Witness Name: Brian O'Donnell

statement No: 1

Exhibits:

Dated: 02/12//2025

**THE LAMPARD INQUIRY**

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Witness Statement of Brian O'Donnell

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## Preliminaries

1. My name is Brian O'Donnell

2. I am employed by EPUT as the Clinical Lead (Band eight) for the St Aubyn's Centre, a Child and Adolescent Mental Health Services (CAMHS) Unit in Colchester

## Background

3. I have worked in CAMHS units throughout my career. My first job in mental health was as an agency Health Care Assistant (HCA) in 2003 – 2004. I mostly worked for NEPT on Longview ward, which was then on Turner Road, Colchester, but I also did some shifts in Lexden Hospital in Colchester. Lexden Hospital was a low secure NHS unit for patients with both mental health problems and learning disabilities who were a risk to the public. Longview ward then asked me to apply for a full-time post and I was taken on by NEPT as a permanent HCA in July 2004.

4. In 2006 I was seconded from the ward to do my nurse training. I studied full time at Anglia Ruskin University for three years and I obtained my diploma in mental health nursing in 2009, returning to Longview ward as a band five registered nurse. Longview ward moved to the St Aubyn's Centre in 2012 and the trust opened a second CAMHS ward in St Aubyn's, Larkwood ward,

which was a CAMHS PICU. At the same time (in June of that year) I was promoted to charge nurse (band six). I worked as a band six on Longview for about three months, then I was sent over to Larkwood, which was having a lot of problems at the time.

5. In 2014 I was promoted to ward manager (band seven). While I was working at that level, in 2018, I completed a course in Eye Movement Desensitisation and Reprocessing (EMDR). In 2020 I moved back from Larkwood to Longview to become the ward manager there. In 2021, I became the band eight matron for the St Aubyn's Centre. In 2022 I completed a course in Dialectic Behavioural Therapy (DBT).

6. In my current role I report to [I/S] the Service manager who oversees St Aubyn's, Popler, and the mother and baby unit. Above her there is [I/S] the area director; she is mainly based in Brockfield. We also have [I/S] who is the Area Director for Patient Safety. Then, until May 2025, there was [I/S] the director of specialist services ([I/S] retired in May). He reported to Alexandra Green, the Chief Operating Officer.

## Overview of Evidence

7. I am giving evidence to the Inquiry on the following matters:

   a. Working conditions on the CAMHS wards

   b. The job responsibilities for each post I have held through my career

   c. Staff training

   d. International recruitment

   e. Staffing levels and quality

   f. Admission decisions

   g. Patient observations and Oxevision

   h. My experience of adult wards

   i. Culture and leadership at the Trust

j. Complaints

k. Datixes

l. The circumstances surrounding specific deaths

m. The Inquest touching on the death of Elise Sebastian

**Working Conditions**

8. When Longview ward was on Turner Road, it was a very small and cramped unit in an old children's home. The building was falling to bits. Security was awful. The front door was open between 9am and 4pm. We needed to have meetings if we wanted to lock the door. If someone was going to the door all the time, you could have a locked door meeting and lock the door for a period. Sometimes the door was locked for days or weeks. But there were other doors in the building that they could just kick out. There were also ligature points everywhere, like exposed pipes and door handles – everything that you wouldn't have now.

9. The ward had both informal patients and detained patients. We had many children who should have been detained but were not. They would be coerced into staying if they tried to leave. This meant that there would be patients who we would be restraining a lot for their own safety; not letting them out because it was not safe for them to go out, but officially they would still be informal patients. Patients would only be detained if they were harming themselves constantly.

10. Our Consultant, Dr [I/S] was very nice, he would say he didn't want to ruin their lives by detaining them (he felt it might have implications for future jobs or travel such as to the USA or Australia). However, when some of us nurses went on safeguarding training, [I/S] the safeguarding lead, would say that if we were restraining them all the time, then they needed to be detained. She would also say that leave was up to the nurse in charge; this caused some tension between the nursing staff and doctors (see the example I give in paragraph 27 below).

11. We didn't have any deaths on the ward. It was a nice place to work, with really caring staff. I saw no evidence of abuse, and nothing really concerning in terms of how the staff treated the patients. We had really good, well-meaning staff. The ward had a nice ethos. I still see some of the kids who were there. They have their own kids now.

12. A lot has changed on the ward since then. It was for very acute care – aimed at preparing to get patients home. We had a kettle and iron there. There were other places for the children to go if they needed more secure care. However, as places closed, we had to manage more and more acuity.

13. When I started working on the ward there were 11 beds, then it was extended to 13. When we moved to the St Aubyn's centre in 2012 and opened Larkwood ward, we doubled the number of patients: the beds on Longview increased to 15 and Larkwood had 8-10 beds. The Trust put all the experienced CAHMS practitioners on Longview and, because Larkwood was a secure PICU, they put adult secure staff there alongside a lot of inexperienced staff.

14. There were loads of problems with the new building. We had one meeting with the architect as nurses and we made some suggestions, but none of them were followed. I think the meeting was held just so the architect could say he met the nurses. A major problem was that the patients could just kick the doors open and leave whenever they wanted to – just by kicking the door in the back. There were lots of doors in the building that were not secure. It was hard to keep track of where the patients were.

15. The walls of the wards were made of plasterboard, so the kids would just punch holes in the walls. There were sinks in the PICU ward that the kids smashed up – throwing metal around. The units also had normal tables and chairs – which they could throw at staff. They could stand on sinks and rip wires out of ceiling.

16. We managed to get the director of estates to come and showed him round. He was shocked by what he saw. I think we had paid nearly 10 million for that building and people had cut corners – we had aluminium doors where they should have been steel; all walls should have been concrete instead of

plaster. We kept raising these problems with the Trust. They would blame the nursing team for not controlling the patients adequately. For example, I exchanged emails about these issues with [I/S] who was in charge of security and things like the buildings, locks and doors. He would say things like "What were nurses doing?". It wasn't until we had [I/S] a Director 's son admitted in about 2013 or 2014, and he absconded through one of the doors. Within a month they finally did something to improve the security of the doors.

## Responsibilities

HCA

17. As an agency HCA my responsibilities were predominantly carrying out patient observations; the ward usually turned to agency HCAs when high levels of observations were required. I did mainly level three observations, where the patient was required to be within eyesight at all times; and sometimes level four, where the patients needed to be always within arms' reach. I would also need to do notes at the end of the shift; recording things like when the patients woke up, if they ate or drank, if there were any incidents, if they went outside, had any visits, etc. My notes were then checked and countersigned by a registered nurse.

18. As an employed HCA I had more responsibility. I still did patient observations, but I would also take patients out a bit more, including out on leave. I did home visits to help facilitate home leave; I could see any problems in the home and report them back to the nursing team. I was also more involved in running the unit; doing tasks such as ordering supplies.

19. I was part of the care team, and I would help to write care plans. For example, I remember working very closely with a girl with really bad anxiety who had problems eating and drinking. I sat down with her and looked at things that might help her, and I gave her some distraction techniques. I would get information from her and then put it in the care plan, then one of the nurses would check it over, make sure they were happy, and sign it. Being an HCA, I would spend a lot more time with the patients. I wouldn't put in anything

about medication or leave from the ward; just things that the patients would find helpful. It was all overseen by the nurse.

20. It is not something I would do now, allowing HCAs to do care plans. This is because of the accountability and responsibility involved. The care plan is a legal document; you could be standing up in a Coroner's court having to explain the contents. It is about accountability and about your registration as a nurse. Care plans are now completed within the electronic clinical system; previously they were just in a Word document. There is a lot more scrutiny now; and I can't see it happening anymore, anywhere in the trust, that HCAs would be allowed to do the care plans.

## Band five nurse

21. After I obtained my diploma, the first six months of my work as a mental health nurse was my preceptorship. I had a book with lots of competencies to complete and get signed off, including care planning, medication management, communication, fire procedures, and security; everything you needed to know how to do as a nurse. A preceptorship is not signed off until the nurse is ready. It could be delayed if a nurse needs extra time, or it can finish early; some people don't take as long as others. The standard period was six months previously; I think it is twelve months now.

22. During my preceptorship I would meet with my supervisor every week and they would monitor my progress. They would also talk to other staff to get reports on how I was doing. I could go to my supervisor if I had any problems. My responsibilities included writing reports and patient notes; this was all checked over by another nurse. I would do the care plans and I would do medication with one of the qualified nurses. Quite often, the nurse watching me would say "You are going to run the shift, I will be watching in background; I will step in if anything dangerous happens."

23. Running the shift involved allocating breaks, allocating observations, seeing who was going to what meeting, allocating who was writing in what notes; signing patients in and out on leave, and making sure the young people were where they need to be. You needed to have an oversight of everything

that was happening; if someone was self-harming, you needed to know. It was a lot, but I would relish it.

24. If you were a new nurse coming to a new unit, the role could be challenging. For me it was ok, because I went back to a unit that I knew well from my time working there as an HCA. During the preceptorship, even though you were being supervised by another nurse there was a lot of responsibility and a lot of pressure. I have seen newly qualified nurses in tears. If a nurse found things difficult during their preceptorship, they might have extra meetings with their supervisor. They might extend the preceptorship and practice things a bit more.

25. Longview had a good nursing team. I did feel supported during my own preceptorship. However, I feel like some people were pushed through this stage. [I/S] was the manager in Longview at the time (in 2009); there was also an Australian manager whose name I don't remember; they were both at band 7 and very nice. It was nothing nasty, but they would say things like "How's your preceptorship going? You could be signed off now don't you think?"

26. Once you finished your preceptorship you were able to hold the medication keys. The nurse in charge for the shift usually held them and you could be in charge at band five, after just six months working as a registered nurse. In that role you had to make some pretty big judgment calls. For example, in deciding who went out on leave. There could be no-one else around and you might have a dad coming to pick up a kid who then says "My dad abused me." If a patient was an informal patient, then leave was up to the nurse in charge. During reviews, the consultant might tell patients whether or not they could go on leave, but, in our training, the safeguarding team would tell us that it was up to the nurse in charge.

27. The consultant would sometimes say things to patients like "You need to stay on the ward, or I will detain you." It did create some problems. We had some headstrong nurses. For example, [I/S] one of the charge nurses; he would say "They are informal, they have been fine all day, they can go on leave." He was for positive risk management; he used to clash with the

consultants a lot. Even where a patient was detained and the consultant had written them up for leave, it was up to nurse in charge at the moment they were about to leave the ward, to decide whether it was safe to let them go.

## Band six and seven

28. Being a band six nurse (charge nurse) felt very different. People looked to you as a leader and your responsibility changed. You might start doing work on rotas, supervising staff and supervising staff preceptorships, overseeing students, making sure training was done. It was mainly about showing leadership in challenging situations; it was a big jump.

29. For each of the two wards in the St Aubyn's Centre we had six band six nurses, three we called deputy ward managers, who had some management responsibilities, and three who were strictly clinical that we called practice development nurses. They were all charge nurses, but we tried to differentiate them.

30. At band seven (ward manager) you moved into more of a management role. There was one band seven nurse for each of the two wards in the St Aubyn centre. You were based in an office on the ward. You were responsible for overseeing the rota and making sure training was up to date. You also dealt with any HR issues, disagreements between staff, and allegations, including those from staff about each other, but mainly from the patients. You could become completely swamped in dealing with patient allegations. You also had some responsibility for overseeing Datixes (I explain more about the Datix system in paragraphs 125 to 127 below).

## Band eight

31. As a band eight nurse (matron), there is just one of me for the centre. I am responsible for everything on the unit, including the building itself and all the people within it. I am responsible for the risk – it is in my name. I deal with a lot of CQC stuff, making sure we are CQC compliant with all domains. I also ensure we keep up to date with the quality network for inpatient

CAMHS (QNIC). All child and adolescent units that are part of QNIC need to become accredited, and we visit each other's units to learn from each other.

32. I need to make sure all necessary actions on the wards are completed, such as ligature audits, and all training and supervisions; I support the ward managers in this. I also deal with recruitment. I am in a lot of meetings with senior members of the trust, such as ligature reduction groups, and senior service manager meetings. I make sure the ward is putting in place anything the trust is trying to implement. I might also be on wards helping – I try to be more present on the wards – like the way you see the matron on the wards at a general hospital. It is very busy; there are lots of HR issues to deal with. I also deal with allegations, and liaising with the police and social workers.

## Allegations

33. There are a lot of false allegations from the patients. Some of the young people can be quite racist. A lot of the temporary staff are black and they are targeted. It might be that a child hits one of the staff, then the child will come in and they say **[I/S]** hit me". When we opened, we didn't have CCTV and we didn't have bodycams.

34. One allegation takes up at least a whole day. You might have a kid come in and say that when they got restrained the staff member bent their wrist. That will be your whole week. A lot of your time at band seven level is spent dealing with these. Nothing prepares you for it. I have seen some ward managers become appointed to the role and they are happy. The next day, when they begin the work, they are shocked.

35. Staff are often suspended when an allegation is made. Some staff were off work for a lot longer than they should have been because of the allegations and because the ward managers are just too swamped to deal with it all.

## Staff Training

HCA

36. I have really serious concerns about the lack of training that I received when I began working as an agency HCA. One of my friends joined an agency called DMN healthcare and I decided to join too. I just had to fill in a form. I remember that there was a box on it for agreeing to a police check, which I ticked. I was working within two or three days, getting messages through to go to different wards.

37. I had come from working in sales and I knew nothing about mental health procedures or about Disclosure and Barring Service (DBS) checks. I assumed I must have been checked after I ticked the box. However, later when I applied for the full-time band three role and got all the forms through, I realised what proper checks involved and I thought "Oh my god I have been working with nothing! I didn't know I needed to do all this."

38. I was working for a few months, on wards full of people, and going to units working with quite challenging patients, with no police checks, no training online, no manual handling training, and no control and restraint training. Sometimes one of the charge nurses and one of the HCAs (I can't remember their names) would give a quick crash course in a corridor and tell you to "Just say you are control and restraint trained."

39. I know that that particular agency, DMN healthcare, was being used everywhere by the trust. You could be on shift and everyone was DMN. It was run by [I/S] He was working in the trust as well. He was a qualified nurse, working on Cedar ward. He would be on his phone most of the time, booking staff and running his agency while he was supposed to be working as the nurse in charge. He was a band five and I think he went to band six. I got sent to that ward – I believe this was around 2008 – and I did witness myself that he was there doing his agency work while working for the Trust. The Trust does not use that agency anymore. I believe it is still operating up in Norfolk somewhere. But something happened in Essex – I don't know what – and [I/S] had to start

booking staff through Reed. He was still running his agency in 2007-8 when he was working. I didn't have concerns about any of the other agencies.

40. As an employed HCA we had control and restraint training every year. We also had training in food hygiene and safeguarding and other topics like that. That was a lot better as far as I remember. We didn't have any specific training for doing care plans; we did that work under the supervision of one of nurses. And we didn't receive any training for doing home visits and checking for risks there.

## Band six and higher

41. The training to get to band six used to be a lot better before. You had to have worked at band five for two years and completed a mentorship course. It was quite involved. Now, because there is such a shortage of nurses nationally, the mentorship course is just one session, and you can become a band six from band five immediately after you get your preceptorship. We get a lot of people saying "I want band six." and therefore lots of people with no experience working as band six. I can't put a specific time on when this changed. It slowly crept in, and I started to notice nurses where I would think "How are they a band six?!"

42. The promotion process to get into the higher bands of nursing is an application and interview process; you just need a nursing qualification. They might also ask for relevant experience in CAMHS.

## Datix

43. The training for dealing with Datixes is terrible. In the old Trust it was better. Someone would come and sit down with you and go through the scenarios with you. Now they offer a bit of ad hoc Teams training; and it is likely another band six will just show you what to do. This needs to be better.

## Life support

44. The nursing staff now get immediate life support (ILS) training. ILS was introduced about three years ago. It is a lot better than we used to get, when

life support was taught as part of Therapeutic and Safe Intervention and De-escalation (TASID) training. However, it is given to just clinical staff. I think it should go to HCAs too, because often you will have an HCA who is the first on the scene and they need to know what to do; or they might need to get things out of the grab bag, but they don't know what the stuff is in the bag. They only do basic life support training.

45. ILS is done once a year. I think it should be twice a year because when you need to resuscitate you only have one chance to get it right and as mental health nurses we don't need to resuscitate very often.

TASID

46. TASID training was introduced in the trust in 2017 in place of Control and Restraint (C&R) training. It is done once a year and emphasises deescalating and therapy over restraint but also teaches you about when you can go hands on and restrain. It is really important, but staff are starting work without it because there is a huge backlog in the training. Sometimes they can't get on it for months. It is really not safe; they should have it before they come anywhere near a ward. It is really concerning.

47. I know some of the backlog in TASID was affected by Covid; obviously, you get very close to people when training in restraint. They had to extend proficiencies without further training. The backlog has certainly been there for the last two years, and I have known people waiting three or four months before they can get on a course.

48. The Trust is aware of the backlog. There are steps in place to address it. The Trust started to take these steps in about 2022 – when things with Covid became less restricted. Over the last two years I know the Trust have taken on extra trainers and they are working on the weekend as well. We released some of our staff from the ward to become full-time trainers on the TASID course. But that means we lost some of our most experienced people.

49. I believe more could be done to address the situation. Sometimes staff can get on a course, but it will not be local. They can be quite far away, in sites like Wickford or Hullbridge, and, if you can't drive, you can't access those

sites because the training locations are not near train or bus stations. So, they might say training is available but, in reality, it is not available to everyone.

50. It used to be the case that staff were not able to start work without the training. Now people can be working for weeks and months without it. It is something I have seen creep in gradually over time. I can't put a finger on when it happened. I just remember over time that we would interview someone, get them set up and tell them what courses they needed to do. Then we started getting calls saying they couldn't get on a course for two months or three months. We have then had to get them starting on the ward. At the time this started happening I was ward manager and I escalated it to the matron who would have passed it on to the directors. I don't think I have had to make the specific decision to allow someone to work without the training. It is no longer something that needs approval, it is just what we do now.

51. In about April 2024 the Trust started an HCA academy, where they do two weeks of training before starting work. I thought it was brilliant and assumed that they must be doing TASID, but they were not. They were just doing inductions.

52. Agency staff have a different training – they use Prevention and Management of Violence and Aggression (PMVA). This means they use different holds. So, you might have half the team using TASID holds and the other half using PMVA. I have reviewed the Body Worn Video (BWV) after incidents, and it is a mess, it is a real problem, it is not cohesive.

53. I am not sure if PMVA is as good as TASID. I would have to check how often they do their refreshers; and I think they might only be one day long. TASID is initially five days and then there are two-day refreshers each year. Then I think there is another five-day training session after three years. PMVA is a nationally approved course and, before we merged, I think South Essex used PMVA. That changed once we merged and Natalie Hammond took over. That was one of the good things she did, to do away with the old training and introduce TASID.

54. TASID is good training; it prepares you well for incidents. It is more about de-escalation as well. I remember when we did the old C&R training, we were taught that we could inflict pain on patients. Some of the trainers were old school and quite macho. They had worked in secure units, and they would make jokes, saying things like "You can tweak it if you need to." I didn't think that was appropriate. There was not much about de-escalation at all; we just practiced holds and breakaways.

55. On the other hand, there is a school of thought that we are not allowed to do as much in TASID, and that the holds are not as good as they were in C&R, and therefore that nurses get hurt more. Each time there is a course we seem to lose more of the holds you can do. It is a difficult balance; obviously we don't want to hurt the patients, but some of them can be incredibly violent and we do need to have adequate holds. There is also a criticism that the guy who runs the TASID course doesn't work on wards. The people who deliver it used to work on the wards, but they come off the wards to deliver the training full time, so they can start to lose touch over the years when they don't see what is happening in real life.

56. We all used to train as a unit a few years ago. That was much better. Every unit is different, and we worked together and trained together. Now we go off as individuals to do the course and there might be 15 people on it with you from all over the place – perhaps some from CAMHS, but then also some from older adults or community mental health nursing, where they never restrain patients. It is much better to train with your own team. It is something that drifted off over years. I don't know if it was a conscious thing. Now you just see available courses and book on. You might get lucky and see a few of your team on the course with you. We have discussed it in meetings, but I don't know if it has gone anywhere, or whether it is something that is easy to change. [I/S] our director for specialist services, would probably have raised it at the executive level for us with the Director of Nursing.

57. The lack of cohesion during incidents has also been reported. I flagged it with the TASID team. They in turn have flagged things with me. They were looking at random BWV and looking at incidents on Larkwood at night. They

saw a definite lack of leadership and control; with one staff member trying to de-escalate and another staff member holding the patient. If you are restraining you've got to decide if you are doing it or not and work as a team and someone needs to take control. I too have seen it a few times looking at BWV. I have also raised this problem with my Service Manager [I/S] [I/S], so I know my managers are aware.

58. The trust started trialling BWV in about 2021, then CCTV was brought in a bit later that year. We had been requesting that since 2015-16 and we had numerous incidents and allegations that could have been solved if we had CCTV much earlier. It wasn't even that expensive, considering the cost of staff being suspended from work due to allegations. It had been agreed and overruled by someone at senior level in 2016, probably because of money.

59. BWV shows that lack of cohesion is still a problem. It depends on the activity on the wards. If you have higher levels of observations, you have to put out for more staff and therefore more of the staff will be temporary and the quality varies. Even the best staff who are hardworking won't be as useful as a regular member of staff if they don't know the patients and the units. They may have been trained in PMVA, or they may have previously been working on units that don't use restraint; and they are suddenly on a CAMHS unit where we use it every day and they won't know what to do.

60. We had a situation when we had to take a patient into seclusion which illustrates this problem. When we seclude a patient, we use a piece of equipment which we call a safety pod, which is like a giant bean bag, so that patients are not restrained face down. It involves two staff-members holding the patient by each arm. We take the patient into the seclusion room and up to the far wall. A third staff member puts the safety pod behind patient and runs out. We step back and turn, the patient goes onto the pod, we exit, and the door is closed. The process is supposed to be really fast. The patient is usually fighting us all the while.

61. On this occasion, in January or February 2024, the staff were mainly bank and agency. I was holding one of the patient's arms and leading the procedure. I asked a staff member to put the safety pod in place, but he took

it and moved it to the other side of the room, further away from us. He just didn't get what I was saying. I don't know if it was a communication issue or whether he just panicked. The patient was fighting us, kicking, head butting, and spitting. We ended up having to restrain the patient for much longer than we should have, and that just isn't safe; it was a complete mess. That is just one example, where I was there, and I am an incredibly experienced member of staff who has led in many different situations.

62. Our options for reporting these issues and incidents included using the Datix system. We could get the TASID team in to do additional training if we had specific problems, and we could also raise it in our team meetings. The Datixes go to the Director of Quality and Safety, [I/S] The problem is that, while using temporary staff this is always going to happen, even if you have the best. But I don't want to blame it just on temporary staff. Some regular staff are not very good at TASID, some just are not as confident. I do wonder how some of them get through the training.

Ligature awareness training

63. The Trust have introduced some ligature awareness training, which is good. I think it was early this year. That is something good which is being done. But often people don't see it until they come onto a unit. It is something they probably have after they start. That is something I would change: ensure that staff have an understanding about ligatures before they first go onto the ward.

Risk management and other mandatory training

64. The registered nursing staff have to do clinical risk training. It is not as good as it used to be. Everything went online after Covid and the risk training has stayed online since then. We used to go into the classroom and interact, we would have really good discussions that got you thinking.

65. I believe I did the training at band six. You have to do it every three years, but it should be more frequent than that. You can cause a lot of long-term harm with poor risk management. It is a skill. For example, a child might tie a

ligature which is very loose when they are obviously distressed. How you manage it is very important, you don't want to pull the alarm and call in six staff to jump on them; you don't want to overreact, because that could reinforce the behaviour. On the other hand, you don't want to dismiss them, say "That's not tight!" and just ignore it. It takes real skill to sit next to them and decide how to manage it appropriately. You also need to be aware that some patients will tie a really tight ligature underneath one that looks loose. There are really crucial judgment calls to be made and a bit of online training every three years is not enough.

66. We also do anaphylaxis training and other online mandatory training modules including things like dementia awareness, diabetes, falls risks (every three years) and infection control (every two years).

67. Training has to be good to give you the best chance of doing things properly. But it is a lot to do with experience in this job.

**International Recruitment**

68. We took on a lot of international nurses recently. It caused problems. The recruitment process was a shambles and the nurses we employed had a different confidence and skill level. I volunteered to help out doing interviews and I met some amazing nurses, mainly from Nigeria and Ghana. I met some brilliant people, for example nurses who had been working in Nigeria in rural places with AIDS patients during Covid, where they had a scarcity of drugs and still a lot of stigma around AIDS. I couldn't wait to work with them. I interviewed a lot of people who were all very keen to come and work with us. It all seemed very positive.

69. However, there was a big issue – how mental health was managed in those countries was very different. They were all general nurses, rather than mental health nurses. My understanding, from the experience of nurses I have worked with, is that they often dealt with mental health patients with serious psychosis or dementia in general hospitals. Self-harm in children was another big difference. From what I have been told there are no mental health units for children in these countries. The staff from abroad told me

that self-harm in children does not exist or if it does it is hidden and managed by family. Mental health is dealt with in general hospitals and the conditions they see are dementia and psychosis.

70. I was told the international nurses would be having three months' training in mental health when they arrived. I didn't think that was enough. It is a very different discipline. It would be like me going to Nigeria to work as a general nurse. The staff that came were very brave, coming into a completely different culture to do a completely different profession. Some told me that they thought they would be doing general nursing duties in a mental health hospital; they thought they would be dealing with physical health. Some were quite shocked. These were brilliant people doing amazing work in their own countries, but they were shocked and out of their depth. They were told that they would be doing a different role and they were not adequately trained.

71. Some reported to me that they hadn't had the three months' training. [I/S] [I/S] one of the directors in the directorate, said that the training was only for nurses who had come from abroad. Some had been in the country for a while, so it wasn't offered to them.

72. We were trying to support them. They were supposed to have a team to support them. One of the recruits was pregnant and she became unwell; her husband was abroad in Saudia Arabia. The person responsible for the overseas project [I/S] said it was her own fault because she didn't time having the baby very well.

73. In the St Aubyn Centre we took three nurses on each ward. I know that Ardleigh ward took 9 or 10 – it was a real safety concern that these people from different professions were coming in to manage the wards. They needed a lot of support and basically needed retraining in mental health. They hadn't seen children banging their heads, cutting themselves or tying things around their necks. Because of their culture, they hadn't seen children hitting grownups.

74. There were problems with communication as well. Accents were different, and the language barrier with some people was a problem. One time

someone was asked to get oxygen and came back with a blood pressure machine; it could have been serious.

75. One of our wards, Longview, started reporting some serious concerns they had about the international nurses. Including issues such as medication errors, and not understanding observations. The regular staff were reporting these concerns, and this then led to a big divide on the ward, with the international staff accusing the regular Longview staff of racism. They said "We're not racist, we are just concerned about safety issues." Larkwood ward PICU worked better for some reason. They took three nurses from Ghana and it worked out really well. The new nurses really took to it and adapted well somehow.

76. Overall, it didn't seem like the international recruitment project was organised very well. It felt like the Trust were desperate to fill a load of posts and shipped a load of people over without preparing them well at all.

**Staffing Levels and Quality**

77. When I first started working on Longview, the staff on the ward during the day would be two qualified nurses and two HCA as a minimum. Between 9am and 5pm there would also be band seven and eight nurses on duty, and consultant psychiatrists there. At night it was different., at night there would be one qualified nurse (the nurse in charge) and two HCAs. There would be higher numbers if more high-level observations were need. There might also be a twilight nurse doing 5pm to midnight. We tried to have an experienced band six on as the nurse in charge at night, but it could also be a band five who had just qualified.

78. As time went on, we were managing children who should have been in secure units or in children's homes. We have had to manage more risk and change our environment. I have been on shifts with 26 staff on the ward for 10 patients. By the time we moved to St Aubyn our basic staffing numbers had increased to two qualified and three HCAs on each shift, five staff members on each ward. I believe that when we moved to The St Aubyn Centre the minimum staffing was the same for day and night.

79. Overnight the nurse in charge can call the nurse on-call for advice or assistance. The nurse on call will be a band eight or higher who is on call for Harlow, Chelmsford, Colchester, and Clapton. Sometimes the nurse in charge can also get help from the site coordinator (a band seven) over at the Lakes. The site coordinator is not responsible for the St Aubyn wards, but they will help if they can.

80. Under the old Trust we didn't have site coordinators or a bed management team. At that time, as a band seven, you would do a week on call and you could be up all night taking calls from Harlow, trying to find beds, managing complex cases and being informed of incidents. A week on call would be a nightmare; everyone dreaded that because you would still have to do your day job. That is something EPUT have improved, bed management; it changed for the better following the merger. EPUT changed the system so the nurse on call was a band 8 and the trust put bed management teams in place and site coordinators on units to take the pressure off on call managers.

81. I can't remember many times we were able to function with just the basic staffing, so we had to go to bank and agency, especially when observation levels were high. The quality of staff was not great. The agencies often sent people who are not up to it. We got some people who shouldn't be working in mental health. One guy turned up who was from Brazil and couldn't speak a word of English. I have heard that people send friends to do each other's online training. That is difficult to prove – but there is an example of that with Elise Sebastian's case, which I speak about in paragraphs 163 to 179 below. Also, even the best temporary staff don't know the unit, so even the good ones can be a liability for that reason.

82. If staffing levels were low, we could raise concerns by doing a Datix. However, that was frowned upon. A previous band 8 matron for the St Aubyn Centre, **[I/S]** (she is retired now) once said to me (speaking about nurses on the wards) "If they had the time to sit and do a Datix they couldn't have been that short." We are encouraged to report stuff, during training, and I am sure there were policies about it. But when you did report problems, you are made to feel like you are being a nuisance.

83. There continue to be daily issues with the number of staff on the wards. As a manager, you still get a bit of a push back if you say you need more staff. It is all about money. I get it; there is not a bottomless pit of money. But some things need to be paid for. Management don't really appreciate how many staff are needed. They don't think about things in terms of observations. It's a lot busier than people think and it's hard to get that across.

84. The problem is that, even when everyone is fit and available, there still are not enough staff to cover every shift. So, we are forced to use bank and agency to ensure every shift is staffed. When we did our rotas, we were told that we needed to spread everyone out, to ensure a good skill mix. However, if I had Mondays and Tuesdays unfilled and tried to go to bank and agency staff, they would remain unfilled. Bank and agency staff take the weekends and night shifts and they don't touch the weekdays. It is busier on the ward during the weekdays and you get paid less. If you are a bank and agency worker and you can pick your shifts, why not pick weekends and nights that are quieter and when you are paid more? So, I ended up having to put our own regular staff on weekdays, then fill the nights and weekends with agency and bank staff. I would have to put one regular qualified nurse on each night and one regular qualified nurse on the weekend, but the rest would be temporary. I had to do that otherwise we would be left short staffed on Monday when trying to do reviews and on Tuesdays when doing Care Programme Approach meetings (CPAs: these are discharge meetings where the patient family and all professionals are involved).

85. The safety of the ward on nights and weekends always worried me. It worried me because, on nights, between 5pm and midnight, the incident rates shot up. It is quite busy at that time, then between 12am and 7am it is quieter. I would try and flag it, but we were always put under pressure to keep costs and staffing down. You are put under a lot of pressure and made to feel that you are not managing your rota properly, by people who haven't managed rotas for years. They are working in offices and are not aware of how things have changed. Young people have changed, legislation has changed, there are a lot more audits. Care is more patient focused now and we need more staff to do that. It is true we used to be able to work with one

qualified nurse and two HCAs, but we can't do that now. Some people still think you can.

86. I have flagged it in meetings, when we do staffing reviews. These are every year or two years and they involve us completing data on what our observations levels are over a two to three-week period using the Mental Health Optimal Staffing Tool (MHOST). We fill in that data and send it to someone (I cannot remember who) who looks at how many staff should be established for. We are then given a budget for staff. There is a finance meeting every month and they tell us if we have over or under spent. It is always an over-spend, so there is pressure to keep it down.

87. The pressure has come from [I/S] he was the area director at the time that Elise Sebastian died in 2021, and from [I/S] especially, she was the Director of Specialist Services at the time. I am sure that they are getting pressure from somewhere too. I don't want to knock it, as there is only a certain amount of money, it is a factor though.

88. As I see it the solution is to employ more substantive staff, so there are more regular staff members to fill the rota with. However, I didn't see any effort to try to employ more substantive staff until the CQC came in after Elise Sebastian's death. It is sad, because I had flagged this before; we had been raising it for ages before then. But it took that poor girl dying and the CQC to come in before anything was done.

89. We were short of staff on both wards on the day of their visit. I remember that the CQC raised it with the director of nursing at the time, Natalie Hammond. They said the unit was not safe; there were too many gaps; there were staff on back-to-back observations and not enough staff to take patients on leave. The CQC had concerns about the observations as well. We were using paper observation records at the time and there were loads of gaps where people either had not done them or had not filled them in. The CQC were really concerned. We heard a couple of days later that they served notice on us that we couldn't admit any more patients. The Trust said they paused us to admissions; but we saw it as being shut by the CQC. We were relieved, we thought thank God someone has listened.

90. Natalie Hammond pulled staff off other units for the next scheduled CQC visit (the CQC came in May 2021 and again about a year later). The staff were only bought in for the day that the CQC was due to be there. She brought them in from other units, such as the Lakes and Brockfield House, and they all turned up and caused even more of a headache. They didn't know the ward and they were not trained. They were all just standing around. The CQC inspectors turned and laughed, they said "I bet this doesn't normally happen."

91. The Trust also brought in a sit rep meeting every morning on the back of the CQC visit, so that they could show that senior managers had oversight of staffing. The sitrep is for specialist services. It is chaired by an admin. You report on how many staff you have as opposed to how many you need or have planned for. You also talk about any ward pressure, discharges and admissions. For the first couple weeks we had senior management attending; now it is just administrative staff who go. They have reports on safer staffing and then ring up and report figures on the phone. They are never on it.

92. After the CQC and Elise's death, the Trust made a couple of changes on the ward. We used to have one member of staff doing all the level two observations, where the patients are checked four to six times an hour. With these observations, you need to find the patients, speak to them, and check that they are OK. We could have 14 or 15 patients with one staff member trying to do it all. They changed it after Elise's death to say that one member of staff could not do more than three level two observations. We also realised that we needed more than two qualified nurses on a shift, because one might go off sick, or might be in meetings all day, so that was leaving only one qualified nurse on the ward. They established minimum staffing levels of three nurses on each ward together with four HCA's, for both day and night shifts. That was on the back of the CQC.

## Admission Decisions

93. As well as the pressure to keep staffing costs down, we also had lots of pressure in relation to taking patients. We shouldn't take some very violent

patients or some with very serious conditions. They shouldn't be on acute wards, but we got pushed into taking people. This happened a lot. Quite often we were forced to take people we couldn't manage and beyond the risk.

94. Before the provider collaborative was put in place, we would get referrals in to the consultant and to me as ward manager and maybe to the clinical psychologist. We would look at it to see if it was an appropriate case for an acute ward. If we thought it was not, we would go back to the referrer and say no, as it was not safe. Or we might say that we could take a patient who had problems with aggression or violence, but we could not take another patient who was a ligature risk as we didn't have the staff. Then their director would talk to one of our directors (to [I/S], the area director, or [I/S] [I/S] the director of specialist services at the time), and our director would say we had to take the patient. Or we would go home and come back on the next shift and find the patient was in a bed and had been admitted overnight. It was all a bit political; directors who knew each other or directors and the Trust wanting to be seen as helpful. Some people just see a bed as a bed and don't realise that the care pathways and treatments in mental health can be completely different. It has to be the right type of bed for the patient's needs.

95. This was the culture in around 2018-19, admissions happening against our clinical opinion. The consultants would get angry. It stopped for a long time after Elise Sebastian's death in 2021, but it has started to creep back in.

96. Since the provider collaborative was put in place referrals go to a bed management team. They then send them to the local appropriate service for screening The team look at the referral and if appropriate offer an assessment of the young person.

**Patient Observations and Oxevision**

97. Across the trust I am still concerned about safety, especially as many units haven't made the changes to staffing we have made on St Aubyn's since 2021. Recently, I have done some bank shifts on other wards, and I saw that

they were still having one person doing all the level two observations. They changed it for CAMHS – we had to put a specific change in our operational policy (I remember being in meetings where they said we had to do so) – but they did not change it for adults.

98. I have seen it myself. I was on Tower ward, which has older adult dementia patients. I had never been there before. There were 12 patients with dementia. I was trying to do their observations. I am highly experienced, and I struggled. I couldn't even ask them who they were due to their dementia. I managed to do it because I asked someone to come round with me to make sure I was checking the right people.

99. I know that it happens that other people don't check properly, they just say that they have seen someone. It happens all the time; I have seen this. It was happening on Topaz and on the Christopher Unit. The mother and baby was ok – there were only four patients – that was really well run. I know that checks are not done properly on the Peter Bruff Unit, because staff have told me. There are 18 patients and staff run around trying to find them all; it is impossible to check them. It is about engagement as well as observation; you can't do 18 in an hour. If a highly experienced staff member like me struggles with them, then someone from an agency – who has never worked on wards before would find it impossible.

100. Oxevision is a system with a camera and sensors in each bedroom. It is very good, especially at night – when the patients are in bed it measures their breathing rate and pulse. It was invented at Oxford University – it is amazing technology. It will tell you whether the patient has gone into the bathroom – raising an alert after I think two or three minutes. It will tell you if people enter the room. In the seclusion room, it will alert you if someone stops breathing. Oxevision is controlled on the wifi and we have had issues with wifi dropping out. It is really important that it is working all the time. I know the trust have invested some money on wifi.

101. It is very good, but it has promoted some laziness in the staff. People check on camera and do not go to see the patients. We have seen it and I have had it reported to me. I have had to pull staff up on it. I have seen people go down

the corridor and then just stand and look at the camera. Also, young people have reported it – you will speak to young people and they will say they have been in the room for an hour and no-one has come in and checked on them.

102. If we are going down to see a patient, we do check on the camera first before going to see them. I have seen a patient on the screen walking around the room and making their bed, but when I got there to check on them in person, the patient had one of the tightest ligatures I have seen, which was not visible on the camera. If I had left them for another 15 minutes, I don't know what could have happened. You have to engage the patient. It is ok just to look on Oxevision at night, when they are asleep in bed, as it saves you putting a torch on them and disturbing their sleep. But during the day when they are awake you should be engaging with them. One guy who I spoke to about only using Oxevision said he did it because he was scared of allegations.

103. Observations can be improved by having more regular staff. But there are regular staff who have been missing observations. The quality of staff varies even among regular staff. There is a bit of a culture on the wards of staff sitting in the office just talking chatting away. The Trusts do observation and engagement training. The trouble is that this is online and you can get anyone to do your training for you. The staff member involved in Elise Sebastian's case had got someone else to do her training for her. Inductions are also important. I think the trust has done quite a lot of work on that. We certainly do inductions and in all the units I went to recently to do bank shifts they did give me a really thorough induction. However, I am a band eight in the trust, and I do get treated differently, it might be different if I was a band three HCA from an agency.

104. I still think that observations aren't as good as they should be on St Aubyn's. I watched footage of Elise Sebastian's death on Oxevision. It was recorded – I sat and watched her die. People don't get it; they become complacent. Things can go wrong very quickly and people don't realise how dangerous it is.

105. When observations are missed a Datix is done on the unit and I write to the staff member. The CQC is aware of it. I believe the CQC have done some work where they have checked the observation record and then checked CCTV and swipe card records to see if staff have actually gone to see the patient physically. I know my unit had an anonymous report made to the CQC about observations, in October 2024 I believe, and I raised it myself with them. Our Trust did a response to the CQC and I was not satisfied with it; I thought our managers just gave a load of rhetoric, so I went back to the CQC. This was after I first made contact with the Inquiry, towards the end of 2024. I told the CQC about my concern with all the Datixes I was asked to clear (I speak about these at paragraphs 128 to 136 below). They responded by asking me for more information. I told them about all the units and all the outstanding Datixes and I told them about my concerns about the observations at the same time.

**Experience of Adult Wards**

106. My recent bank work has been on adult wards, including older adult wards and Psychiatric intensive care. Compared to the CAMHS wards, the adult patients say not much is going on during the day. They are sat around a lot. Not much therapy is going on. This was on Topaz and Christopher Unit. I also spoke to the Derwent Unit, and they said there are often staffing shortages which means that the patients can't go on leave and they are often not checked as they should be. On Topaz and Christopher ward I saw that some staff were really good, enthusiastic and engaging. But others were just there to do their shift and go. Rainbow ward (the mother and baby unit) was very good. The feedback from the patients was that it was very good and very well run. There were plenty of activities, the babies were looked after, and the fathers were supported well.

**Culture and Leadership at the trust**

107. There is a lot of politics in the Trust at the ward level, with nurses and HCA's gossiping and moaning about each other. Some of the staff will be sat in the office a lot. There are some very hardworking staff, you see them out with

patients. They are mainly the HCAs. You will see a lot of nurses sat in the office. They are meant to be doing paperwork but often they are just talking

108. There is a strange culture which has developed, some people think that when they are doing observations they do one hour on and one hour off. We don't want people on level three observations all day, because they get burned out. But if you are off observations you are meant to be engaging with patients and doing other things, some people think they can sit in the office in between. That culture needs to shift. If you are working at Tesco for 11 hours you are working for those 11 hours. The hour on and hour off idea causes problems when you get bank and agency staff saying they have too many observations.

109. There are some really good staff. A lot of people are really very good; they are kind and understanding and they understand why they are on the ward. With others you wonder why they are in the profession. Instead of engaging they are just sitting moaning about the patients.

110. At St Aubyn's we have a good culture of reporting. We do a Datix for every incident. Staff are able to raise concerns and we do our best to try and listen. However, often people are just moaning about each other and want management to do something about it and that's really challenging. I know a lot of managers have been burned out and left – they go into the job thinking they are going to make changes for patients, but they end up mainly dealing with staff issues and bickering.

111. At the management and executive level, at the moment, it feels like there is a desperation to feel like the ward is safe. They have invested in a new Director and a new Deputy Director of Patient Safety who were appointed in 2022. I'm not sure how effective it is. I feel you really need more people on the ground.

112. This desperation about safety has certainly been over the last few months. Before then I didn't think that patient safety was that much on the agenda. I think a lot of it has come from the Lampard Inquiry. A lot of senior managers want to be seen to have oversight of things, but then nothing seems to happen with that. A good example of this is the sit rep call; we used

to have senior managers attending; but now it is mainly just admin staff. Also, the answer to a lot of problems is to audit. But then that's a nurse doing some other piece of paperwork. So, there is more and more paperwork and audits. But what happens to that info? What difference is it making?

113. Or they will introduce something new and annoy nurses who are already overstretched. I don't think consultation with members of staff takes place at all when they decide to implement new measures. A good example is from the ligature risk reduction group that they have. The head of it (I cannot remember their name) has never seen a ligature. I have been cutting ligatures off for 21 years and I recall being in a meeting to do with safety suits and ligatures, where they were telling me to do ridiculous things. I can't remember the names of everyone in the meeting but I remember that [I/S] was there – she is part of the nursing directorate. There were some crazy ideas expressed in that meeting.

114. For example, you may have a 14-year-old girl who is intent on ending her life. She will use everything she sees to try to hurt herself. One of the main things she will do is tie ligatures. [I/S] [I/S] Patients like that are obsessed with it; it is in their mind constantly, the intent to die. They are very good at doing it. Especially at night. A lot of young people won't do this in the day, when they are in public. They don't want to [I/S] in front of other patients. It is at night when they are in their own room with no-one else around that they will do it. The night is a difficult time; for those of them who were abused, that's when it would have happened, at nighttime in their rooms. These kids are so good at making ligatures. They are so clever they [I/S] [I/S] under the covers and make a ligature. When they are in bed they can do it in front of the most experienced nurse who may not notice until they eventually turn blue. If it happens we end up having to restrain them and cut the ligature off.

115. If we have a patient with a pattern of this behaviour, at night before they go to bed we will ask them to [I/S] wear a safety suit, which they cannot tear up to create a ligature. If they say no we leave them [I/S] but when they tie the first ligature, we get an all-

female team in, restrain them, and put them into a safety suit. We agree this approach in advance with the patient's social worker and the parents and the MDT.

116. The ligature team wanted us not to respond after the first ligature with the safety suit, but to leave the young person to tie the ligatures again and again until they had no clothes left, and only then put the safety suit on. It made no sense. It would mean 20 alarms a night, and restraining a young person multiple times until they had no clothes left. Every time we restrain them, we traumatise them, we can hurt them; and every second they have those clothes on they can harm themselves.

117. Once I had explained all of this the team eventually agreed with me. But for a while they were quite aggressive with pushing their idea. If it had been someone there who was less experienced, they might not have listened. They are supposed to be the experts.

118. As a manager, I was lucky because I had so much experience in the CAMHS service; I have never been anywhere else. My managers have always been approachable, and I felt like I could raise my concerns with them. In my current role, [I/S] is very supportive, and I see a lot of [I/S] in the unit.

119. However, while I have sometimes been listened to, sometimes I have not. Especially about staffing levels, and also about the physical building. Therefore, looking back, I would not say I was always supported. When I was trying to raise problems about the building, I was just ignored. When I raised concerns about staffing levels; a lot of people in management who had not worked on the wards for years would say "I used to manage when I was on the ward." Or "We only had two staff when we were on the wards." But the rules and regulations have moved on a lot now. You sometimes feel that if you raise things a lot you feel like you're moaning.

120. I have been working from home since August due to health concerns. The support during this period has been terrible. I have had no-one checking on me to see if I was OK. My emails (to [I/S] [I/S], have been ignored.

## Complaints

121. I have been asked about my experience of how complaints are dealt with. If we can deal with them locally, we will try and do that. Most things can get resolved. The key is communicating with the parents all the time. I am always banging on about that with the staff. Each young person has a nurse who is their key worker, their key nurse on the ward, who is in charge of their care plan. Those key workers should be speaking to the parents at least once a week to touch base and update them on how their child is doing.

122. That's the first way of dealing with complaints; making sure we don't get any. In general, we try to involve the parents with their children's care as much as we can. It's so important. They have opportunities to meet with the consultant and questionnaires get sent out as well. We do as much as we can; we are not perfect, but we try.

123. There are parents who are very anxious or need more support and sometimes the ward manager or I will ring them. How effectively this works in practice depends on the staff member. Some are wonderful at communicating, such as Nurse [I/S]. Other times you need to push staff to do it. We audit it; one of our band six nurses on the unit does regular audits to check that calls have been made and meetings logged.

124. We always try to get local resolution for any complaints. Patients can use PALS as well. We have a complaints team for support and we can escalate things to our managers.

## Datix

125. A Datix is an incident form. All Datix are allocated at the moment they are completed. A member of staff does the Datix and sends it to their manager. You try to send it to the most appropriate person. If you are band three or four or five; it might go to a band six nurse. Something more serious might be sent straight to the band eight. The manager that it is sent to becomes the handler. They may send it on to a higher band. For every Datix raised, an email goes out with a summary to the ward manager, to me (the band eight

matron), to the Service manager, the Area director, and to the Director of patient safety.

126. Different units have different systems for dealing with the Datixes. Some units will allocate them to specific staff members on the basis of which day of the week the Datixes come in. Others may allocate all Datixes automatically to the ward managers or, if it is something more low level, possibly to the charge nurses.

127. Clearing a Datix involves looking at what the incident was; rating how serious it was; double-checking that all the people named were actually on shift during the incident (because sometimes staff are named by mistake); checking for accuracy; looking for any patterns of behaviour; seeing if things are escalating; checking if parents have been informed; or social services if relevant; seeing if there were any learning points to implement; then signing it off. People often don't have time to clear them and then they can pile up.

128. I have been working from home since August 2024 due to an issue with my health. In August 2024 the interim Director of Nursing (I can't recall his name) spoke to me and asked me to deal with a Datix project. He told me there were about 4,000 Datixes that no-one had looked at and he said to me "We need them gone; we need them processed, and we want you to help with that." This was an oral request he made in a meeting over MS Teams. The director has now left; when we had our meeting he said he was leaving in a month. I agreed. I thought there may be managers who were busy and had not been able to get round to dealing with them.

129. I was put in touch with [I/S] he is in charge of the Datix system and he is part of the risk management team. He also provides technical support or helps you access data you need. I like him, he is always helpful in getting me the information I need. But I think he is very busy with a very small team.

130. He started sending me all the outstanding Datixes from Basildon Urgent Care Unit. These go back to 2021. They include incidents of self-harm, absconding, alleged abuse, assaults, poor practice, security issues, violence and aggression, and racial incidents. We have a very clear policy for dealing

with racial incidents and making sure that staff are supported. No one has touched them; or even looked at them; they are all still there waiting to be closed. The only part that has been filled in has been where the handler has been changed to me.

131. The Datixes sent to me were not just for Basildon Urgent Care. They also included the Early Intervention Psychosis team in Colchester; Herrick House Community Adult team in Colchester; Kelvedon ward; the Mental Health Assessment Unit in Basildon; Crisis Response in the Lakes; Mental Health Liaison team in Basildon. Each unit had about 100 Datixes. More recently I was also asked to deal with about 150 outstanding safeguarding concerns from 2023, from different services in Chelmsford, Thurrock and Colchester. But I said I wouldn't be comfortable doing these; they needed to be done by the relevant team. They know more about their units then I do. I wouldn't be comfortable with someone doing my safeguarding concerns either.

132. I started doing the Datixes. I tried to go through the notes on Paris to find out relevant information. I contacted staff. Almost no-one got back to me. It has been so long now that some people have moved on. Some people did get back to me, but they were annoyed, they told me they didn't have capacity. For example, Louise Bolton at Basildon. She was one of the handlers for a case in which the general hospital had raised concerns and safeguarding issues about how mental health patients were managed. I asked her for the incident report. She said she had it somewhere but she was about to go on leave. Someone else said they needed to speak to their manager because they didn't have capacity to help.

133. You could potentially predict a patient death with a Datix. For example if there are reports of someone self-harming more and more. You need to know about it as the manager of the unit. It is not right for someone else working from home to try and deal with it. I know EPUT has been criticised for not investigating incidents.

134. There are lots of Datixes from lots of units that have just not been looked at. In our service (Specialist Services) things are not perfect; we have about 80 Datixes to be closed. But there are no Datixes sat there for three years. I have

never seen any policy or guidance on the time within which Datixes should be dealt with. They should be dealt with as soon as possible. If ours start to pile up, my manager will say "Brian can we get these done." I look at them; the ward manager will also look at the Datixes for their ward. There is always someone who has eyes on it. I don't know what's gone on with these other units. Something has gone wrong.

135. I raised my concerns; firstly, by speaking to [I/S] I just got told "We need to do something about that; that is going to need a bit of thought." I then raised it with my director [I/S] again on the day of my interview with the Lampard Inquiry (to prepare this witness statement) I told them that I was speaking to the Inquiry about it and that I had raised it with the CQC. I imagine that this caused mass panic.

136. I think that I was asked to do this task because of this Inquiry. No-one has said that, but a lot of people are panicking about the Inquiry, and with so many uncleared Datixes, that was the sense I got.

**Circumstances surrounding specific deaths**

137. I have direct knowledge of some of the circumstances surrounding the deaths of six young people who were inpatients on our wards.

Rebecca Watkins

138. Rebecca Watkins died in 2009. I met her when I had just returned from nurse training, as a qualified nurse. She was part of the Beatrice Inquiry, which was about her death and failings in communication between Longview ward, Sicla care and her family.

139. Rebecca's case was a social care case. She had been admitted into hospital for tying ligatures. It was felt by the MDT that being in hospital was not the best thing for her. It often isn't; the kids can pick up lots of tips from other patients. I think she was referred to by one of the charge nurses as a bed blocker (it was not meant maliciously; it was a common term if a patient did not need a bed that someone else could make better use of). She was quickly shipped out into a social care placement. I don't know all the details,

but I don't know if her dad was aware of the discharge. There was not appropriate support for her (such as Crisis team and community CAMHS) and she hung herself.

140. When I came back to unit from my nurse training a lot had changed. We had previously been predominantly nurse-led. When I returned, they had employed a psychologist and family therapists. There was some friction between members of the MDT in relation to Rebecca's death. They were blaming each other. There was a lot of bad stuff.

## Charlotte Cobbold

141. Charlotte's case occurred on my first day as a ward manager, in August 2014, after I returned from leave. I had been involved with Charlotte's care a lot when I was a band six charge nurse; she was in my care team. She was a lovely girl. I believe she came in from the Priory in Chelmsford.

142. She had an [I/S] and she was all bruised and battered from punching herself. She would try to hurt herself all the time. We had to walk her around with two staff keeping her in hold at all times. Otherwise, she would punch herself in the head and headbutt doorways, or knee herself in the face. We were doing this for a long time. Then we got an agreement with safeguarding and everyone that we wouldn't restrain her to prevent her from hitting herself, we would only intervene if it went on too long. She would punch herself for a time but then she would stop. It was hard to watch, but the new approach seemed to work.

143. She started to make progress; she was eating and looking much better, and she started to have periods of leave, beginning with 15 minutes at a time. She seemed to be doing well, managing her leave with us. However, it wasn't all one way; we had to stop the leave for a bit after an incident when she stepped out into the road.

144. Her mum and dad had split up. Her mum was on the unit a lot, but Charlotte didn't want any information going to her dad. After she started making progress, she also started doing family therapy with her mum and dad, and she was contacting her dad. [I/S]

145. Her parents were both farmers and her career was going to be in farming and training sheep dogs. We knew there were many risks at farms, but she seemed to be doing well, managing leave with us and her parents. Then she went to her dad's one day and injected herself with [I/S] which is illegal in this country. She told her dad she had done it, then she ran away. He called the ambulance and her mum, and her mum called me to see if there was anything I could do. They got her to hospital and resuscitated her; but, [I/S] no one knew what to do about it; they even rang the national poisons office in America. She died of a heart attack.

146. She had been going out on leave a lot before this happened and no-one was worried when she went out, everyone was happy to sign her out. She had seemed so much better. I don't think there was much more we could have done for her; she was just determined. Her mum still comes to the unit and brings things for the other children.

147. We tried to do some learning after Charlotte's death. We realised we missed some information. Charlotte didn't want any information going to her dad, but that didn't mean he could not talk to us. This came out as a learning point. He would call up and we would say "We can't say anything to you." But we could have listened to him. Just because a patient doesn't want us talking to their family doesn't mean we cannot get information from them.

148. The Trust also brought in environmental risk assessments – having us go out into the community to see whether there were risks for patients – before allowing them to leave the wards. But it all got out of hand; the assessment form would ask whether there were any risks, but of course there were always risks: roads, pubs, shops, drug dealers etc. it's risky as soon as the patients leave the building.

149. I attended a serious case review meeting, held at a hotel, about Charlotte's death. I was told about it only the day before. My manager at the time, [I/S] [I/S] an email about a meeting and asked me to go. He was a really good manager – I don't think he realised the seriousness of the meeting. I went

and found out that it was a serious case review. Everyone who had anything to do with her care was there and I was sat there on my own on behalf of the Trust. Luckily, I was in her care team, so I knew all of her information. There was subsequently a follow-up meeting, and the Trust sent the head of safeguarding. I don't know if there was an Inquest; I wasn't asked to go to the Coroner's court.

150. I have been asked about the support we received as team to deal with Charlotte's death. After an incident like this the trust always do one of their debriefs immediately. We have a good psychology team, and I would say we were supported.

Madison Naylor

151. I was involved in the case of Madison Naylor in September 2019. I got a call at home at around midnight from a band 5 who told me that Maddy had died on the ward, so I went in. Madison had been tying lots of ligatures and this time she tied one when she was in her room, and she vomited and choked. She was only 14 years old.

152. There were quite a few things that went wrong in her case. She was on level two observations, meaning she was being checked six times an hour. The environment nurse was responsible for her observations. The environment nurse (also called the security nurse) is usually an HCA. Their role is to maintain the security of ward, check the doors and bring patients and visitors in and out of the ward, and to get things for patients. At the time, our environment nurse could also do observations and, that night, he was doing the observations for all the patients alongside his environment duties. He went to get something for another patient and he was late in checking on Madison.

153. There was also an issue with the suction machine. It had just appeared in our clinic room one day and no-one was trained how to use it. Madison had vomited and when staff took the machine to her, it needed to be plugged in to work. First of all, a patient is not necessarily going to collapse next to a socket. Also, on this occasion, when the staff member plugged it in, the

socket didn't work – it had been isolated and never turned back on. So that was a factor: the provision of equipment that staff were not properly trained on.

154. Since Madison's death, we have changed the environment nurse role, so they no longer do observations. I think the suction machines have also been done away with now and we now have manual ones in the grab bag.

155. We could have had Madison on level three observations, where someone would have been with her all the time. I remember being in the Coroner's court, having to explain that having a kid on level three means you are always watching, including when they are in the shower and on the toilet, and that that can be really damaging. Having someone with her would probably have prevented her death, but we were trying to take positive risks. Our role is to get kids to a place where they can leave hospital, and we have to take calculated risks.

156. We had a Trust report which said that staffing was not an issue, but I am sure it was a factor. When I turned up on the ward it was really, really busy and chaotic. They had a lot of patients there requiring a large amount of care. I went in to try and help and we also happened to have an extra nurse there, from Larkwood, who just happened to pop in. I ended up in the numbers, trying to de-escalate quite a violent and aggressive patient who had been on long term segregation. In the run-up to the death staff had been rushed off their feet.

157. The Trust had been pushing us to reduce the level of observations, saying that observations were damaging, which they can be, but it was also to try and save money. On that same night, we had someone called **[I/S]** (who used to work for the CQC before he came to the Trust) visiting the ward to talk to staff and patients about how we could reduce obs.

Molly-Ann Sargeant

158. Molly-Ann had autism and would self-harm. She could be aggressive, but she was well liked. She lived with her nan. She was a patient on Longview ward, then she went to PICU, then back to Longview. We thought hospital

was not right for her. She went out on leave and, although she harmed herself while on leave, her consultant and I had a meeting with social services and with Molly-Ann and, after a long discussion, we decided to aim for further leave and discharge. She was promised a community package with a lot of social care and we thought that, with that input in place, she would have a chance of living her life and not just spend her life in hospital. We pressed on with the discharge. We took a risk discharging her, but we thought on balance her longer-term future would be better if we could get her out of hospital. We were worried that she would get worse if she remained admitted.

159. Within three months of her discharge her nan called me to say she had hung herself from a tree in Mersey. Her nan was really thankful to us. She was scathing of social care, saying they had not done the things they said they would do. I don't recall there being an internal investigation in the trust about Molly-Ann's case. I think we assisted with the Inquest, but didn't do our own. I didn't go to the Coroner's court – the consultant did – but from what I have seen the criticisms were mainly with social care.

160. The Discharge CPA usually works well in my experience. The problem is that community CAMHS is under another Trust now. It is run by NELFT. It used to be run by us and we all used to be in the same building. I have seen NELFT do good work, but they seem stretched. Sometimes the community services promise lots of different things and we go ahead with discharge and later find out they haven't done what they said they were going to do. Or perhaps the care coordinator leaves. We have had children back in hospital saying the care was not given and promises were not kept. It was better when we had the service and we were all in the same building; it was a bit more joined up. We would see their staff and ask how the patients were doing after discharge. If something wasn't done well, we could talk to each other about it.

## Antonia Trapani

161. I didn't have much to do with Antonia Trapani's care because I was away on paternity leave while she was on our ward and I was not involved in the care

she received (I was off from November 19th 2019 and came back on 20th December 2019). I think we only had her for a week or two, it was not long. This was before Christmas 2019.

162. The only issue I know about occurred during her transfer to another hospital. NHS England secured a bed for her closer to home, in a PICU in the midlands. There was then some breakdown in communication. She went in a secure transport up to the other unit, but about an hour into the journey they said they couldn't take her, and the transport had to turn round and bring her back to our ward. It wasn't ideal or great for the patient. But I don't think there was anything EPUT could have done.

Elise Sebastian

163. Elise Sebastian had diagnoses of autism and anxiety. She also had a lot of psychosomatic symptoms. She had experienced trauma; [I/S] [I/S] [I/S]. Elise had had quite a few admissions to acute wards – I think about four or five – in the Priory Chelmsford and in Longview. She never settled: when she was in hospital she wanted to be at home; and when she was at home she wanted to go back to hospital.

164. Her last admission was in 2021, during Covid; it was a difficult time. The ward was busy, with 15 or 14 patients. We had a mixture of young people, many of whom should have been in social care or in PICU or on a low secure unit. The ward had turned into a hybrid ward full of young people who shouldn't be there.

165. We put in a referral for Elise to go a low secure unit, a longer-term unit, in Potters Bar, I think. It was run by Elysium Healthcare. In the provider collaborative they are the provider for low secure care in our region. One issue was that she was waiting a few weeks between referral and getting a bed. Although she had been referred, we were still trying to work towards discharge. We always try to work towards getting the young people out of hospital and we need to take some risks.

166. Elise was a ligature risk, particularly when she was isolated. However, we felt that having a staff member with her all day reduced her chance to gain independence and get herself out of hospital, so we put in place a hybrid system of observations. Her observations were at level two when she was in the social area of the ward, but at level three when she was in isolated areas like her bedroom. It is a complicated strategy, but it can work well with a regular team that know each other.

167. This occasion was a Saturday. We had nine staff on the ward and all of them were doing bank shifts; no-one was on a substantive shift. We did have [I/S] working, he was one of our regular staff members, but he was doing a bank shift. Also, he was on his own as the only qualified member of staff; there should have been two. Some of the other staff members were regular employees doing bank shifts, but I think there were four staff who had only done between one and four shifts. There was also an activity coordinator doing activities just outside the ward. It is an area which we call "the Street", where the young people can play pool and, on a Saturday, they order a takeaway. It was quite busy.

168. Elise found the least experienced member of staff on duty and said she needed to go to her room. The staff member took her to the room and left her there. I watched the footage from the Oxevision recording. Oxevision was new at the time, we had had it for about two weeks or so. I knew it saved footage only for 24 hours so, as soon as I got the call to say there had been a serious incident, I called them and asked them to save the footage. It is black and white. It shows Elise coming into the room. The staff member stays outside so you can't see who it is. Elise [I/S] lay face down at the end of the bed with a ligature pulling under her weight. She was lying there lifeless; she never moved, and no-one came. You just see the clock ticking at the top of the screen. She was there for 25 minutes before anyone came back to the room.

169. Then the alarm got pulled and there was a chaotic scene with staff coming in with the grab bag. It was a really inexperienced team; people were panicking. Elise was not put on oxygen soon enough. It is another testimony to staff needing more training in ILS. It was only when two staff members

from the other ward came in that there was some sort of order. Elise was taken to hospital, and she died there on Monday when her life support was turned off. She had been starved of oxygen.

170. If there had been a regular team on the ward they would have known all the patients and they would have known all the observation levels. They would have known that Elise would go to every staff member asking for things. If it was a regular member of staff they would not have agreed to take her to her room. The person who did that didn't come forward for about three months. We didn't know who it was; we didn't have CCTV. She eventually came forward; she broke down and admitted what happened to the police in her interview under caution. She had even worked a few shifts afterwards. I guess in the panic she was scared to say anything and the longer she left it the harder it was to come forward. We found out from the police that she admitted that someone else had done all her training.

171. The Trust went to the wrong people to get information about things, instead of coming to me. For example, they were not sure why Elise and the staff member had taken the route they did back to Elise's room. They wasted ages trying to work it out. When the police eventually asked me, I was able to tell them the reason immediately – we had someone in long term segregation and the route was taken to avoid that area of the ward.

172. I was involved in Elise's care. I would see her every day; normally as ward manager I did Monday to Friday 9am to 5pm. I would usually do a shift on the ward every week too. I was involved in making decisions about her care in reviews and her observations. Looking back, I think doing split observations was risky – the ward was not stable enough because of the temporary staff. I got told after the incident, by [I/S] that I needed to sort the rotas out. But it was an example of one of those situations where you might have enough numbers on the weekend, but they are not the right staff.

173. Elise's death was one massive failure. I hold the Trust to blame; staffing was definitely an issue. If we had enough appropriate staff working on that shift, her death would not have happened. Someone should have found her

sooner. She should have been on level three observations. They thought she was on level two and at the time we had one person doing all the level two observations.

174. Observation levels were written on the board; discussed in handover; and there was an allocation sheet in the office saying what each staff member was doing and the level of observations each patient was on. There were lots of avenues for staff to get the information. But the kids are always one step ahead, always thinking about and intent on harming themselves, and they can be very convincing if you're inexperienced. It is another reason why it is important to know them really well.

175. A Datix was done and I would look at the Datix report to see the additional sections that were added to it as it progressed. Elise's family would not speak to us. However, someone had gone to see her dad and I saw on the report that he said he blamed me for the death; he named me specifically. I had had a run-in with him previously. He was quite an angry and aggressive guy and he had been shouting at a female consultant. I had to go in to tell him to stop.

176. There was a police investigation. The police only closed the case a few months ago; the family had asked for it to be reviewed. The Police kept handing the case to different departments. We had to spend hours going through the case again with each new investigator. I didn't mind, but I felt sorry for the family.

177. The Trust also did their own internal investigation. The report spoke about observation levels, and it questioned the value of the split observations. I don't remember the investigation being that helpful. It was only when the CQC turned up that changes started happening. They would have been aware of what happened because we have to report deaths to them. They just suddenly turned up in May 2021. They were on both wards pretty quickly. That's when I saw the Trust suddenly take notice. It took this girl to die, and she died because of staffing; that is what I believe.

178. The Trust put in place an action plan and weekly meetings about different things, the meetings would have different directors present, someone from

finance, someone from estates, all people who could make immediate decisions. There was also a CQC support group every Friday; that was quite good – we had everyone in there who could make decisions. They increased the staffing and introduced a CQC compliance admin person on each ward. That was a really good, initiative. This is a band 4 staff member who does all the audits and checks on patient safety, including checking use by dates on medicines. It frees up the nurses. Other wards want one but don't have them. I don't know how they manage because they have matrons and nurses doing all the admin stuff we don't need to do. CCTV got pushed through and we also got more training around Oxevision, better inductions, and more training about observations as part of our induction.

179. One of the main things that changed was that our consultants were so upset about what happened; they said they were never being pushed into taking inappropriate patients again. Our consultants would be strong, and they would say "no, that's not the type of patient we take". However, it is slowly starting to creep in again that we are being pushed into taking inappropriate people. They also decided we needed three consultants for the unit in order to take up to 25 patients (to fill all the beds on the two wards). We have never achieved that so, since May 2021, we have never been full. The unit was closed to new admissions for around a year. Then, for the past four years after that it has never been full because the Trust cannot employ enough doctors to run a full unit safely. We went down to one consultant for a while with maternity leave and for a long time there were only two patients on each ward.

**Elise Sebastian's Inquest**

180. The Inquest for Elise Sebastian was held in April 2025. Her death happened in 2021, it was such a long delay!

181. I was represented by the Trust. I felt that they didn't encourage me to be open. They told me to say as little as possible; they also warned me that the family's barrister would try to trip me up.

182. I was called to give oral evidence at the Inquest twice, on 1st May then 8th May. On the first day I was asked to talk about Oxevision. I thought it was quite a good system and the company were very good. We were quite well supported when it was being implemented. It is only when EPUT got their hands on it that things went wrong, for example, with Wi-Fi problems. I was in the stand for three hours on that first day. Afterwards my manager, [I/S] [I/S] messaged me saying "I heard you did really well in the Coroners court".

183. When I was called for the second time, I knew I would be talking about Elise's care. I decided I would say it as it was. I said that staff were being asked to do too many observations and that the Trust will say that it is fine now, but it is not, observations are still being missed. I have seen Datixes recently stating that the Wi-Fi was not working as it should and observations are still missed with some patients not being seen for 2 hours. I gave the Coroner examples of some Datixes that I had seen. Managers and legal team were there during my evidence. Then I was all over the press.

184. Four days afterwards my Datix access was cut. All the Datixes that used to come through via email from CAMHS have been stopped. I am still employed by the Trust. I am currently on secondment (working remotely on a trust initiative called the 10 Dignity Dos), but I am still the clinical lead for St Aubyn's. I found it strange that four days after I gave evidence in the Coroners' court my access was cut. I made some inquiries, and I found out that there had been a meeting between [I/S] (Director of Specialist Services) and [I/S] (Service Manager) and HR and they decided to cut my access to Datix.

185. I am still receiving the Oxevision reports at midnight every night and I have looked and I can see that there are still missed obs every day on Longview.

## Motivation

186. My motivation for coming forward to give this evidence to the Inquiry is to be listened to and for the Trust to realise that staffing is an issue. They need to listen to what staff are asking for.

187. I was also worried about all the Datixes that had not been looked at. I saw with my own eyes that it was a real problem. When I was asked to just get these done, just get these shut down, I felt like I was being asked to cover it up. I am shocked that it happened in so many services.

188. I also wanted the Inquiry to be aware that the Trust chose to cut my access to Datixes knowing that I was someone who would come forward to speak up if I knew there was a problem.

I believe the facts stated in this witness statement are true.

Signed: [I/S]

Date: 02/12/2025