Witness Name: Adam Benson Clarke
Statement No.: 001
Exhibits: ABC/1 – ABC/12

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THE LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF ADAM BENSON CLARKE

I, **Adam Benson Clarke** of Resuscitation Council UK, First Floor, 60–62 Margaret Street, London, W1W 8TF, will say as follows:

1. I am the Director of Clinical and Service Development of Resuscitation Council UK (registered charity number 1168914). I was appointed to this role in April 2026, having previously held the position of Interim Director of Clinical and Service Development since November 2025, Deputy Director of Clinical and Service Development from June 2023, and previously Courses Manager/Clinical Lead from 2017 to 2023. I am a registered nurse (NMC 06E0784E).

2. I write this statement in response to the letter from the Inquiry dated 23 April 2026 requesting information under Rule 9 of the Inquiry Rules 2006, concerning resuscitation in mental health inpatient units. Where matters are not within my direct knowledge, they are based on organisational records and documents held by Resuscitation Council UK ("**RCUK**").

3. In preparing this statement, RCUK undertook searches of organisational records, including archived and current Quality Standards documents, associated equipment and drug lists, course subcommittee papers, course materials and website publications. Information on current and historic publications relating to resuscitation standards and training in mental health inpatient settings was also obtained through consultation with relevant members of the RCUK's Executive Committee – Dr James Cant (Chief Executive Officer), Professor Gavin Perkins (current President of RCUK) and Professor Jasmeet Soar (past President and lead for the Quality Standard group during their initial publication).

Introduction

4. RCUK is a non-statutory, Charitable Incorporated Organisation dedicated to saving lives by developing guidelines, influencing policy, delivering courses, and supporting innovative research concerning resuscitation practice. RCUK is a global leader in resuscitation for the UK and recognised globally for its contribution to improving the care of critically unwell people, and cultivating a community of healthcare professionals who share our passion for saving lives through evidence-based resuscitation practice. Our guidelines, courses, and quality standards serve as a foundation for their education and practice. RCUK is working towards the day when everyone in the UK possesses the skills needed to save a life.

5. Our core membership comprises clinical and academic experts recognised as international leaders in resuscitation. They play vital leadership roles with the International Liaison Committee on Resuscitation ("**ILCOR**") and the European Resuscitation Council ("**ERC**"), which scrutinise published scientific evidence on an international scale. Our wider membership includes over 15,000 specialist healthcare volunteers who provide training to over 150,000 members of the UK healthcare sector every year to an internationally recognised standard.

6. As the organisation responsible for issuing resuscitation practice guidelines and standards for the healthcare sector throughout the UK, our practice guidelines and standards development process is conducted to the highest standards. Our practice guidelines and standards are developed through extensive processes of reviewing existing and emerging research evidence, both nationally and internationally. The process for development of the guidelines and standards was previously accredited by the National Institute for Health and Care Excellence ("**NICE**") until NICE's accreditation programme ended in 2024; however, RCUK still follows the same development processes in order to maintain transparency and quality.

7. RCUK is committed to improving outcomes for cardiac arrest patients by ensuring that:

   (i) more individuals arrive at hospital with the best chances of survival; and
   (ii) that following our standards and guidelines ensures that they receive proper care during their recovery.

   In parallel with this, we advocate for robust processes to respect the right of individuals who do not want to receive Cardiopulmonary Resuscitation ("**CPR**") if they have a cardiac arrest, so that their wishes are met.

CardiopuImonary Resuscitation (CPR)

8. CPR is used, where appropriate, when a patient has a cardiac arrest, defined by the absence of normal breathing and/or signs of life. Unlike a heart attack (myocardial infarction), where the heart continues to pump, and the individual usually remains conscious, cardiac arrest occurs when the heart stops pumping, and the patient loses consciousness. In adults, cardiac arrest is most commonly due to a primary cardiac (heart) or circulation problem, whereas in children it is more often caused by a respiratory compromise (breathing problems). Cardiac arrest is the ultimate medical emergency, and in the absence of CPR, the patient will not survive.

9. The basis of effective CPR is the combination of administering chest compressions and delivering rescue breaths. This is supplemented in the hospital setting by additional key skills provided by a specific expert team (often called the cardiac arrest / resuscitation team), which will be mobilised to attend the patient when a cardiac arrest call is made. This is an emergency system that, when activated, usually by phone, alerts the cardiac arrest / resuscitation team members of the cardiac arrest and the location to attend. These additional skills include delivering interventions such as advanced airway management, defibrillation (delivering an electrical shock to the heart to restart its normal heart rhythm), and using resuscitation drugs, alongside key leadership skills in managing the cardiac arrest team (where one is present), looking after the patient, and being able to diagnose and treat underlying conditions, which may have caused the cardiac arrest.

10. A larger proportion of cardiac arrests in healthcare settings, including mental health settings, are secondary cardiac arrests. These usually occur in response to a trigger (e.g., from a ligature in a mental health setting), and cardiac arrest occurs at the end of a process that includes loss of consciousness and breathing stopping. These cardiac arrests usually have non-shockable cardiac arrest heart rhythms (i.e. the defibrillator will not work), and survival tends to be poor. The key interventions for this group are therefore related to the prevention of cardiac arrest.

11. The underpinning principles for CPR are consistent across patient groups; however, there are clinically important differences between adults (patients over 18 years of age), children (patients aged 1-18 years) and infants (patients less than 1 year old), including compression-to-ventilation ratios, drug dosing and the role of defibrillation.

12. In adults, chest compression-only CPR may be sufficient in the first instance; however, rescue breaths in addition to chest compressions are particularly important for children

and infants on all occasions. The role of CPR is to buy time until definitive interventions, most likely to save a life, e.g., defibrillation and airway management, can be instigated.

13. National audit data demonstrate that survival following cardiac arrest remains limited. The Out-of-Hospital Cardiac Arrest Outcomes ("**OHCAO**") Registry for out-of-hospital cardiac arrest treated by ambulance services, epidemiology report for England[1] reported adult out-of-hospital cardiac arrest survival to hospital discharge of 9.5% in 2024. National Cardiac Arrest Audit data from in-hospital cardiac arrests treated by a hospital cardiac arrest team report survival to hospital discharge following in-hospital cardiac arrest of approximately 26%.

Resuscitation Council UK Quality Standards Relating to Mental Health Inpatient Care

14. RCUK developed and publish the **Quality Standards for Cardiopulmonary Resuscitation Practice and Training** (the "**Quality Standards**") for healthcare organisations to follow in order to provide a high-quality resuscitation service. The Quality Standards reflect that there are a number of different types of settings where clinical care is provided, and are subdivided into eight sections (separate documents), including the **Quality Standards: Introduction and Overview** and the following seven setting-specific documents:

    - Quality Standards: Acute care
    - Quality Standards: Primary care
    - Quality Standards: Primary dental care
    - Quality Standards: Mental health inpatient care
    - Quality Standards: Community hospitals
    - Quality Standards: CPR and AED training in the community
    - Quality Standards: Survivors

15. The Quality Standards: Introduction and overview was first published in November 2013 [**Exhibit ABC/1**]. The current version of the Quality Standards: Introduction and overview, was last updated in June 2020 [**Exhibit ABC/2**]. Chapter 3 of the Quality Standards: Introduction and overview sets out the nine Core Standards for the provision of CPR that apply in all healthcare settings. Chapter 5 of the Quality Standards: Introduction and overview explains that, where appropriate, each of the separate sections within the specific Quality Standards contains links to implementation tools or examples of good

[1] University of Warwick Clinical Trials Unit, *Out-of-hospital cardiac arrest epidemiological report 2024: England overview* (Version 1.0, 9 September 2025). [Available at: https://warwick.ac.uk/fac/sci/med/research/ctu/trials/ohcao/publications/epidemiologyreports/ohcao_epidemiological_report_2024_england_overview_v1.0_09.09.2025.pdf]

practice, and contains guidance on measures for organisations to use to assess their own adherence to standards. It further explains certain terminology used throughout the Quality Standards, namely that:

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

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

The term 'RECOMMENDS' is used when the consensus is that the standard promotes best practice." [**Exhibit ABC/2**, **pp5-6**].

16. RCUK first published the **Quality Standards: Mental health inpatient care** document in May 2014 [**Exhibit ABC/3].** Alongside which, RCUK published the **Quality Standards: Mental health inpatient care equipment and drug lists** [**Exhibit ABC/4**].

17. The current version of the **Quality Standards: Mental health inpatient care** document was last updated in May 2020 [**Exhibit ABC/5**]. The current version of the associated equipment and drug list was also last updated in May 2020 [**Exhibit ABC/6**]. The "Quality Standards: Mental health inpatient care" document outlines expectations for clinical practice and training, while the accompanying "Quality Standards: Mental health inpatient care equipment and drug lists" specify the minimum resources required to support effective resuscitation. These documents are intended to guide healthcare organisations in delivering high-quality resuscitation services rather than to serve as mandatory regulatory requirements. For ease, I will refer to these two documents collectively as the "**Quality Standards MHIC**".

18. The Quality Standards MHIC set out expectations for CPR practice, governance, training, equipment and medication provision and emergency response arrangements within mental healthcare provider organisations.

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

20. The Quality Standards MHIC provide a framework for CPR practice, training, and resource provision within mental healthcare settings, primarily adult and child mental health inpatient units.

21. As described within Chapter 4 of the current Quality Standards: Introduction and Overview document [**Exhibit ABC/2**], the Quality Standards were developed through a formal working group established by RCUK. Stakeholder organisations nominated individuals to that working group, which included representation from the Royal College of Physicians, Royal College of Anaesthetists, Intensive Care Society, College of Emergency Medicine, Council for Professionals as Resuscitation Officers, Faculty of Intensive Care Medicine, Paediatric Intensive Care Society, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatrics and Child Health, and the Royal College of Psychiatrists.

22. The involvement of the Royal College of Psychiatrists and representation from mental health clinicians ensured that relevant mental health expertise informed development of the Quality Standards MHIC.

23. The working group identified and incorporated existing standards where appropriate, and updated them using a consensus-based approach. Draft versions of the Quality Standards were circulated to contributing organisations for comment and approval, and were also reviewed by the RCUK Patient Advisory Group. The RCUK Patient Advisory Group consisted of patients and relatives who had experienced cardiac arrest, and the group was utilised to provide input to guidance and standard development from the patient perspective.

24. Draft Quality Standards were also published on the RCUK website for a minimum four-week consultation period to invite wider feedback. It has not been possible to identify the precise dates when the consultation period for Quality Standards MHIC ran, but it would have been in late 2013 or early 2014.

25. Feedback from all stakeholders and sources was reviewed by the working group, with responses agreed by consensus prior to finalisation. Final approval of the Quality Standards was given by the working group, with governance oversight provided by the RCUK Executive Committee at the time of publication.

26. At the time of the initial publication of the Quality Standards MHIC in 2014, the finalised documents were also shared directly with relevant stakeholder organisations involved in their development, including the Council for Professionals as Resuscitation Officers ("CPRO") (now disbanded), to support dissemination through relevant professional networks.

27. RCUK did not undertake direct distribution specifically to NHS mental health trusts or private mental health inpatient providers. Dissemination therefore relied principally on publication through the RCUK website and wider professional and stakeholder

communication channels. Today, RCUK has a more formalised communications team, and where we publish updates, we write directly to the respective Royal Colleges to put them on notice of relevant matters. RCUK does not, however, disseminate update information directly to NHS Trusts or private mental health inpatient providers.

28. The Quality Standards do not have a fixed revision cycle. The May 2020 updates to the Quality Standards MHIC principally reflected revisions to references, terminology and supporting material, including alignment with contemporary escalation and early warning scoring practices, rather than substantial changes to the underlying expectations within the standards. The process followed for the 2020 updates involved the establishment of writing groups formed under the RCUK Executive Committee, tasked with reviewing the documents and proposing updates. Given the nature of the revisions, the process for review did not involve the same level of stakeholder engagement as when the quality standards were initially developed. The core expectations under the Quality Standards MHIC have not, therefore, substantively changed within the past seven years.

29. However, all RCUK's Quality Standards, including specifically the Quality Standards MHIC, are now due for review. At the time of preparing this statement, the review process has not yet begun, but is part of the work plan for calendar year 2026. The review will be undertaken through the RCUK's established governance processes, including consideration by the Executive Committee, and will follow a similar methodology as utilised for original development, incorporating expert input, stakeholder engagement, public consultation and formal approval. As the review process has not yet commenced, the timetable for publication of any updated Quality Standards cannot be confirmed at the time of writing this statement.

Expectations within the Quality Standards MHIC

30. The "Quality Standards: Mental health inpatient care" document is subdivided into the following 13 Chapters, each containing the standards, supporting information and supporting tools for a specific aspect of CPR in mental healthcare:

    1. Resuscitation Committee / service structure
    2. Resuscitation Officers
    3. Training staff
    4. Preventing cardiorespiratory arrest
    5. Resuscitation teams and/or responding personnel
    6. Resuscitating children in mental health inpatient units
    7. Resuscitation in special circumstances
    8. Transferring patients

9. Post-cardiac arrest care
10. Resuscitation equipment
11. Decisions relating to cardiopulmonary resuscitation
12. Audit and reporting
13. Research

31. Chapter 14 of Quality Standards Mental health inpatient care is an Appendix containing suggested measures to assess adherence to the different standards set out in the preceding 13 chapters.

32. As detailed within the Quality Standards MHIC, RCUK's recommendations are that NHS Trusts and private organisations providing mental health inpatient care (together the "**Provider Organisations**") should have an organised, governed, and adequately resourced approach to resuscitation. These expectations were and are intended to support Provider Organisations in determining appropriate local arrangements based on service configuration and risk, rather than constituting a mandatory regulatory framework.

33. The Quality Standards MHIC set out that Provider Organisations should have an identified resuscitation service structure with clear terms of reference, board-level accountability, and integration within clinical governance, risk management, quality improvement and education.

34. Under the Quality Standards MHIC, Provider Organisations are expected to designate one person, i.e., a resuscitation officer (or resuscitation lead, resuscitation services manager or equivalent role), to coordinate training, support quality improvement and incident review, and oversee maintenance of clinical equipment. Provider Organisations should also ensure appropriate facilities, training, equipment, administrative support and financial resources are provided to deliver an effective resuscitation service.

35. The Quality Standards MHIC provide that all healthcare staff within Provider Organisations should receive resuscitation training appropriate to their expected clinical responsibilities, including induction and refresher training. The recommended frequency of training for clinical staff is yearly, with the level of training to be informed by local risk assessment and training needs analysis. Training should include recognition and management of physiological deterioration, use of early warning scores, escalation processes, CPR, summoning help and, where appropriate, defibrillation within three minutes of collapse.

36. The Care Quality Commission ("**CQC**") has separately issued a "**Brief guide: Immediate Life Support training for services that may use restrictive interventions**" [**Exhibit ABC/7**] which refers to NICE guidance that recommends any settings where staff are

involved in restrictive interventions (namely, rapid tranquillisation, physical restraint or seclusion), should receive Immediate Life Support ("**ILS**") training as a minimum standard), informed by local risk assessment, patient population and service configuration. The CQC Brief guides are a learning resource for CQC inspectors, which provide information, references, links to professional guidance, legal requirements or recognised best practice guidance about particular topics in order to assist inspection teams. The CQC's "Brief guide: Immediate Life Support training for services that may use restrictive interventions" refers to the recommendations within the RCUK's Quality Standards MHIC.

37. The Quality Standards MHIC also set out recommendations for policies and procedures covering prevention of cardiac arrest, response to collapse or cardiac arrest, special circumstances relevant to mental health inpatient care, transfer to acute services, post-cardiac-arrest care, decisions relating to CPR, and audit and reporting.

38. The special circumstances include ligature, hanging, suffocation, self-harm, seclusion and rapid tranquillisation. Depending on local arrangements, the initial response may be provided by designated responding staff or a locally established resuscitation team while awaiting the arrival of ambulance services and according to the setting. Staff responding prior to the arrival of further help are expected to deliver CPR, use an automated external defibrillator, provide basic airway interventions, and support immediate post-resuscitation care.

39. The Quality Standards MHIC provide that unless a mental health unit is co-located with an acute hospital where an acute hospital resuscitation team is available to respond, a 999 ambulance should be called immediately for a patient who experiences cardiac arrest, in order that they can be safely transferred to an acute hospital for more specialised care [**Exhibit ABC/5, Chapter 8**].

40. The "Quality Standards: Mental health inpatient care equipment and drug lists" [**Exhibit ABC/6**] define minimum requirements for adult and paediatric (child) mental health inpatient settings, including emergency airway equipment, defibrillation capability, emergency drugs, ligature cutters and systems for equipment checking and replacement.

Implementation and Organisational Responsibility

41. RCUK does not routinely liaise directly with NHS Trusts or private providers of mental health inpatient care regarding implementation of the Quality Standards MHIC or RCUK's wider associated guidance documents (e.g., the 2025 Resuscitation Guidelines). Dissemination is primarily achieved through publication on the RCUK website and

communication and feedback through professional networks and stakeholder organisations.

42. RCUK is a non-statutory professional body and is not a regulatory or inspection organisation. It does not mandate, oversee or monitor implementation of the Quality Standards within individual providers.

43. The Quality Standards are intended to support organisations in developing local policies, procedures, training and resourcing arrangements that reflect their own clinical setting, patient population and local risk assessment.

44. RCUK may provide clarification or informal advice where organisations contact RCUK directly to seek guidance on interpretation or local application of the standards. Such engagement is responsive and advisory in nature.

45. RCUK does not maintain a formal central repository of concerns, complaints or implementation reports relating specifically to compliance with the Quality Standards MHIC.

46. Responsibility for implementation therefore rests with individual NHS Trusts and private providers through their own governance arrangements, workforce planning, policies and local risk assessment.

Implementation, Education and Training

47. RCUK does not provide a formal implementation programme or mandatory implementation guidance specifically for the Quality Standards.

48. As a professional and charitable body rather than a statutory regulator or commissioner, RCUK does not direct or oversee implementation within individual organisations.

49. RCUK provides education and training through its nationally recognised resuscitation courses and associated guidance issued to RCUK-registered course centres. These include NHS Trusts, private healthcare organisations and providers of mental health inpatient care. The Immediate Life Support (**ILS**) Course Regulations (April 2021) [**Exhibit ABC/8**] together with the ILS Course materials (November 2025) [**Exhibit ABC/9**] and the Paediatric Immediate Life Support (**PILS**) Course Regulations (December 2019) [**Exhibit ABC/10**] together with the PILS Course materials (November 2025) [**Exhibit ABC/11**] set out the course requirements for accredited training delivery, including standardised course materials and scenarios, instructor eligibility, governance arrangements and assessment processes.

50. Within the ILS training, RCUK has developed mental health-specific ILS course materials and simulation scenarios for healthcare professionals working in mental health inpatient settings. These include scenario-based training content, assessment materials and instructor resources tailored to mental health environments. The materials were developed through the ILS Subcommittee (which is a subcommittee of the RCUK Executive Committee responsible for the development of the ILS training) as part of wider course development activity and were introduced around 2019. For the purposes of this statement, an extract of the minutes of the ILS Subcommittee from 26 February 2019 has been prepared, which sets out the basis for the development of the mental health-specific ILS training [**Exhibit ABC/12**]. Subsequent revisions and updates, including updated instructor guidance, were issued by RCUK in 2021 and 2025. Development of the mental health-specific ILS training involved input from subject matter experts and clinicians experienced in mental health resuscitation training. Use of these materials is dependent on local course centre adoption.

51. The simulation materials are intended for staff who may act as first responders to a deteriorating patient or cardiac arrest in mental health inpatient settings, including doctors, registered mental health nurses and healthcare assistants.

52. The materials focus on recognition of deterioration, initiation of CPR, use of defibrillation where appropriate, escalation of care, and handover to ambulance services or other advanced responders.

53. Instructor guidance recognises that emergency response arrangements vary between organisations and settings and allows scenarios to be adapted to reflect the candidate's workplace and local systems of care.

54. The PILS course is designed to support the recognition and initial management of the seriously ill or deteriorating child prior to the arrival of a paediatric resuscitation team or advanced responders. Although RCUK has not developed equivalent mental health-specific PILS course materials, instructor guidance across all RCUK courses recognises the importance of tailoring training scenarios and discussion to the learners' clinical environment, patient population and local systems of care where appropriate. This may include adapting paediatric scenarios for staff working in child and adolescent mental health settings or other environments where paediatric deterioration and emergency response form part of clinical practice.

Monitoring and Data Collection

55. RCUK does not undertake operational monitoring of individual cardiac arrest events within mental health inpatient wards or other healthcare settings.

56. RCUK does not operate a national reporting, inspection or surveillance system for cardiac arrest events occurring within mental health inpatient wards or other healthcare settings.

57. Responsibility for monitoring, audit, governance and incident review therefore rests with individual Provider Organisations.

58. RCUK supports broader national audit and quality improvement activity relating to cardiac arrest and resuscitation care, including support for the National Cardiac Arrest Audit ("**NCAA**") and the OHCAO Registry. These audits are independently managed and are intended to support benchmarking, quality improvement and research. Neither the NCAA nor the OHCAO Registry are designed specifically to monitor resuscitation activity within standalone mental health inpatient settings (see further, paragraphs 74-75 below).

59. RCUK therefore does not hold comprehensive national data relating to the frequency, characteristics, management or outcomes of resuscitation attempts occurring within mental health inpatient wards.

60. RCUK has not undertaken a national audit, compliance monitoring programme, inspection process or provider-level assurance exercise relating specifically to the implementation of the Quality Standards MHIC within the NHS or private mental healthcare providers, and has therefore not produced specific monitoring reports, compliance datasets or equivalent assurance documentation relevant to the Inquiry's request. RCUK does not have the resources to conduct a formal national audit of that nature.

Adult and Child Mental Health Inpatient Settings

61. RCUK's Quality Standards, resuscitation guidance and educational approach apply across both adult and child mental health inpatient settings.

62. The overarching principles are consistent, including prevention of deterioration, early recognition, timely escalation, effective CPR, defibrillation where appropriate, and safe handover to advanced responders.

63. Differences between adult and child mental health inpatient settings are primarily clinical and operational. Paediatric resuscitation requires differing age-appropriate assessment, paediatric airway and ventilation techniques, appropriately sized equipment, and weight/age-based medication and defibrillation dosing.

64. These differences are reflected in RCUK's paediatric educational provision, including the PILS course [**Exhibit ABC/10** and **ABC/11**].

65. The rationale for these differences lies in the distinct clinical requirements of paediatric resuscitation rather than any difference in the underlying standards.

Further Information Relevant to Risks, Gaps and Areas for Improvement

66. RCUK considers that the principal areas of risk and potential improvement relate less to the content of national resuscitation guidance and more to the variability with which that guidance is implemented, resourced and assured within mental health inpatient services.

67. The Quality Standards MHIC recognise that mental health inpatient settings face specific challenges in delivering resuscitation care, including workforce skill mix, environmental constraints, patient factors and access to advanced emergency response.

68. Some elements of the Quality Standards are intentionally aspirational and require organisations to develop capability and capacity over time rather than assume immediate compliance.

69. In RCUK's view, key areas for organisational focus include:

    - clear governance and accountability for resuscitation services
    - role-appropriate training and refresher provision for staff
    - reliable access to appropriate equipment and medicines
    - robust escalation arrangements where advanced support is not immediately available on site.

70. Effective coordination with ambulance services or acute healthcare providers is particularly important for mental health inpatient units that are geographically remote or not co-located with acute hospitals.

71. Emergency response arrangements in mental health inpatient settings vary depending on geography, staffing models, service configuration and proximity to acute care.

72. This variability increases the importance of structured local risk assessment and implementation approaches adapted to local service configuration, workforce models and geographical considerations.

73. Resuscitation Council UK recommends that the ongoing NHS England review of statutory and mandatory training requirements should consider Immediate Life Support (ILS) training as a minimum standard within inpatient mental health facilities, proportionate to local risk assessment and service configuration.

74. RCUK also notes a limitation in the availability of national data specifically relating to resuscitation events occurring within standalone mental health inpatient environments. Currently, there is no body with a national remit for collating or analysing such data.

75. Existing national cardiac arrest audits were not designed for that purpose, and RCUK does not itself collect or hold setting-specific resuscitation datasets for mental health services. As a consequence, a broader understanding of resuscitation practice and outcomes in these settings is likely to depend on the quality of local reporting, governance, audit and incident review processes.

76. Finally, as noted at paragraph 29 above, RCUK recognises that the Quality Standards MHIC are due for review as part of its standard governance and maintenance processes. A future review provides an opportunity to consider whether the standards remain clear, current and practical for contemporary mental health inpatient services.

Statement of Truth

I believe the content of this statement to be true.

Signed: **[I/S]**

Adam Benson Clarke

Dated: 04 June 2026