you believe that?
A. Because -- I can't remember what paragraph it is on my statement, but I'm aware of the patient who ligatured in the bathroom, some days, probably the following month, I think, some days later her observations were changed so that she was no longer on one-to-one observations and I don't think that was driven by her not needing the one-to-one observations. I think it was driven more by the fact that they didn't have enough staff to go around.
Q. I think we can -- if it helps, I think that's at page 12, paragraph 38 of your statement. I wonder if we can have that up. Page 12, paragraph 38.
This is on 19 April, the fifth shift on the Willow

Ward. You say here that the patient had made an attempt to ligature, that you responded to on your first shift. The patient was taken off one-to-one observations. You were surprised; concerned to discover this. The patient had made numerous suicide attempts and you'd spoken to her at length about this. The patient told you that she still felt suicidal. That concerned you, and so you informed the senior nurse on duty but was told that the patient wouldn't return to one-to-ones.

Is that the part you were thinking of?

A. Yeah, I think --

Q. Does that help you at all?

A. I think -- does it not go on to say that she, I think on 23 April or 22 April, a few days after that, I think she tries to ligature again, on --

Q. She does, that's on page 13, paragraph 40 of your statement.

A. Yeah.

Q. But just before we turn to that, here at paragraph 38, you say:

"It doesn't seem that a further risk assessment was made following my conversation with the patient and the nurse was happy to take a chance."

A. Mm.

Q. What do you mean by that?

A. Obviously, you know, I was employed as a healthcare assistant, but I think, if somebody had come to me and, you know, as a nurse and said, "The patient has said that they feel suicidal", there needs to be a conversation between the nurse and the patient as to exactly what these feelings are. You know, but to dismiss that when she has previously, you know, tried to ligature on numerous occasions, I was surprised.

Q. But do you know that a conversation didn't take place?

A. At that -- during my shift it didn't take place.

Q. And do you accept that you're not a clinician yourself?

A. Absolutely, yeah, I accept that.

Q. And that those decisions are made by clinicians; would you accept that?

A. I do accept that, yeah.

Q. And so, in terms of reductions of observations, I think your answer is that that was your impression. Was it something that you assumed?

A. What, that the reductions --

Q. The staffing levels impacted --

A. Yes. I would say it is something I assumed. But kind of with very, I think, with very good reason. The thing is, when you have a limited number of staff and that limited number of staff ends up being displaced amongst the one-to-ones, suddenly you've got no one else to look

after the other patients that are not on one-to-ones.

So if you've got six members of staff turn up for duty and you've got six patients that need one-to-one observations, you've got no other staff to look after the rest of the patients. So what do you do in order to resolve that?

And that was what was happening. You know? There were very few staff coming in. You've got no one to respond to an incident. So if somebody does self-harm, where are the people going come from to help you if you've got somebody who's trying to ligature? Because all the staff are on one-to-ones, so you can't leave your post. You know, it was a big thing on Willow Ward, I would say, that the lack of staff meant that people's observations were getting changed to basically backfill the lack of staff.

Q. I've got two more topics to ask you about.

A. Okay.

Q. Whistleblowing. You mention in your statement that there was one permanent healthcare assistant who told you that she'd been moved to the Willow Ward after whistleblowing about another healthcare assistant being abusive to that patient and no action being taken against that person.

Was your own experience of the ward culture that

staff were encouraged to report poor practice, or did the culture appear to discourage whistleblowing, or did it depend on your status if you were permanent or an agency staff, for example?

A. I don't think the conversation ever really -- I don't think the issue ever raised its head. You know, I have to say that when I was on Willow Ward, it was quite isolating when you are permanently on one-to-ones. You don't get time to interact with members of staff. You are -- obviously you're there to deal with the patients. That's what you're there for. But there is very little interaction with the -- with other staff members. The lady that I'm referring to, the healthcare assistant, she will come round when she was doing the four-hourly checks and talk to the healthcare assistants sitting with the patients. Not everyone would do that.

So you were very isolated and you'd go from one patient to the next to the next, like I say, so you didn't really get the opportunity to interact with other members of staff.

So I couldn't, you know, tell you. There'd be things I, obviously I was undercover so I was -- my eyes and ears, I was listening for any information. That was never really broached, the subject of reporting wrongdoing, or concerns. It was never really mentioned.

Q. Finally, investigations. CQC inspection. You talk about that in your witness statement, paragraph 36, pages 11 and 12. Did you witness any changes to staff practice during the CQC inspection?

A. No, I didn't. I was on a one-to-one, again, I think, most of the time that was there. But yeah, I would go out with my patient into the -- to get the fresh air, try and encourage them as much as possible to come out of their room, interact with other patients, and I was aware of a couple of the patients being spoken to by the CQC and they obviously were -- they were voicing their concerns. But I didn't see anyone from the CQC there. And I didn't interact with anyone and I didn't see any change in behaviours, as well, while they were there.

Q. And what about being briefed at the start of your shift, or given any information about how to conduct yourself whilst the CQC inspection was ongoing?

A. I'm not even sure that we knew that they were coming. I don't remember them mentioning it. They might have done, but it was supposedly an unannounced visit so I'm unsure whether or not the ward actually knew the day before. I don't know.

MS MALHOTRA: Thank you very much. Those are all the questions I have for you. We're now going to take a break for ten minutes to see if any Core Participants

have any questions. If there are none, that concludes your evidence, and you'll be free to leave. And if there are some, we'll be back.

THE WITNESS: Okay.

MS MALHOTRA: Ten minutes, Chair.

(1.10 pm)

(A short break)

(1.21 pm)

MS MALHOTRA: Thank you, Chair.

We do have two questions for you.

Firstly, were there any incidents that you found memorable that were not included in the documentary footage?

A. Several.

Q. Can you tell us about them?

A. In relation to the whole thing? The whole ...? There was a female patient on Cherrydown Ward, and I had to go -- I don't know if I mentioned this in my statement actually, I don't think so -- but I had to go to A&E with her. I think I briefly mention it.

Q. You do mention it in your statement; is this the patient you took to the accident and emergency department because her sugar levels were low?

A. Yeah. But, for me, obviously, completing my statement doesn't really get across, I think, how much things

resonate with you because you cannot really express it. So she'd been -- she'd had a very -- quite a powerful job, quite a high-powered job, and she'd ended up with some physical health concerns, and then this ended up with her having some mental health issues and she ended up on Cherrydown Ward, and she should have not been there. She should have been at home, but because they had nowhere to put her, they kept her on Cherrydown Ward.

Now, she had children and she was going out to Basildon town centre on a daily basis, but that really -- it really resonated with me, the fact that the only suitable place to keep her was in a mental health ward where she was witnessing people ligaturing on a daily basis, and was potentially triggering her to -- for her mental health to decline.

And obviously, because I wasn't working and I never went back there to that ward, those sort of things leave you wondering whatever happened to her, because she shouldn't have been there. The -- she'd been seen by the mental health professionals, she'd been given her medication and she did not want to be there but there was nowhere else for her to go because she needed to be in ground-floor accommodation, but she was separated from her children by being in that ward, she should have

been at home with her children and she wasn't.

So I don't know if that goes into a bit more detail than the statement.

There was another patient on Cherrydown Ward in Basildon who was regularly on one-to-ones, not always, but I think that depended on how she was presenting at specific times. And she'd done something quite nasty to herself, which wasn't found for some time because she wouldn't allow anyone to look at her. She wouldn't let anyone examine her. It was actually to her arm.

The lady who absconded from the Linden Centre, I spent a long time with her, talking to her, understanding that she'd only come in that, sort of the day before or in the evening, and spent a long time talking to her. Those things I don't come across in my statement.

Several of the patients on Willow Ward I got to know them, and built up a, you know, a good relationship with them, a good rapport with them. And I found it quite difficult to witness patients coming in and basically -- you know, it's a hospital, so they're there for treatment. Patients, women, who have got children, who've got families, who've got husbands back at home, have had an episode and they're ended up in Willow Ward and they get taken to their room and left. You are in

your room "This is your room, this is your toilet" then they're left.

Then "Lunch is at 12, dinner's at 5, breakfast is at 7."

I just found that really difficult to understand how that could be helpful to them. They've been taken away, whether it's by choice or because they think "I need help", or whether they've been sectioned, they're put into somewhere where they think they're going to be helped, and then they're kind of left. I found that really difficult to comprehend.

There was lots of things that, kind of, I remember, but it depends in what context.

Q. Those were the ones that stood out for you?

A. Yeah.

Q. I have one more question. You've referred to the CQC inspections both in your evidence and in your witness statement, and I have asked you about them before we took a break.

A. Mm-hm.

Q. Given that many of the concerns that you raise appear to have been apparent throughout your shifts on the Willow Ward, how obvious do you consider they should have been to the inspectors visiting and assessing the ward? Can you comment on that?

A. I actually remember having a conversation with one of the healthcare assistants who'd done the whistleblowing and I said to her that I don't think that they can have really got the gist of how this ward is operating. Because I didn't -- for one, I didn't see them. They were talking -- I know that they spoke to the patients and I know that they spoke to a couple of members of staff -- who the members of staff were, I don't know, I did know who they spoke to, which patients they spoke to, who weren't particularly backward in coming forward with their opinions on the ward. But the things that I've highlighted about the people falling asleep, people on their phones, you know, the way that patients were spoken to at times, and the way that there was a lack of de-escalation during incidents, unless that happened when they were there, you know, I appreciate that I was only on Willow Ward for, you know, was it seven or eight shifts, which is --

Q. Nine shifts.

A. Sorry, nine shifts, and that I went to other -- went to other wards, as well, and I've, you know, that is a very small amount of time spent on those wards in the great scheme of things, but they were there for a few hours. So I don't see that they could have seen how it really was.

MS MALHOTRA: Thank you very much.

THE WITNESS: Thank you.

MS MALHOTRA: Those are all the questions I have for you.

Thank you, Chair.

THE CHAIR: And can I thank you very much for coming to give evidence.

THE WITNESS: Thank you.

MS MALHOTRA: And be back at 2.15.

THE CHAIR: 2.15.

(1.30 pm)

(The Short Adjournment)

(2.15 pm)

(Proceedings delayed)

(2.19 pm)

MR McALLISTER: Good afternoon, Chair.

THE CHAIR: Good afternoon.

MR McALLISTER: We are ready to hear from this afternoon's witness, Mr Ian Arthur.

Mr Arthur, please can we begin by you stating your full name.

THE WITNESS: My name is Ian John Arthur.

MR McALLISTER: And please can the witness be sworn.

IAN JOHN ARTHUR (sworn)

Questioned by MR McALLISTER

MR McALLISTER: You have provided a witness statement to the

Inquiry, dated 4 June 2026, in response to a Rule 9 Request from the Inquiry. You have a copy in front of you. It runs to 42 pages, and 272 paragraphs.

On the last page, it's been signed by you, is that right?

A. That's correct, yes.

Q. And it bears a statement of truth. Have you had an opportunity to read that statement recently?

A. I have, yes.

Q. And is there anything in it that you wish to correct?

A. No.

Q. And can you confirm today that the contents are true and accurate to the best of your knowledge and belief?

A. That's correct, yes.

Q. Now, that statement stands as your evidence before the Inquiry and I'll be asking you questions based on it, but if there's something I don't cover that's in your statement that evidence remains in front of the Inquiry.

I will broadly follow the headlines -- the headings in your statement. It starts with a section of your career background and experience, on the first page, paragraph 3. You're a Registered Mental Health Nurse since completing your training in August 2000; is that right?

A. That's correct, yes.

Q. And currently, and since November 2025, you've been seconded to the Mid and South Essex NHS Foundation Trust as an Integrated Discharge Hub Mental Health Lead; is that right?

A. That's correct, yes.

Q. But before then, and in fact still, you've got uninterrupted employment with what is now EPUT, and its predecessor Trust, since January 2003?

A. That's correct.

Q. So that's substantially with the North Essex Partnership NHS Foundation Trust?

A. That's correct, yes.

Q. Referred to at various times as NEP or NEPT in your statement.

There will be times in your statement when I try and clarify with you, when you're talking about a trust, which one you're talking about and substantially that's whether it's before or after April 2017 at the point of merger.

I'm going to take you through, in brief terms, the summary of some of your experience.

In 2003 you were Charge Nurse at Drake House in Chelmsford. And was that an older adult dementia assessment ward?

A. That's correct, yes.

Q. You then had community roles from 2004 to 2008, including adults of working age and older adults?

A. That's correct, yes.

Q. From January 2009 to December 2011 you were Ward Manager at Lucas Ward, at the King's Wood Centre in Colchester. Was that an older adult inpatient ward for those with complex care needs?

A. That's correct, yes.

Q. And you describe that as your first leadership position.

A. That's correct, yes.

Q. Lucas Ward was decommissioned at the end of 2011, and at which point you went back, I think, to a community-based role from January 2012 to -- starting in January 2012, at the newly commissioned dementia services at the King's Wood Centre.

A. That's correct, yes.

Q. That's at a stage in, I think before March 2015, you became an Advanced Nurse Practitioner within the same team; is that right?

A. That's correct, yes.

Q. And then, come November 2015, you were appointed Clinical Manager or Inpatient Services Matron at the Crystal Centre, Chelmsford at the Broomfield Hospital site. Is that right?

A. That's correct, yes.

Q. And you describe that as mid-locality.

A. *(The witness nodded)*.

Q. Mid-locality, is that the geographical assignment that there was under NEPT?

A. That's correct, yes.

Q. And there you had leadership of two wards: Topaz Ward, which was a dementia care ward?

A. That's correct, yes.

Q. And Ruby Ward, a functional older adult ward.

And I think you also had responsibility for the then community team for people with dementia.

A. That's correct, yes.

Q. And at that stage you had Ward Managers, three senior staff, and about 100 staff under you?

A. That's about right.

Q. Without naming names, your managers at that time, your direct reporting manager, I believe, correct me if I'm wrong, stayed as your direct reporting manager for a substantial amount of time?

A. There was a break when I was at the Crystal Centre when the line management changed --

Q. Okay.

A. -- from my previous line manager and then there was an internal reorganisation for a community and inpatient split and my previous manager who had been my manager

from 2009 to 2015 when I went to the Crystal Centre, she became my manager again. That break was around about a year, possibly about 18 months. I can't remember exactly. But then that person became my manager again from that period of time until she retired in 2022.

Q. 2022?

A. *(The witness nodded)*.

Q. Okay. So a substantial period of time with substantially the same line manager but with some structural changes at times?

A. Yes.

Q. Come December 2017, so now this is post-merger, your location changes to the northeast area but I think your role is still the same in terms of Clinical Manager, Matron? And your responsibilities were now for the Tower and Bernard Wards within the Landermere Centre on the Clacton District Hospital site?

A. That's correct.

Q. And they're both dementia care inpatient wards?

A. They were both dementia care wards. Tower Ward was, at that time, a female dementia care ward and Bernard Ward was a male dementia care ward and they were both geographically based at Clacton Hospital at the Landermere Centre.

Q. And I think you also had a responsibility for Henneage

Ward.

A. *(The witness nodded)*.

Q. And that was an older adult functional ward at the King's Wood Centre, Colchester?

A. That's correct, yes.

Q. So some geographical split between the wards you were managing.

Then at some point in 2018, your responsibilities additionally included the management of the Peter Bruff Ward; is that right?

A. That's correct, yes.

Q. Can you remember when in 2018?

A. I can't remember exactly when in 2018.

Q. Any idea at all, as to beginning, end --

A. I could not even pretend to guess.

Q. Okay. I'm not asking you to guess, thank you.

A. That's fine. It was in 2018. I really cannot remember.

Q. And Peter Bruff, can you describe briefly what the Peter Bruff Ward was?

A. So Peter Bruff Ward is physically based at the King's Wood Centre which is a part of -- both Henneage and Tower and Peter Bruff are both based in the same building. Peter Bruff itself is an assessment unit that was designed to be working in a similar way to what is currently Grangewaters at the Basildon Hospital. So

geographically the old South part of the organisation had Grangewaters to offer patients an assessment unit model and Peter Bruff was what was an old North geographical-based assessment unit model for the northeast, the mid and the northwest localities.

So both Grangewaters and Peter Bruff offered that -- offer that similar kind of way of working and service for the patient, patient use.

THE CHAIR: Remind me where physically Peter Bruff Unit is.

A. Peter Bruff is based in Colchester at the King's Wood Centre.

THE CHAIR: Right, thank you.

MR McALLISTER: So, at some point in 2018 you have an additional ward. I don't think that stretches your geographical area.

A. No.

Q. And then the Bernard Ward is mothballed, I think you say in April 2020, and Tower becomes a standalone mixed-sex ward at the Landemere site --

A. That's correct.

Q. -- is that right?

A. Yes.

Q. Focusing on the Peter Bruff Ward, do you know why you were asked to manage that ward?

A. I -- my portfolio, a lot of my work was geographically

based at Henneage Ward at King's Wood Centre and I believe I was asked to take it on because, actually, of the physical locality of me being on site predominantly most of the time. The previous Matron split their time between The Lakes and the King's Wood Centre and I think probably for pragmatically obvious reasons, if I'm physically based on one site it would make more sense for me to take over Matron responsibilities for two wards based of -- if they're similar on the same site.

Q. And how did you split your time -- and I'm focusing here on 2018 to 2020 -- between the wards you had responsibility for?

A. I would generally spend two days of my week in Clacton and three days of my week in Colchester. That's a generalisation. If there was something more urgent on one of the other sites then my time would be split wherever the priority would be but predominantly I would be spending probably three days at Colchester and two days in Clacton.

Q. And so emergency aside, not travelling between sites on the same day?

A. No. I have done in the past, if there was a need for me to do that, then I would travel urgently to whichever site might be needing my time in a more pressing kind of

situation but on the whole, no. The distance between Colchester and Clacton is not substantial, but it's not the best use -- it wasn't the best use of my time to be driving across sites frequently.

Q. And is it fair to say that pre-2008, most of your work had specialised -- had focused on older adults?

A. Probably two-thirds of my career has been older adults and a third has been adults. So my time prior to 2000 to 2003, I worked on an adult mental health ward in London and I've had a fair amount of my community career with adults of working age, as well, in the community. That's physically based, thinking about it, the old North East, Mid and North West localities.

Q. What support, if any, were you given to prepare yourself for a change in age group in 2018 with responsibility for Peter Bruff Ward?

A. My previous experience working with older -- with adults, is something that was -- not something -- it wouldn't be alien to me, to be working with people who have severe mental health problems who are adults of working age, as well. So from my experience with the community and my previous time in working in London, my skill sets weren't -- it wasn't alien to my experience of working with this kind of patient population.

Q. Going back to splitting your time between two different

sites in the way you describe, what challenges were there in managing wards on different sites?

A. It's, having split sites is never a particularly easy way of working, particularly if something urgent arises. Sometimes work is quite predictable, sometimes work is very unpredictable. The ability to utilise my time where the services were experiencing complexities, particularly for the patient cohort, it wasn't something that was very challenging for myself. So for example, if I needed to go to Clacton for an urgent reason, my line manager was based at the King's Wood Centre at the time and if there was something she needed to pick up for me she would do, or again, if there's vice versa, if I was in Clacton and something urgent was happening in Colchester, I could come back to Colchester with relative ease.

It wasn't a complicated issue to manage two sites; it was just something that I was aware of needing to make sure that the plans that I had put in place were followed as best as they could be.

Urgent situations happen at the drop of a hat but my plan was generally to split my time as equally -- equitably between both Clacton and Colchester, and -- and I did that to the best of my ability.

Q. Then between specific wards, did you spend -- were you

able to spend relatively equal amounts of time on each ward?

A. Yes.

Q. And were there times when you were at either site when you weren't on the ward?

A. Prior to Covid, quite often there would be meetings that were based geographically in Chelmsford or the Wickford areas after we merged, so there would be periods of time where seniors would be attending meetings for whatever particular reason that was called for. So there would be times that me as a Matron, I would not be on site, and that also continued through the Covid period and since use of remote systems like Teams, that has helped, the less need to drive to lots of different sites at the same time.

So yes, there would be times when I wouldn't be around on both sites.

Q. And isn't it right that Peter Bruff Ward, because it's an assessment unit, patients were acutely unwell but the expectation is that they don't stay for very long, perhaps a number of days only?

A. That's correct.

Q. How, if you're split in the way you describe, how do you ensure that you're aware of the needs of the population at any particular time?

A. My routine as a Matron generally used to be of walking the wards predominantly first thing in the morning, so when Clacton went down to one ward, I'll go and physically check on the ward by physically going on to the ward itself, I'll check in with the team that's working, because of the fact that there are shifts, I wouldn't see the same team within one time that I'd visit the ward to another.

And that would be the same for when I was physically based at Colchester, as well. So I would go predominantly before I'd even put my bag down, I'd go and check on the wards to see if anything urgent had happened over the past time that I'd been there, so if it was a weekend I'd check in the morning, on the Monday, to see what's going on and then that would carry on when I physically arrived on the wards, that I'd go to check on Peter Bruff and go to Henneage Ward, as well.

So the ability to get a feel of what's going on was something that I was hopefully able to pick up very first thing when I visited the wards.

Q. And in terms of your -- we may come back to Peter Bruff Ward later, but in terms of your roles and responsibilities, come November 2022, you become Secondment Interim Service Manager for the North East

locality which you describe as a leadership role for the Urgent Care Pathway, and when you had responsibility for six wards, still including Peter Bruff, and others, in what ways did your role change then?

A. So my Matron role had responsibility for two sites and three wards. The secondment gave me responsibility for all six wards in the North East locality so they are based at The Lakes in Colchester, which has Gosfield, Ardleigh Ward, King's Wood Centre has Henneage and --

Q. Sorry I'm going to pause you there. My fault. We're going slightly too fast.

A. I beg your pardon.

So my responsibilities would be for those six wards including a rehab ward which is based in the community and the Urgent Care Pathway for -- the Urgent Care Pathway is teams including hospital liaison at Colchester Hospital and the demand from there, the Crisis Response Team, for people in a state of urgency and Home Treatment Team for people that might need interventions similar to a hospital setting that are quite significantly complex in their presentation at that time.

So it would be six wards and the Urgent Care Pathway which had three domains within that pathway itself.

Q. So it sounds like a significantly wider role?

A. That's correct.

Q. Does that take you away from the wards, even though the wards are under your management, does it take you further away from them?

A. Physically, yes. My location changed -- my base was at the King's Wood Centre and my base then was moved to The Lakes which is probably 200 metres down the road but it's still part of an EPUT site and that's because historically that's where the Service Manager role was, and the admin arrangements around it as well.

So I swapped one site for another but I also had the ability to access physically to go down and see the wards at The Lakes if there was a requirement for me to do so, but there was also a Matron there in position as well, so in some respects it took me further away from the day-to-day contact but there was an added layer of responsibility for the extra demands from three other teams -- three other wards, and another Urgent Care Pathway as well.

Q. Do you think this impacted on your exposure to or understanding of what was happening at ward level?

A. In -- it had the opportunity to do so, but my practice would allow me to make sure that I would have time with the clinical leads of the team. So I would make sure that I had time with the consultants that were booked in

for informal catch-ups, that sometimes was on Teams and sometimes because they were based in the same building, and I'd also have contact regularly with the Matrons and Ward Managers for things that might pop up that as a Service Manager I probably was unaware of myself, being a Matron. So that gave me a better overview of some of the demands in particular areas hotspots, Peter Bruff being one of those quite clinically demanding areas. And I was probably quite aware of the demand on the Matron level but also as a Service Manager you become aware of the other demands more strategically for the other teams and the Urgent Care Pathway, as well.

Q. And had the role that you'd been doing immediately prior to the Secondment Interim Service Manager, was that backfilled by somebody? I'm not asking you who by --

A. It was, yes.

Q. It was, okay.

And really only to clarify, if you look briefly at paragraph 18, which is at the send of the section, very end of the section on your career history and summary experience, you say that prior to your time of working with dementia-specific services "I did not receive any specific training in regards to dementia care."

Was that written -- what year were you thinking about when you were writing that? Your whole career or

the much earlier part of your career?

A. My entire career. Up until that point in time, there was actually no -- well, you are exposed to lots of different things as part of your nurse training, there was no specific -- dementia-specific training for looking after people with dementia. That was something that was borne out of development of the dementia service that I'd become team leader of in 2012. So that actually -- working with people with mental health problems is a complex process but working with people with dementia adding into that is a very complex process and to have some formal training was felt that it was needed, and that is now, there is mandated training for most people to undertake some sort of dementia training, but prior to that, there was no formal training of any sort of any form for looking after people with dementia care.

Q. And you say in that -- in paragraph 18, it continues:

"In 2011 NEPT developed dementia-specific professional training that was offered via Essex University."

Do you know why that came about? Were you anything to do with it coming about?

A. It was part of the development of what was then now -- what was then the Dementia Pathway. The Dementia

Pathway was commissioned following the closure of Lucas Ward, and the Dementia Pathway looked at to enhance people's understanding and offer patients who have dementia a better experience, particularly for people in hospital settings, as well.

So it was developed in collaboration with Essex University at the time, which was then obviously part of NEPT. And I am unsure whether, in 2011, that was offered to people that had access to Essex University that might have worked for SEPT. So the reasons why I made reference to NEPT is actually that was developed in collaboration with Essex University and what was NEPT at the time.

Q. And you say it's still offered to this day?

A. I believe it is, yes.

Q. But to registered professionals only?

A. That's correct.

Q. So if you're an unregistered staff, and you say this in your statement, you have access to mandatory training to increase understanding for those who have a diagnosis of dementia. I take it that's something different and less involved than the training you describe in collaboration with Essex University?

A. That's correct. The mandated training for people who have dementia is part of EPUT's mandatory training

compliance. But for people with dementia -- with registered practitioners, they can have access to further professional development themselves for people with dementia, and there is a difference, obviously, between registered and unregistered colleagues. But the level of training to help understand why people might present in a particular way, my personal time -- understanding of that came out from that from experience, but it's not mandated for -- if you have a professional interest in working with people with dementia, you'll probably have access to these kinds of professional services. But if you're an unregistered colleague who's coming into a new position to try to understand why somebody might be presenting in a particular way can be quite difficult to understand why that is the case. And having limited mandatory training will give you some knowledge but might not give you the full understanding of why somebody might be presenting in a particular way. And I just think it's important to note that.

THE CHAIR: Can I ask, have you done this training with Essex --

A. I have.

THE CHAIR: -- Essex University? Thank you.

MR McALLISTER: And you say at the very last part of

paragraph 18 that you're not aware of any specific training for older people who have a functional type of illness.

Is that still your understanding?

A. That's true, yes.

Q. Is it right that there are different pathways for those suffering with dementia, dementia on the one hand and functional mental illness on the other?

A. Yes, there are.

Q. Are there patients with an ambiguous presentation?

A. Yes, there are.

Q. And how does the service treat those people, or seek to treat those people?

A. If we're talking about from an inpatient point of view, until a confirmed diagnosis of dementia is made, an older person who may require hospital care, they'll be offered care in a functional ward. So somebody who might have a suspected diagnosis of dementia who has not yet had a diagnosis made will be cared for in a functional care -- functional ward.

So the -- I'm trying to think. There are five functional adult wards, probably will be caring for somebody at this moment in time who has probably got a diagnosis of dementia coming, hasn't yet been made, because lots of different tests and diagnostics need to

be made, but again, caring for a person that might be presenting with some level of confusion, possibly, probably, on a functional older adult ward who will be caring for typical mental illnesses such as depression, anxiety, schizophrenia, it's a complex cohort of patients to be caring for, and caring for functional patients, a traditional older person with a typical mental illness, there's no specific training for that, as part of what -- either people have a professional interest in working in, or it is something that is learnt on the job, as well.

So caring for people with a functional illness is a very -- from a nursing point of view is very much a traditional pathway but there's no specific understanding of the fact that somebody who has comorbidities, possibly, might present with a confusional presentation but might have very clear physical reasons why they're presenting in that particular way.

So it's quite -- mental health is quite a complex situation, add in older situations, add in lots of things that might be reversible, is complex and can be quite tricky.

Q. And is there a risk, therefore, that there is the wrong diagnosis or a functional illness is mistaken for

dementia or the other way around?

A. Potentially, but the fact that the teams doing this on a day-by-day basis become very skilled but there is always going to be that element of that being made. I'm not aware if that is the case, but I know that there will be probably most of the functional wards will probably have a person, probably waiting for a diagnosis of dementia to be made for. It doesn't mean that they should be moved to a dementia care ward straight away but actually it's about understanding where that person sits and adding the complexities of caring for a dementia patient on a functional ward who might be presenting in a slightly confused or potentially unpredictable way is something that is not always widely understood, and I think it's important to just recognise that.

Q. Moving forward slightly under the heading of "Assessments" in your statement, can we have on the screen paragraph 20. Again, chronologically, we're back into 2009 and you move forward in your statement. In 2009, you were the Ward Manager of Lucas Ward. And you say that NEPT had -- had structure set via the Care Programme Approach, the CPA. And then it's a framework utilised across all mental health services that allow care and risk planning to occur, both within community

and inpatient services.

And things that takes into account -- I'm summarising -- includes historic issues for the patient, current risks, levels of observation, underlying physical health considerations, manual handling issues, family connections and thoughts for their loved ones in hospital.

And you say these would be recorded on the Patient Administration System that at the time was Carebase. And that clinical staff and administration staff had access to that system.

Would that include access for non-registered staff?

A. That's correct, yes.

Q. What about agency staff?

A. They would also have access, as well.

Q. And when you say they would have, did that always take place?

A. I can't recall a time where there would not have been a -- a worker not being able to record on to Carebase. The fact that it's a very, very, very long time ago that we used Carebase, I'm not able to recall that, sorry, but at the time, I would not have been aware of anybody not being able to access Carebase to make records and put entries in.

Q. And using that as an example or more generally, in

practice, were both patient and family views always sought as part of assessment processes?

A. I would hope that it was at the time. Particularly for people with dementia who -- or people who have got a cognitive impairment, the families and loved ones around them would be the experts and actually for us to be able to provide a really good level of care for a person that has got a confused presentation or dementia presentation, we would -- the clinical team would rely heavily on getting information from the family and loved ones to be able to offer a really good level of care and an individualised care plan for that particular person.

Q. And were there any barriers to taking on family views, for example?

A. Not that I was aware of.

Q. And you say later on at paragraph 22, we don't need to look at it on the screen, but it is there if you'd like to, you describe Lucas Ward at the time receiving complex presentation patients from Henneage and Bernard Ward. How, in practice, do the needs of complex patients, are they communicated to non-registered staff and agency staff?

A. So the care plan would be predominantly the biggest driver for sharing of information. The care plan would

also be discussed and looked at at handovers. So at the time when Lucas Ward was operational we had a three-shift system, so we had early shifts, late shifts and night shifts. So the handover and sharing of information predominantly was done at these points of time in the day.

And if there was an event such as an MDT or a care review or a ward review where you have the MDT coming together then if there were significant things that would need to be discussed that weren't urgent but needed to be discussed, they would be followed up and actioned there, and again, shared via, predominantly handover, which at that time was a three times a day occurrence.

Q. I'm going to take you to a little bit later in your statement, page 6, paragraph 31 under the heading of "Admission", we don't need to necessarily see it on the screen but just for those who are following. You, having worked in the community for a period of time from 2011, you returned to a blended role of clinical manager and Matron at the Crystal Centre in 2015. We've discussed what that consisted of in general terms already.

You describe in paragraph 32 a move under NEPT in the mid 2010s, from a traditional community and mental

health team approach, which is age dependent, to a needs/problems approach which was not age related.

And I think this is what you refer to as the Journeys programme; is that right?

A. That's correct, yes.

Q. And then at the end of paragraph 32, if I understand correctly, you say that SEPT followed the traditional CMHT age-inclusive approach and that they may still do.

A. *(The witness nodded)*.

Q. Is that right?

A. That's correct, yes.

Q. So within EPUT, there are two different approaches; is that right?

A. In regard to community care? Yes.

Q. Yes. And are you aware of whether there's been evaluation undertaken to assess different outcomes for patient cohorts?

A. There may have been but I'm not aware of that.

THE CHAIR: But it's not applicable in inpatient care?

A. No.

THE CHAIR: Thank you.

MR McALLISTER: If we can look at paragraph 34 on the screen, and again, I'm being reminded to slow down --

A. Apologies.

Q. No, my issue as much as yours. If we look at

paragraph 34, this is one of a few places in your statement where you talk about the sitrep and bed management and so on. So I'm not confining you to this paragraph but this is where it first comes up, really. So this is back in 2015 in the Crystal Centre, you say:

"There's no specific bed management sitrep calls as NEP did not operate an entire bed stock approach to community demand. Generally, localities such as Mid Essex, North West Essex and North East Essex, worked independently in managing bed stock."

Then you say, "After merger", so we're now in post-April 2017, "there were management structure changes and there was a much more integrated approach to the utilising of bed stock", with early morning telephone calls about bed availability by the Bed Management Team.

As a general impression, was it -- was a locally based bed stock approach easier to manage? Better for patients? Are you able to say?

A. There were two strands. It would make the individual localities aware of the demand to think about, actually, how, if there's ways that we can be creative with the bed stock that we've got. So if a patient theoretically is in Chelmsford and needed a bed in, let's say, the Crystal Centre on Ruby Ward, it would be up to the team

to think about if there's ways that we can safely generate some discharges for the patient to come into.

If there wasn't the ability to do that, then the ability to lean on other parts of the organisation, if there was any other capacity elsewhere, would be helpful. The flipside is the fact that if you are asking a patient to come from Harwich to go all the way over to Epping to go to a mental health bed in Epping, it's a very long distance for their loved ones and families to get to but if the clinical risk for that patient is requiring a hospital bed and there was a bed identified then the ability to use a Trust-wide approach to bed management, offers the ability to offer them a bit more of a timely response with the fourth one of thinking of how can a patient be offered a bed in their own locality as quickly as possible?

Q. At paragraph 38, you describe effectively the development of the sitrep bed management calls to morning and afternoon and a Trust-wide 12.30 sitrep call to review clinical demand and expected discharges from the wards.

And you describe that there's input from, or representation from inpatient services, community and also urgent care teams.

And at paragraph 39:

"Patients who were deemed necessary for admission but without an immediate bed available, the sitrep call usually offers mitigation that a community service will continue to support until a bed is identified and vacant."

How does that work in practice?

A. So if an identified patient was requiring a hospital bed for -- a mental health bed, and there wasn't one ideally located in their vicinity or even inside the entire organisation, the conversation on the call would look at what are the current risks for that particular patient? Are there mitigations that we can put in place until a bed can be identified? So, for example, a patient who might be under the care of a Crisis Team or a Home Treatment Team and their risks have changed to the point that they are now requiring inpatient stay, in regards to thinking about why the mitigation can be put in place doesn't obviously just sit with a Home Treatment Team, a community team, a care coordinator, would still be expected to offer a timely intervention to a patient in a state of urgency and the Home Treatment Team might also be expected to increase the interventions they're offering as an alternative to try to offer a holding ability for that person until a bed does become available.

And sometimes, depending on the risks that the person is presenting with, the sitrep calls would look at whether a request for a private bed would be clinically justifiable for a person to go into, which does happen and it happens to this day for EPUT at the moment with our three times a day sitrep calls, and that decision is made by everybody participating in the calls at that moment in time.

Q. Again, we'll try and slow down a little.

A. Apologies.

Q. And the same issue comes up several times in your statement, both under admission and discharge. If there's monitoring of who needs admission, who might be able to be discharged, isn't there a danger that there's both bed pressure on people not being admitted when they should be, but also potentially being discharged too soon?

A. The decision to admit, the decision to discharge, would be clinically-based decisions. The -- what's called the flow, such as discharges to the organisation, is a constant pressure that the organisation jostles with on a day -- throughout the entire day, I am aware that there is conversations about offering people discharges but I'm not aware to conversations where people have been discharged in order to create a bed for somebody

else to come into solely on the fact that there is significant demand in the community to generate a discharge for someone else to come into.

Discharges I would hope are clinically in -- made at the right time for the right patient, not solely to generate a discharge to allow an admission to come in.

Q. And where you say, at paragraph 43, "Over time the sitrep call has evolved to have much more clinical oversight by the expanded patient flow team, and senior attendance to assist with decision making", the suggestion there is that there may have been a lack of clinical oversight in earlier iterations of managing patient flow.

A. Quite possibly.

Q. And has the set-up perhaps not involved the right mix of representative groups?

A. Are you talking prior, when it was first set up?

Q. Well, I'm trying to understand what you say at paragraph 43, because you tell me that, over time, the sitrep call is involved to have much more clinical oversight. I'm wondering what was the absence?

A. Initially the -- my experience of the sitrep call was predominantly there were solely bed management colleagues who have an admin background looking at where the bed stocks were. So if there was a bed available in

Colchester and there was a patient in Chelmsford who needed the bed, they would find that bed for that person to go into.

Over time has progressed is actually thinking about the clinical presentation for a patient to come in, what is the clinical mix on a ward at a particular time, are there significant demands in one area in comparison to another area? So rather than relying on admin colleagues to help generate a resolution for us clinical staff, there's much more clinical oversight of actually where patients are best placed in their most safest way inside of EPUT and possibly outside of EPUT, as well.

So rather than an administrator finding -- saying there's a bed on Gosfield Ward at Colchester, actually, there might be reasons why a patient might be best off placed somewhere else inside the organisation as well and that clinical oversight is made by people that work in the Flow and Capacity Team and they do that on a day-by-day basis.

THE CHAIR: Can I just be clear, can you recall instances where there might -- previously, where there might have been no clinical oversight of some of that decision making?

A. Off the top of my head I don't think so because, actually, predominantly, even when the sitrep calls were

initiated there were clinical staff on the calls always making the decisions, and I probably have been -- well, I have been privy to lots of those kind of conversations myself.

THE CHAIR: So it's a case of not enough as opposed to not any?

A. That's correct, Ma'am.

MR McALLISTER: Perhaps just one last question on this topic at this time. In your paragraph 47, you say you were aware that there is guidance of levels of -- of what the levels of care are needed in the interim time for when a bed is identified as needed and then accessible, but in your role, you're unfamiliar on the scoring tools that the Flow and Capacity Team use to identify the most urgent patients needing admission.

So is that because it's outside of your remit?

A. The ability to score a level on patient's clinical risk and demand, that's something that the Bed Management Team do with the people that are requesting admission in the first place. That might be Home Treatment Team, it might be a community care coordinator or somewhere on the urgent pathway or someone who is waiting to be detained under the Mental Health Act.

Q. And are you able to tell me anything about how that tool is being developed, or quality assured, or quality

-- (overspeaking) --

A. I can't give you the detail of that, I'm afraid, I'm sorry.

Q. And the way, as I read your statement, the focus is significantly on patients within -- patients being admitted to EPUT wards. It doesn't talk about out-of-area placements. They happen, as I understand it. How is that factored in? At this sitrep, or something else?

A. So the number -- patients placed in a private bed is not the best experience for anybody. They might be placed potentially quite a long distance away, not always. There are private hospitals in Essex but the number of patients that are in the private sector is discussed at the sitrep calls. It's discussed every day. I don't know if it's discussed three times a day but I know that the number of patients that have been placed in a private bed are discussed as part of the sitrep detail and is monitored, with the overall aim to try to reduce that down. But it's something that the organisation is aware of on a daily basis.

Q. Before we take our first break, I just wanted to ask you a few questions on, under the heading of "Ward Environment" -- not at this stage about Oxevision. There's some more -- some questions about the physical

ward environment issues.

It seems that back in 2009, one of the main concerns, as Ward Manager of Lucas, was a risk of falls; was that fair?

A. That's very true, yes.

Q. And you can't recall whether ligature concerns were part of the risk assessments at NEPT at that time?

But come November 2015, when you moved to the Crystal Centre, as I understand it, you were aware that there had been a ligature incident on the Ruby Ward before your arrival. Is that fair?

A. That's true, yes.

Q. And you say you vaguely recall ward-based ligature risk assessments pre-EPUT, but they became more formalised when EPUT was created. Is that a fair summary of your understanding?

A. Yes, that's true.

Q. And I take it from your statement that you accept there's a responsibility for someone in your role to ensure that wards remained as ligature-risk-reduced as is possible. But you seek to emphasise that there's a balance to be struck with making an area as comfortable as possible. Is that right?

A. That's true, yes.

Q. And do you recognise there's a potential tension there?

A. That's correct, yes.

Q. And is it something that there can be consistency about, or is there a strive for consistency or is there an element of discretion there?

A. The consistency is definitely being applied to my time prior to going and working for MSE, Henneage Ward had a significant refresh and replacement furniture which was well due for, last year. The furniture that was replaced, particularly the dining room furniture, was of a reduced ligature design, which helps reduce the overall issue for ligature for fixed -- for furniture but the furniture is incredibly heavy and designed to be very heavy and not very easily moved, but you might have older people that might not have as good core strength to be able to try and move a chair around as a complex aspect to try to offer them on a day-by-day basis.

It's a balancing act to get ligature-reduced furniture without also giving people who might not have the strength to be able to not move furniture around. It sounds strange but it's quite complicated, complicated to move a chair from 2 inches from one side of a table to another.

But it's something that is being applied to all aspects of EPUT wards.

Q. And before we break, if I may, I just want to try to

better understand the evidence you give about motion sensors and so on. You tell us in your statement, paragraph 58, there was assistive technology in bedrooms to help mitigate unwitnessed falls that had been noted on the entire Trust at the time. So we're talking about November 2015 to perhaps November 2017, at that part of your statement.

So there were mattress sensors; is that right?

A. That's correct.

Q. And there were sensors on the floors to detect when somebody had put their weight on the floor?

A. That's correct.

Q. And there were edge-of-bed sensors, as well?

A. That is correct, yes.

Q. And I just want to clarify, these were not part of Oxevision, these were a different physical

-- (overspeaking) --

A. Absolutely yes, not part of Oxevision at all.

Q. And in that context when you describe in a couple of parts of your statement about there being a key that can turn these off or on, does that cover all of the assistive technology that I've just described?

A. So there will be a controller on the outside of a patient's bedroom so if somebody is at higher risk of falls, the technology would be switched on and off by

a controller box outside a patient's bedroom so if somebody who had no risk of falls and didn't need any falls equipment to be turned on, then that bedroom wouldn't be activated, as such, to be, quote, "on" for a falls risk. So it gave you the ability to turn an individual bedroom on for warning systems for falls risks, and "off", as a falls risk, as well.

So it was not part of Oxevision. It's not tied into that system at all.

Q. You give evidence that I'll come back to -- or I may deal with it very briefly now, actually. You give evidence about a part of Oxevision that was an edge-of-bed sensor, and you've distinguished that and I think it is that that was -- not your words, my words -- oversensitive?

A. That's correct, yes.

Q. And might cause alarm fatigue?

A. That's correct, yes.

Q. But that's distinct. All right?

Madam Chair, I think that's a convenient moment to take a break.

THE CHAIR: How long would you like?

MR McALLISTER: For the purpose of the transcriber, I think 15 minutes.

THE CHAIR: Fifteen minutes.

(3.15 pm)

(A short break)

(3.31 pm)

MR McALLISTER: Mr Arthur, just before we restart, we'll both keep an eye on our speed, and perhaps pausing during longer answers, which I may have elicited just to give everyone a chance to hear what you're saying and to make sure that the recording and transcript are accurate.

I'm going to take you to paragraph 77 of your statement. Page 14. The heading is "Treatment", which starts back on page 12. The first section is significantly about older adults, which we've touched on already, and as I understand the structure of your statement, paragraph 77 onwards is about emotionally unstable personality disorder, and/or borderline personality disorder, and the potential challenges dealing with that in an inpatient setting.

You describe, at paragraph 80, how -- it appears in two places, both at paragraph 79 and 81, you say that ward-based psychologists are readily available to compile a formulation for the clinical presentation with recommendations made for further community-based therapy when clinically indicated.

At paragraph 80, you describe as I understand it,

that there's been a shift towards wards having their own dedicated individual professionals, so including psychological, both -- well, psychologists in particular, both to help staff and presumably in the assistance provided to patients and service users.

A. That's correct.

Q. The question, after that long introduction, is: are there enough psychologists to -- either on an inpatient basis or, to your knowledge in the community, to deliver what is needed?

A. From my professional point of view, the ward -- having an individual ward-based cohort of professionals to look after that ward has seen a significant increase in a level of input that probably wasn't there 15 years ago on the inpatient wards. Is it sufficient is probably a question you might need to ask our AHP colleagues themselves directly. My suspicion is the fact they probably would say no, they probably would require more increased input which would probably benefit both community and inpatient services.

Q. And the general impression from your statement is that patients with EUPD present challenges, there's a tension between what may be -- what can be done on an inpatient basis and what maybe ought to be done in the community. How do you resolve that, in practice?

A. At some point, every single patient will be discharged back to a service that isn't an inpatient setting. Predominantly most patients go back home so the conversation about looking at what a safe discharge looks like --

THE CHAIR: Hang on.

A. Sorry.

THE CHAIR: Slow down.

A. I beg your pardon, Ma'am, sorry.

There will always be a tension between community and inpatient discharges for people that are quite complex, particularly with an EUPD type or a personality disorder type diagnosis. It's very -- their discharge shouldn't be dependent on whether there is a delay in something happening on an inpatient ward or a community setting at the same time. So the question in regards to -- ask the question again, so I can answer it best, please.

MR McALLISTER: Really, I was asking what the challenges were between inpatient care versus community care.

I can rephrase it this way with the benefit of part of your statement. At paragraph 82 to 84, you, at paragraph 82, you say:

"The ability for mental health services to make a judgement call for a person presenting with severe emotionally dysregulation but the need to offer care in

the community is a day-to-day clinical decision that MDTs make each and every day. There is significant evidence that this cohort of patient group have a poor experience within an inpatient setting, develop other poor coping strategies and increase impulsive self-harming behaviours."

To give the question some focus, what if there are threats of self-harm or suicide whilst an inpatient but otherwise potentially on the way to discharge?

A. That's a real risk that the teams manage on a day-by-day basis and I doubt very much if there's any inpatient teams that are not having that conversation probably today with all the inpatient wards with a situation where a patient might be making a threat to end themselves if they are going to be discharged to an inpatient setting. It's a really complicated, risky situation that teams work constantly on to think about what actually is in the patient's best interest and what is the risk that would be if a person who was expressing that level of thought, what are the mitigating factors that community services and colleagues can offer to allow a safe discharge to occur?

Patients do say at point of discharge, and make suggestion that they're going to end their life at the point of discharge. And that's something that teams

have to manage as best as they can do with the situation that they're presenting with, knowing what the situation that the person -- that individual, that patient, whether their level of impulsivity or not or -- it's really complicated and it's something that teams have to manage on a day-by-day basis, and will constantly have to manage going forward for future.

Q. This ties in with a paragraph under the next heading, which is "Medication" but I think it's a more general point. If you can look at paragraph 94, please. And perhaps we can have that on the screen.

I think this relates to patient flow that we discussed earlier and also to what may be happening with an individual patient.

So whilst the paragraph starts talking about prescriptions, the bulk of the paragraph is about red to green meetings. They are described as "Daily MDT meetings to ensure that there is a purpose for a patient being in hospital".

A. *(The witness nodded).*

Q. "Green days are where there is a purpose ... A red day is where there is no purpose for that patient to remain on the ward. After three consistent red days, the MDT should discuss what needs to occur to either gain purpose or consider what the delay to discharge could

be."

Do you accept that in mental health conditions which are prone to fluctuation, three days may be a relatively short period in which to draw meaningful conclusions about readiness to discharge?

A. Red to green is part of the discharge plan process. So three red days could be the fact that someone hasn't exhausted -- or that a resolution for accommodation hasn't been reached. It doesn't mean the fact that that person, just because they've reached three red days, is going to be immediately discharged from a hospital setting; it's to highlight the fact that an achievement for a person towards a discharge hasn't been achieved.

So whilst it's not solely a consideration for discharge, it's to highlight the fact that there needs to be some movement and purpose for someone's admission to help them achieve what a discharge might look like.

THE CHAIR: So it's a tool, rather than --

A. It is a tool.

THE CHAIR: -- than a predictor?

A. Yes, Ma'am.

THE CHAIR: Thank you.

MR McALLISTER: Moving to the next section headed "Transfer" starting on page 17, paragraph 100, you give an example, for example, of internal transfer, for example Peter

Bruff, to Ardleigh, discussion in a sitrep call. And you say:

"The wards will undertake a telephone conversation to understand risks and a handover sheet will be completed and sent to the receiving ward in preparation for the transfer."

That's what should happen but does that always happen?

A. Yes, my expectation it would be.

Q. You mention at paragraph 101 decisions that:

"There's been changes over the years, I can recall decisions being made without individual wards being involved or consulted with."

When did that change? Is there a particular point in time that things improved or changed?

A. I can't recall, sorry. I can't recall when that was.

Q. Do you -- you were asked as part of your statement, you were shown a list of illustrative cases, and responded much later in your statement to those names that you recognised. You don't mention Bethany Lilley; does that name ring a bell?

A. It does.

Q. And she was on Peter Bruff Ward at various points, as I understand matters, in 2016, 2017, and then in November 2018, December 2018, into early January 2019,

then 9 January, 2019 to 15 January 2019.

Peter Bruff was under your responsibility at that time.

A. That's correct.

Q. And without going into all the details, there came an occasion when Beth went to A&E and then wasn't able to come back to Peter Bruff and there was a transfer to Thorpe Ward. Do you know about that?

A. Bethany's care was prior to my time taking over the Matron responsibility for Peter Bruff, but I am aware of the case.

Q. And one of the criticisms in her case was that the transfer to Thorpe Ward on 15 January, there wasn't a risk assessment, an inventory, an escort, and no communication was received about the level of observations required.

Do you have direct knowledge of recommendations in the RCA report, for example?

A. I'm aware of some of the recommendations.

Q. And would you have had a role in implementing the recommendations?

A. Yes.

Q. So when I asked about what should happen and what maybe didn't always happen, do you accept that there are examples where best practice or expected practice, in

terms of ward transfer, doesn't happen?

A. (No audible response)

THE CHAIR: Sorry, I didn't hear the response to that.

A. Sorry, yes.

THE CHAIR: Yes? Thank you.

A. Sorry.

MR McALLISTER: I'm just pausing for a moment, Chair.

I'm going to take you forward in your statement to the section of discharge, page 22, paragraph 136. We've touched upon discharge already, but I just want to clarify paragraph 136 with you.

In paragraph 136, you say two things. First of all:

"Discharge planning should occur prior to any patient being admitted ... Wards plan discharge at point of admission to ensure that the patient, carer/loved ones and other clinical teams involved in the person's care work towards an expected discharge date."

Is that the same thing or are those two different things? So pre-admission and point of admission.

A. They're the same.

Q. And from your point of view managing an inpatient unit, at the point of admission is there work that's being done that you can base your assessments on?

A. Yes, there are.

Q. And if you look at paragraph 138 on the same page, you

say:

"I'm unaware of any factors that were beyond my control that impacted on the discharge plans for patients."

Over the page at paragraph 139, you identify, for example, the sort of considerations that might be taken in mind: appropriate community support, the availability of clinically needed home treatment teams, suitable accommodation if needed.

Help me understand this. Some of those factors will be beyond your control, as an Inpatient Ward Manager. So they must be impacting upon the discharge plan for patients.

A. The most common ability for discharge planning for patients generally is accommodation, it tends to be something that is a barrier for a discharge to occur in a safe and timely manner. Some patients that come in might already be homeless or might become homeless whilst in hospital. So that is one of the biggest barriers to the ability to achieve discharge in a timely fashion. And that happens very frequently, throughout, probably, all inpatient wards at some point.

Q. So how do I understand -- with the benefit of that answer, how do I understand your evidence: that there clearly are things outside of your control but they're

managed as part of discharge or ...?

A. So I'll go to homelessness as an example. Prior to Covid, I was very unfamiliar with patients being discharged to bed and breakfast accommodation. So that is something that happens much more frequently now. If a -- due to the fact that councils have difficulty in managing their own issues regarding homelessness, to allow a patient to be discharged safely, we are using temporary accommodation in a bed and breakfast manner in a much more frequent process now for the organisation.

It might have happened prior to Covid, prior to 2020 I don't remember it happening very often at all but that is actually a route for allowing a patient who is clinically ready for discharge to be discharged out of their mental health bed who is safe to be discharged out of a mental health bed. That's probably one of the more recent examples I can describe to allow -- sorry, Ma'am.

THE CHAIR: Presumably that causes delay, the fact that there is not --

A. Yes.

THE CHAIR: -- somewhere to go immediately and you have to think about alternatives and one of those is bed and breakfast?

A. That's correct, Ma'am.

THE CHAIR: Okay, thank you.

MR McALLISTER: Thank you.

I want to touch briefly upon matters under the heading of "Safety" in your statement starting at page 25, paragraph 159 in particular.

The context here is emergency events such as a patient ligaturing and the emergency call system being activated. What I'm particularly interested in at this stage is at paragraph 159 where you say that the EPUT training department undertakes yearly emergency response drills on each inpatient ward, I presume?

A. That's correct.

Q. Are they planned or are they like a fire drill, that they just get announced?

A. They are unannounced. The Ward Manager may be -- well, the Ward Manager will be aware that the team are coming to do a training session but the clinical team on shift will not be aware of a planned scenario-based situation.

Q. Is annual sufficient?

A. It will be an assessment on the time. I am aware of one of my clinical teams, Henneage Ward's response was not satisfactory on one occasion and the team came back and did further unplanned scenario-based situations to allow the team to become much more competent and offer a much better response for the next planned -- or unscheduled visits.

Yearly is the Trust standard at this moment in time but can be made more frequent if needed. So if a manager or a clinician wanted to have a more frequent response, they can contact the team to make that happen, but yearly is the minimum.

Q. How long ago was it that Henneage needed the additional --

A. Off the top of my head, I think it was around about two or three years ago. I can't recall.

THE CHAIR: Can you describe some of the scenario-based situations that might be the subject of one of these?

A. It's a CPR drill, a patient is found unresponsive and the team are expected then to work on a -- there will be a resus dummy in a bedroom and the patient -- the team that are on shift will be expected to undertake a full CPR resuscitation on the dummy to be able to demonstrate their response levels.

MR McALLISTER: Madam Chair, if you're ready I'll move on to a separate topic, Oxevision, which we skirted earlier.

You tell us at paragraph 184 on page 30 that you were the Matron for Peter Bruff Ward in 2020 when the team was identified as a pilot area for Oxevision, and that Peter Bruff was a number of wards identified within EPUT to ascertain if there was a lesser restrictive option to care for people in a safer manner than without

this technology.

Does that reflect your understanding of the reason for the pilot?

A. It does. I wanted to make sure, if Peter Bruff was going to be the pilot area, that this was going to be truly assistive technology, not to replace nursing interventions. And with the rollout of Oxevision, that became very clear that that was the case; it was to assist nurses, not to replace us.

Q. And how did you gain that understanding?

A. Through the workstreams that the ward team were initially invited to and conversations with the internal organisation, as well, to offer myself and the team reassurance that this was to assist the team and certainly not to replace nursing hours with technology.

Q. But what about -- so that's one thing, nursing hours. But, actually, the nuts and bolts of what a system could do and how that might affect the job, did you have similar reassurances in that respect?

A. The actual ability to offer patients a lesser intrusive way of caring for them is how the Oxevision conversation was had for me and the team for Peter Bruff. It was much more about an enhancement to providing them a much more -- lesser intrusive way of caring for them.

Q. What did you, at that time, understand would be less

intrusive? Comparing what and what?

A. So offering levels of observations that are what the organisation would call level 3 and level 4, they are within eyesight or at a very bare minimum, or sometimes within arm's sight, depending on what a risk of a patient might be presenting with at any one time.

So with that in mind, the ability to offer a level of safety for patients without having the need to constantly observe somebody is -- it's a much more caring way of caring for a patient, rather than having the constant need to provide a person with them at any one time.

The idea is, for myself, my understanding when Oxevision was being thought about for the Trust was about the assistiveness of it and the ability to offer care in a much more caring way rather than constantly having somebody walk with you all day every day, which is restrictive by its very nature, and very intrusive.

Q. Were you consulted on whether Peter Bruff should be part of the pilot, or was it announced?

A. I think it was probably announced, but given the fact that Peter Bruff was or is one of the two assessment units for the Trust and to have something to provide an enhanced level of care for patients, I wasn't averse to that happening on Peter Bruff.

THE CHAIR: You've just talked about it offering the opportunity of not having to observe someone all the time.

A. *(The witness nodded).*

THE CHAIR: In what way do you think it is relieving that obligation? When is it being used which would otherwise require you, without it, to be observing somebody?

A. All patients that are on observations at some point will come off an enhanced level of observation, such as level 3 or level 4. They will recover to the point that they can come off.

THE CHAIR: Yes.

A. To be able to do that is a risky decision process the team will make. Prior to the use of Oxevision, it was based on the team's ability to offer themselves assurance that a patient was able to keep themselves safe without the need to constantly observe them. With the use of Oxevision, there was an added layer of the ability to care for a patient who might be still unpredictable, but not be as intrusive with the restrictions of having one-to-one care provided by them via level 3 or level 4 observation.

THE CHAIR: So in other words, using it as an observation tool, Oxevision, but less intrusively than somebody sitting with someone all the time?

A. Absolutely, yes, Ma'am. It's less --

THE CHAIR: Is that how you understood it was going to be used?

A. In the fact that it would offer people who are in a bedroom, predominantly, because that's the only place that the Oxevision is in, that it would be a lesser intrusive anyway to offer somebody who doesn't need level 3 observations but still potentially might be unpredictable still with their impulsivity, to give us an added layer of assurance that somebody can be offered care for in a lesser restrictive way.

THE CHAIR: And that is, as you understand it, how it is used and has been used?

A. Yes. Yes, Ma'am.

THE CHAIR: Thank you.

MR McALLISTER: Did it -- did the introduction of Oxevision change, for example, staff making visual checks on patients at various times of the day?

A. For Peter Bruff it did, which is not the way that it should have been followed when it was being rolled out.

Q. And the context of that is -- can you explain the context of your answer?

A. There was an incident that occurred on Peter Bruff -- forgive me of my time frames -- 2021, where it came to light that the team were offering care for patients for

observations via Oxevision and not undertaking visual checks on patients' bedrooms.

Q. And is this what you discuss, for example, at paragraph 194 of your statement, just to check that we are -- that it's the same example or a different example.

A. Yes.

Q. And in particular, you say:

"After the death of Mr Steel on Peter Bruff Ward the Ward Manager and I discussed the need to shift the team's recordings from 'Observed' to a culture of engaging with the patients and being more descriptive in the notes they record."

A. That's correct, yes.

Q. So there's a few things there. There's reliance on perhaps looking at Oxevision monitor rather than physically going into somebody's room?

A. That's correct.

Q. There's the recordkeeping point. So if someone just records "Observed", that doesn't tell you very much.

A. That's correct.

Q. So you were encouraging a more descriptive account of what was observed?

A. That's correct, yes.

Q. And reinforcing that there should, for example, in this

instance be a physical, in-the-bedroom visual check?
A. Opening the door, going in and checking, yes, sir.
Q. The implication, I think, from paragraph 194 is that the sight lines into the bedrooms weren't very good; is that right?
A. For some bedrooms that's correct, yes.
Q. Reinforcing, perhaps, the need to go into the room?
A. That's correct, yes.
Q. Just going back slightly in time, in terms of the pilot, did you understand pilot as meaning trying something out for the first time, or "This is the first time, we'll try something we've already decided we'll use"? Is it implementation? Trial implementation?
A. Peter Bruff was one of the first trials for the entire organisation. Pilot, sorry. Beg your pardon.
Q. And you say that you helped to co-produce the standard operating procedure; is that right?
A. That's correct, yes.
Q. And how did that process work?
A. The team that would help setting it up for the company that Oxevision is, is in the middle of -- this was in the middle of Covid -- set up online Teams meetings to help look at conversations with the various sites inside EPUT that were piloting Oxevision and looking at what the procedure would look like. So it was made with

myself and other team members inside Peter Bruff but also people inside the organisation looking at generating a Standard Operating Procedure for the entire organisation.

So it was a real collaborative approach for -- to look at what the policy might look like. Oxevision was not something that was very familiar to me, and to the entire organisation. So we're looking at using people who might have a better understanding of what it actually was to look at a good procedure, as it was at the time.

Q. And how did you try and make sure there was a good procedure? Who did you -- who were you able to speak to, or speak with?

A. Zeph was one of the people that helped co-produce the procedure.

Q. Internal or external?

A. Both.

Q. Both? Okay.

A. Predominantly --

Q. I'm not asking for names.

A. Sorry.

Q. Okay, so it was internal and external. So other Trusts who had experience?

A. I cannot recall if there were other Trusts. I am fairly

confident that Oxevision company was there as part of the development of the SOPs. And I -- if I vaguely recall, I think we had some SOPs from -- Standard Operating Procedures from other Trusts, as well, to reference to what they had used in relation to documentation for Oxevision.

Q. So documentation rather than liaison?

A. Yes.

Q. Okay. You highlight within your statement at paragraph 188 that when Oxevision was rolled out to Peter Bruff and Ardleigh Wards who were under the same senior management structure, in spring 2020 the issue of consent was not specifically considered or referred to.

Do you accept that that was an oversight or a failing?

A. Absolutely, yes.

Q. We have already touched upon earlier before the break an element of the Oxevision system which you said, in terms of the edge-of-bed, which gave rise to the risk of alarm fatigue. Can you see other risks with Oxevision about over-reliance on technology, or on what you're shown on a screen rather than physical interaction?

A. As I said earlier, Oxevision helped -- very clearly come to me as an assistive part of what I do as a nurse, it's not replaced me. So if I have concerns or a gut

instinct that something might not be right then I would expect myself and the team to be able to respond to that. Oxevision is there to assist me; it's not there to replace the nuances of nursing. So I would hope that people don't overtly rely on Oxevision for everything regarding what mental health nursing is about.

Q. But is that risk there?

A. Potentially.

THE CHAIR: But you have already said to me that you think it's a -- it offers somebody who doesn't need level 3 observations, still might be unpredictable with their impulsivity, and it gives you added layer of assurance.

What assurance does it give you? It's got alerts regarding older people on edges of beds, it's got alerts for bathrooms and doors, but is it also giving you assurance by just allowing you to zap into somebody's room and see how they're doing?

A. It can do both.

THE CHAIR: And is that what it is used for in your Trust?

A. I would hope that it's used for its intended purpose of, actually, if there's a situation that alerts us, us being the care team, that something's happening that shouldn't be happening in a patient's bedroom, that that is checked rather than using it as a checking device. It's there to alert us when something is going not the

way it should be. So it might be picking up somebody's oxygen saturation is changing or their rest being unusual, as opposed to a checking mechanism.

THE CHAIR: But you suggest it might be being used as a checking mechanism.

A. Possibly, possibly.

THE CHAIR: Okay, thank you.

MR McALLISTER: Madam Chair, given the timings, I'm going to move on to the subject of staffing, briefly.

You -- I'm taking you to page 34, paragraph 209 of your statement. Briefly, earlier, you talked about the shift pattern, I think at an earlier point in your career in paragraph 209. You are describing, I think, the more recent position of there being long day and long night shifts.

A. That's correct.

Q. And that's the general rule. There are exceptions, but that's the general rule, isn't it?

A. That's correct, yes.

Q. Does that have an effect on the ability of staff to maintain care standards, to maintain compassion?

A. A 12-and-a-half-hour period of time is a very long period of time. I believe probably most NHS organisations do a long day and long night shift pattern, but they are incredibly long. The ability to

remain fresh and composed after a 12-and-a-half-hour, potentially very complicated shift, is that much more difficult for long shifts but they are -- I believe most NHS organisations do long shift patterns. But the ability to feel tired at the end of a shift is very real.

THE CHAIR: Do you think it's safe?

A. It's very tiring, Ma'am.

THE CHAIR: Do you think it's safe?

A. I'm glad I'm slightly older in my career. I don't know long days and long nights. Short shifts have their complications as well. But they are very long.

MR McALLISTER: Just a couple of paragraphs below whilst we're there, in summary, to paragraph 211, you describe the disruption, effectively, of temporary staff if they're unfamiliar with where they're working and working patterns.

Is that a fair summary?

A. Yes.

Q. I want to touch upon supervision and performance management, that's the heading in your statement.

A couple of points. At paragraph 228, you say that:

"Clinical (non-management) supervision for nurses has always been 'optional'."

And that you've rarely taken it up.

And:

"... currently unaware of any nurse that undertakes clinical supervision."

Is there a missed opportunity there?

A. Possibly. For most other professions they have protected dedicated time for non-mandatory supervision. Nurses don't. And that's been historical, I think.

Q. So whilst you say it's optional and you've rarely taken it up, underlying that, would you take it up or would it be good it was more readily available or

-- (overspeaking) --

A. I believe so, yes, sir.

Q. Then you describe -- and I'm not seeking to identify the manager -- but you had the same, effectively, long-term line manager from, I think, 2015 or 2016 up until 2022 with the break you described earlier.

A. *(The witness nodded)*.

Q. But then it appears that things have changed, you describe in paragraph 232, so that senior staff you now describe as "remote and disengaged with the structure below them", that you don't have one-to-ones at your grade or above, and appraisals are not completed, and you've had several line managers who are disinterested, remote, and who wanted less than once a week contact with you. And you've raised this as an issue with

limited actions or response to your concerns.

Is this -- it's more than one individual you're talking about so it sounds like it's a systemic problem; is that fair?

A. I've had conversations after -- prior to me going on to my secondment. I would not say it's a systemic issue. I think it's -- it was my experience at the time. But I don't work as frequent at this moment in time.

Q. Yes, because of your secondment.

A. Yes.

Q. I have some general questions to ask you about investigations you've undertaken. This appears at a couple of different parts of your statement, firstly at paragraph 250 and then more specifically under -- on the last page of your statement.

So just starting at page 42, just for context, this is when you were shown a list of illustrative cases and you identified that you had undertaken the root cause analysis investigation for Sharon Kelly in 2019. And that you undertook that PSIRF investigation for Joshua Leader in 2020.

And also an RCA for W8.

And you say at paragraph 270 you did not encounter any barrier to complete the reports needed.

A. *(The witness nodded).*

Q. Keeping that in mind, I want you to turn back to paragraph 250, just so I can better understand your evidence. You give a description of having undertaken various investigations in the past including HR related. But if it was, for example, a root cause analysis report, the Patient Safety Team would determine the Terms of Reference.

And then you describe the process.

At paragraph 254, the first sentence suggests that your experience was effectively gained by undertaking investigations rather than training. Am I right about that?

A. Yes.

Q. And then where you say, "Training to undertake investigations is part of an individual's own learning and development plan", what does that mean? Does that mean that now there is specific training that is given, but it wasn't when you started investigations?

A. That's very true, yes.

Q. Do you also provide training, personally, or not?

A. No.

Q. And in terms of -- briefly touching upon the examples that you've offered of investigations that you've undertaken, or more generally, if that provides a better basis for answering the question, with an RCA, in

what -- are there examples of where you've had a connection with the matters under investigation, either in terms of personal relationships with those involved, or it being on your ward or part of the history being on your ward?

A. On the whole, no, the investigations are tried to be as neutral as you possibly can do. My RCAs/PSIRF investigations that I refer were asked for me to be -- I was commissioned to do them as I was as impartial as I possibly could do, I was not aware of the community services and the colleagues and the patient at all, in all of these situations.

Q. And do you think you're able to maintain that independence when it's your own Trust colleagues, even if they're not close colleagues?

A. I would hope so, but it's -- in any organisation investigating its own work, the impartiality should be there but I can't always say that it will be the case.

Q. A related point is in respect of Sharon Kelly, where part of the focus was care given in the community, if you hadn't worked in the community for a good number of years, does that put you too far away from what the issues in practice might have been?

A. Potentially, possibly, yes.

Q. Were you aware that, albeit briefly, Sharon had been

admitted to the Peter Bruff Ward and the Ardleigh Ward in May 2019 when it was under your responsibility?

A. I don't believe I had Matron responsibility at that point in time prior to her admission to Peter Bruff.

Q. You give evidence generally and also specifically in respect of investigations of the importance of taking into account families' concerns?

A. *(The witness nodded)*.

Q. Do you think you did that in respect of Sharon Kelly and Joshua Leader?

A. Yes.

Q. And did you meet with them or was that Family Liaison who met with them?

A. Both. So with Sharon Kelly's family, I met with them face-to-face, that was before Covid and the lockdowns, and the other investigation I met online with the family on a number of occasions, again with the FLO, Family Liaison Officer.

Q. And in respect of Joshua Leader, the family provided a document with matters to effectively bring to EPUT's attention, which you consider in the report you wrote.

A. *(The witness nodded)*.

Q. But their overall sense is that their recommendations weren't fully taken on board. Is that something you are willing to acknowledge or is that something that is

difficult to answer in these circumstances?

A. It is difficult to answer.

Q. And in respect of generally, that these two cases as examples, if there are inquests and potentially Prevention of Future Death reports would they come to your knowledge as the person who had done either the RCA or the PSI?

A. No, the PFDs would not come to me, they will go to the team that they are in relation to. So if there was a notification that come to the organisation, that would then be shared as an outcome for the actual inquest hearing. It wouldn't necessarily be part of the investigation process that the Trust is undertaking.

Q. So if you're investigating, either in an RCA or a PSI, at what point does your role end?

A. Once the investigation has been signed off, that generally would be the end part of the investigatory process. If, for example, I was called to an inquest in January for an investigation I did last year, so my -- whilst the investigation part is finished, there might be some other aspect of the investigation that I might be called to and this example was me having to go to inquest to go through the report with the coroner.

Q. I'm just going to pause for a moment.

We are coming up to 4.30. I'm just going to double

check whether I have any further questions at this stage.

Madam Chair, whilst I'm doing that, do you have any questions?

THE CHAIR: Yes, I have one question I want to ask. It's about paragraph 213. You talk about patients who have comorbidities, on older adult wards, but not exclusively older adult wards, who have increased demand on them -- who make an increased demand on the nurses' time and you refer to not just medication rounds and attending at acute hospitals with them, but also the nursing needs that they might have and we can think what those might be: feeding and washing, and along with all the other mobility issues that they might have.

That strikes me as a very significant increase in the workload. Do you think that staffing levels have fairly reflected the demands of older adult wards with large numbers of people with comorbidities?

A. My professional experience, probably since 2009, the levels of nursing time that have been offered to patients has significantly increased, to help mitigate the fact that actually the cohort of patients that we looked after in 2009 to the level of dependency that are present now is very different, with the fact that there is much more dependency for things that you've alluded

to, such as washing, feeding, and those kind of things.

If at this moment in time what was some of my older adult wards had a higher level of dependency the ability to access extra staffing hours is much more easily available --

THE CHAIR: Now?

A. -- depending on the demand at that moment in time. So if there is a patient, probably for the adult wards, as well, who is generating a lot more level of dependency then the organisation's ability to respond to that in a much more timely fashion is there, and there are processes now set in place that allow the extra demand that might be coming out of a clinical area to be discussed, understood, and if it need be, agreed extra staff over a 24-hour period.

THE CHAIR: And would that -- are you suggesting to me that it's not always been that happy a relationship --

A. Absolutely not.

THE CHAIR: -- in the past?

A. Absolutely not.

THE CHAIR: In the quite recent past, this -- (overspeaking) --

A. Probably prior to Covid, possibly. Since Covid, the ability to access short-notice staff is much more easily available.

THE CHAIR: Thank you.

A. But there needs to be a very clear understanding about what that demand might look like.

THE CHAIR: Thank you.

THE WITNESS: Thank you.

MR McALLISTER: Thank you.

I have no further questions at this stage. We'll take a break. There may be some further questions.

Madam, 15 minutes?

THE CHAIR: I'm happy with that. Thank you.

(4.29 pm)

(A short break)

(4.50 pm)

THE CHAIR: Mr McAllister.

MR McALLISTER: Madam Chair, we've received a few supplementary questions arising from the evidence given before the break.

Mr Arthur, you were asked earlier about out-of-area placements and your answer focused on placements to private providers. Are you also familiar with out-of-area placements to other NHS Trusts?

A. Short answer is no. I'm not aware of EPUT patients being in other mental health provider beds. There might be patients waiting to come up in from a section -- a 136 (unclear) somewhere perhaps, but I don't know of any

EPUT patients being placed in other general mental health beds.

Q. So your experience of out-of-area is private provision?

A. Solely, yes.

Q. Notwithstanding your answer before, so covering the private providers, based in your evidence, who retained responsibility for oversight of a patient's care, discharge planning, liaison with family members, during such placements?

A. There are dedicated individuals inside the organisation that look at patients placed in the private sector. So there are people in the Discharge and Flow Team that look at patients who are placed in a private bed to see what arrangements need to be made to bring them back to an EPUT bed when it becomes available or what other arrangements need to be put into place to support a discharge for them to go back home straight from a private bed.

That will also include the community care coordinator and there are, as I say, named people inside the Flow and Capacity Team that undertake that role, as well.

So the fact that a patient is in a private bed, the EPUT still look at what needs to occur to achieve a discharge or transfer back to an EPUT bed.

Q. A different topic, we discussed earlier accommodation being a barrier to discharge -- those are my words not your words -- are there circumstances in which EPUT funds B&B accommodation for patients in the circumstances discussed earlier?

A. Say that again, sorry.

Q. Are there circumstances in which EPUT funds B&B accommodation for patients?

A. Yes, and that funding comes from, as I believe it to be, from the ICBs, so to look at helping to unblock a safe discharge that can occur just because someone hasn't got a home to go to, EPUT, I'm aware of that they will fund interim bed and breakfast accommodation to the local authority, or whichever council it might be, to look at a resolution for the homelessness situation. So EPUT will fund, I know -- I have known people to be funded a week's bed and breakfast accommodation until their local authority have the ability to respond to processing that person's accommodation application.

Q. And what processes are there in place to ensure that the B&B accommodation is safe and suitable for the patient?

A. So that, again, will be part of the conversation that the patient's ward that they're on at that moment in time. They'll be making sure that if a patient's discharge is feasible and it's safe for that person to

go in bed and breakfast accommodation, that will be a conversation that the ward will have pre to that person being discharged. It's not -- everybody's not going to be discharged into bed and breakfast accommodation because it's not safe for them to be doing so, but there will be a number of patients that can, once they've achieved recovery or good stabilisation of their mental health, they can go into temporary accommodation.

So that does happen but it's dependent on the risks and what the next step might look like for that person post going to bed and breakfast accommodation, as well.

Q. Changing the subject again back to Oxevision. We discussed the standard operating procedure, the SOP. Was there a template provided by Oxehealth at the time of the pilot? You made reference to other Trusts' documentation, for example, but was there a template provided to you by the provider of Oxevision?

A. I don't believe there was one. I can't recall, is probably a more accurate answer.

Q. You, in response to a question from the Chair, you said that Oxevision might pick up on someone's oxygen saturations changing. Is that a capability of Oxevision?

A. Is that a capability? Yes, it is. So Oxevision will

monitor, whilst somebody's in the bedroom, the level of oxygen saturations in the person's blood via the sensors that it uses.

Q. And to the best of your understanding, is Oxevision configured within EPUT to alert staff to a clinical deterioration on wards outside of seclusion wards and Section 136?

A. Yes, it's in patients' bedrooms.

Q. So generally across the Trust?

A. Yes. There are still some areas that are still having it installed, I believe, but the areas that I am aware of, I think the majority of the Trust has got it. I think there is still some older adult wards, particularly dementia care wards, that are still having it installed at this moment in time, or plans to have it installed.

Q. As to whether it's configured, whether or not there's a capability or whether it's configured to EPUT staff -- sorry. Whether it's configured to alert staff to clinical deterioration, is that functionality there --

A. Yes.

Q. -- across the wards, as far as you know?

A. Yes.

Q. Are you aware of examples of staff monitoring patients constantly on Oxevision when, for example, there are

concerns about patient safety?

A. It's been reported that has happened in other parts of the organisation, prior to -- well, when I was having responsibility for my clinical teams, I wasn't aware of that happening. But I am aware that it has happened in other localities.

Q. I'm trying to clarify some dates and areas of responsibility you had from the evidence you gave earlier, when I asked you questions about Bethany Lilley, what role did you have in relation to Peter Bruff Ward in December 2018 and January 2019?

A. I don't believe I was the Clinical Manager, Matron for Peter Bruff then, I --

Q. Why do you say that?

A. I ... I took over responsibility for Peter Bruff after the Bethany Lilley incident.

Q. In your statement, as I read it, it was some point in 2018?

A. Quite possibly. I may have put the wrong date down. I took over -- I took over responsibility for Peter Bruff after the Bethany Lilley incident.

Q. What makes you sure to the extent that you are about that?

A. I was asked to take over responsibility for Peter Bruff after that incident occurred. I am aware of the

incident that occurred for that and I was also aware of the -- some of the Prevention of Future Deaths actions that needed to be carried out after the incident, as well, particularly in relation for the handover from Peter Bruff to what was Thorpe Ward at the time in Basildon.

Q. So just so I understand it, your answer and your level of certainty is partly informed by the context of you taking over responsibility for Peter Bruff?

A. Yes.

Q. And did that include responsibilities for addressing recommendations in Bethany Lilley's RCA --

A. Yes.

Q. -- and how they were monitored?

A. *(The witness nodded)*.

Q. What steps did you take?

A. So one of the key actions from the inquest was to ensure that there was a regular meeting between the two sites. So for example, there was a monthly meeting that was set up to discuss between what was Peter Bruff and the Thorpe Ward, which is now no longer operational, it's a different ward. And there was an action that myself, my counterpart for that site, and the ward managers, would have a meeting to look at if there were any transfers that had occurred that had difficulties or

omissions and that was definitely one of the clear actions from the investigation, that that should happen, and that has continued up until my going on my secondment for Mid and South Essex at the moment. So that has continued all that time between the incident occurring and the notification of the Prevention of Future Deaths to myself going on secondment.

Q. More -- related in terms of dates, we also discussed the case of Sharon Kelly and your answer to the questions was that you did not have major responsibility for Peter Bruff Unit in May 2019, which was the date of Sharon Kelly's admission to Peter Bruff. Can you, in light of what we've just discussed, be any clearer about the date at which you took over responsibility of Peter Bruff?

A. I can't give you categorically a clear timeframe for when I took over Peter Bruff responsibility. Sharon Kelly might have been a patient when I was doing the RCA investigation for her. Whilst I was the clinical manager for Peter Bruff at the time, I cannot recall specifically the specific date that I took over Peter Bruff, specifically in regard to those particular time frames.

Q. And more generally in relation to the investigations based on the evidence you've already given, when

drafting reports, would you normally seek family views, in terms of their input, and also with recommendations?

A. My professional experience has been the fact that generally the FLOs will be the conduit for asking questions that the family would like EPUT to be investigating. For myself, professionally, I will overtly meet with the family myself to make sure that actually I listen to whatever kind of question it is that they are wanting to put towards the organisation that the FLO could pick up but I think it's only reasonable that they meet with me to actually look at what it is that they would like to articulate to the organisation clearly themselves. Whilst not taking way the FLO's role, I think for the two cases that we were referred to, I met with the family to make sure that they felt that they were able to articulate to me what it is they would like me to try to investigate as part of my investigation for EPUT.

It's not always something that I did previously, but it's something over probably the last 10 years I've felt has been very helpful for the families to be part of that kind of conversation with an investigator.

And to then make sure that it's very clear what it is, if there are any extra questions that the family would like to put, to be put, that we could answer them

clearly, as well.

Q. And how would you ensure that you had all relevant material and information for your reports?

A. The most obvious resources are the people that have been working with that particular person, so it will quite often be the clinical care team that have offered care for that particular person. The clinical records that we use for recording patient details are a very good resource. We don't have as much these days but paper records are still available for, if I need them to undertake an investigation, which I have done, accessed patient records, and staff colleagues, and also sometimes the family to make sure that if there are things that I'm not too sure about, I will also use them as a resource, as well.

The resources can be quite significant, but predominantly it's colleagues and people that have worked with the patient.

Q. We discussed earlier Adam Steel's death in October 2021. And I just want to take you back to paragraph 192.

A. One hundred and --

Q. Ninety-two.

A. Thank you.

Q. On page 31. You describe the practice of -- that appears to have developed by not going into patients'

bedrooms so as to not disturb them through the night. You say:

"I was unaware that this practice had developed over the time of the Oxevision system being installed. With the approach being brought to my and the team's attention, revisiting of the Standard Operational Policy ... for the entire team was revisited."

What was it about revisiting the SOP that you thought would assist the team's understanding and what misunderstanding or practice were you seeking to address?

A. The team were trying to offer a less disruptive way of caring for a patient so rather than having the door opened, going in, potentially putting a torch on someone to make sure that they're breathing safely, the team are utilising Oxevision as a tool to be less intrusive. The policy itself is very clear -- well, it hopefully is clear enough to say that physical check is part of the expectation, Oxevision is there to assist the team, not to replace the team, in doing what they need to do. So the Standard Operating Procedure is clear in saying: actually, observations still need to be done face-to-face as the policy stipulates.

Q. And lastly, on the same subject, at paragraph 194, you say that following Mr Steel's death, you refreshed the

ward team's understanding of the need to adhere to the SOP and sought to move the team from simply recording observed to engaging with patients and recording more descriptive notes.

Why did you consider that adherence to the SOP would achieve that outcome?

A. As the fact that it's about making sure people are doing visible physical checks in -- to engage with the person rather than relying on the tool that is there as a supplementary aspect.

Q. And so is it that that you understood the SOP to require that staff were not doing?

A. Yes.

MR McALLISTER: Thank you, Mr Arthur, I have no further questions.

Madam Chair, do you have any?

THE CHAIR: No, I don't. Thank you very much indeed.

MR McALLISTER: Thank you, Mr Arthur.

THE CHAIR: Can I thank you very much indeed for coming to give evidence.

THE WITNESS: Thank you, Ma'am.

THE CHAIR: And we sit again on Monday.

MR McALLISTER: Yes, Madam.

(5.09 pm)

(The hearing adjourned until Monday, 13 July 2026)

I N D E X