Witness Name: Adam Benson Clarke
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Exhibits: ABC/1 – ABC/26

Dated: 22 June 2026

THE LAMPARD INQUIRY

SECOND 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. For the purposes of this statement, references to RCUK's "core membership" means a group of approximately 23 individual clinical and academic experts, rather than RCUK's wider instructor and volunteer community. RCUK can confirm that this core membership group does not currently nor previously include any qualified psychiatrists, psychologists or mental health nurses, nor anyone whose principal role is within inpatient mental health services in the UK. RCUK can also confirm that it is not aware of any member of this core membership group whose principal employment is with a Trust or provider of mental health inpatient services in Essex.

6. 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. RCUK maintains a register of its membership, including its instructors and the wider specialist healthcare volunteer community. At the time of preparing this statement, RCUK does not collect structured demographic or professional qualification data in a way that would enable RCUK to reliably identify how many of its membership who are volunteers are qualified psychiatrists, psychologists or mental health nurses. Similarly, from the data RCUK collects, it is not possible to identify how many of its membership who are volunteers work in an inpatient mental health care setting. As part of its register of membership RCUK does not collect structured employer data in such a way that would allow it to reliably state how many of its membership who are volunteers work for Essex Partnership University NHS Foundation Trust (**EPUT**), North East London NHS Foundation Trust (**NELFT**), Cygnet Group, St Andrew's Healthcare or The Priory Group. Individual members may choose to provide an employer or organisational address rather than a home address, but this information is not

mandated or verified by RCUK, and therefore cannot be relied upon to produce accurate figures for the purposes of this statement. RCUK is currently reviewing this dataset to include this information. It is anticipated that future demographic data collection will allow individuals to identify whether they work in a mental health hospital and whether they are a mental health nurse, psychologist, psychotherapist, or other healthcare professional.

7. 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.

8. 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.

Cardiopulmonary Resuscitation (CPR)

9. 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 respiratory compromise (breathing problems), which can deteriorate into cardiac arrest. Cardiac arrest is the ultimate medical emergency, and in the absence of CPR and defibrillation (where needed), the patient will not survive.

10. 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.

11. A larger proportion of cardiac arrests in healthcare settings, including mental health settings, are secondary cardiac arrests. These usually occur in response to a preceding clinical event or trigger such as low oxygen levels (hypoxia), airway obstruction, overdose, severe physical deterioration, or ligature-related asphyxia. In these circumstances, cardiac arrest occurs at the end of a process that includes deterioration, loss of consciousness and breathing stopping. These cardiac arrests usually have non-shockable cardiac arrest heart rhythms (i.e., defibrillation is not indicated unless the heart rhythm is shockable), and survival tends to be poor. For example, if an individual has a cardiac arrest secondary to low oxygen levels (hypoxia), the key treatment would be to manage the individual's airway and provide high-concentration and high-flow oxygen, by providing artificial ventilation along with CPR. Management of a cardiac arrest should follow the standardised advanced life support algorithms, depending on whether the individual is a child or an adult [**Exhibit ABC/13**, **Exhibit ABC/14**].

12. Initial rescuers should provide treatment to the level of their training while urgently summoning appropriate expert help, such as a cardiac arrest team, ambulance clinicians or other staff trained in advanced resuscitation skills. The key interventions for this emergency response group, therefore, include both prevention of cardiac arrest and effective resuscitation where cardiac arrest has occurred. Preventive interventions in mental health inpatient settings may include measures to reduce ligature risk, recognition and prompt management of airway or breathing compromise, monitoring and escalation of deteriorating vital signs, use of an early warning score where applicable, management of overdose or intoxication, and early transfer or escalation to acute medical services. Any delay in calling for help is equally relevant in both primary and secondary cardiac arrest. In circumstances where it is possible secondary cardiac arrest may occur, early escalation is particularly important because there may be an opportunity to identify deterioration and intervene before cardiac arrest occurs.

13. 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.

14. 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.

15. 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

16. 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

17. The Quality Standards: Introduction and overview was first published in November 2013 [**Exhibit ABC/1**]. At the point of publication, the **Quality Standards: Mental health inpatient care** [**Exhibit ABC/3**] and **Quality Standards: Mental health inpatient care equipment and drug lists** [**Exhibit ABC/4**] were still in development and subsequently published in May 2014. The current version of the Quality Standards: Introduction and

[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]

overview, was last updated in June 2020 [**Exhibit ABC/2**]. As is stated in the Quality Standards: Introduction and overview, the Royal College of Psychiatrists was one of the organisations which contributed to the Introduction and Overview, and was represented by Dr Richard Williams as a member of the Working Group. The updated version from June 2020 [**Exhibit ABC/2**] records that the Royal College of Psychiatrists was the organisation that contributed to the Mental Health standards.

18. The Quality Standards: Introduction and overview document sets out nine Core Standards for the provision of CPR across healthcare settings. These Core Standards reflected the UK national resuscitation guidelines in place at the time [**Exhibit ABC/15**], including the principles of early recognition of deterioration, summoning help, immediate CPR, timely defibrillation (where indicated), post-resuscitation care, staff training, CPR decision-making and access to appropriate equipment. They were not, in substance, wholly new in November 2013; rather, they presented existing guideline-based principles as a single set of Core Standards applying across healthcare settings. For the purposes of preparing this statement, RCUK has not identified a separate record setting out an individual justification for each Core Standard. The nine Core Standards remain part of the current **Quality Standards: Introduction and overview [Exhibit ABC/2]**.

19. RCUK has not identified any substantive changes between **[Exhibit ABC/1]**, published in November 2013, and **[Exhibit ABC/2]**, published in June 2020. The purpose of the document, the development approach, and the nine Core Standards remained materially unchanged. The changes were principally minor updates and presentational, including updated organisational naming and formatting, and updating the reference from the 2010 to the 2015 Resuscitation Guidelines.

20. 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 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**].

21. The **Quality Standards: Mental health inpatient care** document was first published by RCUK in May 2014 [**Exhibit ABC/3**]. This was the first time that formalised national standards from RCUK had been published in respect of mental health inpatient care specifically. Alongside which, RCUK published the **Quality Standards: Mental health inpatient care equipment and drug lists** [**Exhibit ABC/4**].

22. 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**".

23. 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.

24. 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.

25. RCUK is not aware of any organisation that undertakes a formal accreditation process specifically for the implementation of RCUK's Quality Standards MHIC. RCUK understands that formal regulatory oversight of mental health inpatient providers in England sits principally with the Care Quality Commission ("**CQC**"), as the independent regulator of health and social care services. The CQC may have regard to recognised professional guidance, including RCUK's Quality Standards, when assessing whether providers have safe and effective systems in place. RCUK does not direct the CQC's inspection methodology and does not receive routine provider-level assurance information about implementation of RCUK Quality Standards.

26. Responsibility for implementing and assuring compliance with RCUK's Quality Standards rests with provider organisations through their own governance, clinical risk, training, audit and assurance arrangements. RCUK also recognises the role of the Health Services

Safety Investigations Body ("**HSSIB**"), formerly the Healthcare Safety Investigation Branch, in undertaking independent patient safety investigations. However, HSSIB does not operate a compliance, accreditation or assurance process for RCUK's Quality Standards; its role is to investigate patient safety concerns and identify system learning.

27. 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.

28. 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.

29. Dr Richard Williams of the Royal College of Psychiatrists is the named working group member identified in the Quality Standards documentation as providing Royal College of Psychiatrists representation. RCUK has not identified a record confirming that any other named psychiatrist, psychologist or mental health nurse was a formal member of the working group that developed the Quality Standards MHIC.

30. RCUK has, however, identified consultation feedback received during development of the Quality Standards MHIC from individuals associated with mental health provider organisations and resuscitation services supporting mental health settings. RCUK's consultation was also circulated through relevant professional networks, including the Council for Professionals as Resuscitation Officers ("**CPRO**") (now disbanded), which included resuscitation officers and practitioners working in mental health environments. RCUK cannot confirm from the records currently available whether all individuals who provided feedback were mental health clinicians by professional background.

31. The "working group" referred to above is the working group whose members are listed in **Exhibit ABC/1** and **Exhibit ABC/2**. RCUK has not identified a separate or different working group membership list for the development of the Quality Standards MHIC.

32. The RCUK Patient Advisory Group comprised individuals who had either experienced a cardiac arrest themselves or had been affected by the cardiac arrest of a relative or loved one. RCUK has not identified records indicating whether any member of the Patient

Advisory Group had experience of cardiac arrest specifically within a mental health inpatient setting.

33. The involvement of the Royal College of Psychiatrists, together with consultation feedback from individuals associated with mental health provider organisations and resuscitation services supporting mental health settings, provided relevant mental health input into the development of the Quality Standards MHIC.

34. 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 to allow a patient perspective for the Quality Standards.

35. 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.

36. 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.

37. 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 CPRO, to support dissemination through relevant professional networks.

38. 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.

39. 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 reviewing under RCUK's Executive Committee governance arrangements by individuals supporting the Quality Standards workstream. RCUK has not identified a record confirming the individual membership of the writing group involved in the 2020 updates to the Quality Standards MHIC. Given the nature of the revisions, the process for review did not involve the same level of stakeholder engagement as when the Quality Standards MHIC were initially developed. The core expectations under the Quality Standards MHIC have not, therefore, substantively changed within the past seven years.

40. In respect of Quality Standards MHIC drug and equipment list document, as published in 2014 [**Exhibits ABC/4**] and the updated version published in 2020 [**Exhibit ABC/6**], RCUK confirms that the substantive changes between the 2014 and 2020 versions included the addition of a requirement to have a laryngoscope (a tool used to help visualise the back of the throat to the vocal cords), alongside Magill forceps (a tool used to help place breathing tubes or remove objects blocking the throat), to the adult and child mental health inpatient care airway and breathing equipment lists. In the 2014 version of the document [**Exhibit ABC/4**], Magill forceps were listed, but a laryngoscope was not separately specified. The addition in the 2020 version of the document was made to support the management of airway obstruction, including circumstances in which a patient may have deliberately obstructed their own airway. A laryngoscope can assist appropriately trained staff to visualise the upper airway and, where clinically appropriate, support the removal of an obstruction using Magill forceps. Both the laryngoscope and the Magill forceps are items of equipment which are listed as "*immediate*" in terms of their suggested availability, but the 'comments' record that their use remains dependent upon local policy and staff training [Exhibit ABC/6, p5 and p16].

41. RCUK also confirms that the 2020 version of the Quality Standards MHIC drug and equipment list document added, in respect of child (paediatric) mental health inpatient care, "*Access to algorithms, emergency drug doses, paediatric drug dose calculators (e.g. Broselow tape)*." [**Exhibit ABC/6, p20**]. This was added because paediatric resuscitation differs from adult resuscitation due to age and weight-related equipment sizing and drug dosing. These factors can be complex, particularly in time-critical and stressful emergencies. Algorithms and dose calculation tools are intended to support safe and timely decision-making, reduce cognitive load, and assist staff in identifying appropriate equipment sizes and drug doses.

42. The 2020 updates within **Exhibit ABC/6** also added notes in both the adult and child (paediatric) sections concerning the storage of resuscitation drugs. This reflected concerns that had arisen following advice given by CQC inspectors that drugs on

resuscitation trolleys should be locked away to prevent tampering. RCUK's position (alongside the Royal Pharmaceutical Society of Great Britain) was that emergency resuscitation drugs and equipment required for immediate use should not be made inaccessible in such a way that could delay emergency treatment. The additions made to the 2020 version of the drug and equipment list [**Exhibit ABC/6**] were intended to make clear that organisations should undertake a local risk assessment when deciding how and where to store emergency drugs. That such risk assessments should balance the risk of access to drugs by patients or visitors against the risk of delay in accessing emergency drugs during a cardiac arrest or other emergency.

43. Neither the 2014 nor 2020 version of the drug and equipment lists [**Exhibit ABC/4** and **Exhibit ABC/6** respectively] mandates that a mobile telephone must be available on mental health inpatient wards as a means for calling for help. However, both versions of the document do require all settings to have a means of calling for help, giving examples such as a landline telephone, a mobile telephone with a reliable signal, or an alarm bell. The standards were not drafted to prescribe a single method of communication because RCUK considers the appropriate method will depend on a range of factors including, for example, the local environment, the physical layout of the ward, staff response model, availability of internal emergency systems, telephone infrastructure, mobile signal, patient population, security arrangements and local risk assessment.

44. RCUK does not consider it appropriate to mandate that every mental health ward must have a mobile telephone for that purpose. The routine availability and use of mobile telephones in mental health inpatient environments may introduce additional risks, including risks relating to patient safety, security and privacy. Those risks, and the benefits of mobile communication, are matters which RCUK considers fall for determination by the organisation based on local risk assessment.

45. RCUK would expect provider organisations to have clear, reliable and tested procedures for summoning emergency help, including calling 999 when required. Those procedures are expected to enable staff to provide accurate information to ambulance control without avoidable delay, while ensuring that the method of communication does not introduce unnecessary risk to patients, staff or others. The appropriate communication arrangements should therefore be determined locally, based on risk assessment, service configuration and the practical arrangements required to support an effective emergency response.

46. 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

47. 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

48. 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.

49. 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.

50. 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.

51. 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.

52. 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.

53. The Quality Standards MHIC further provide that mental healthcare organisations should have a clear policy requiring staff to respond to "calling criteria" or early warning systems, described in the document as a "track and trigger" system [**Exhibit ABC/3**]. A "track and trigger" system is a way of recording and scoring a patient's physical observations, such as respiratory rate (breathing rate), oxygen saturation (oxygen level in the blood), pulse rate, blood pressure, temperature, and level of consciousness (how responsive the patient is). The purpose is to help staff identify when a patient is becoming physically unwell or deteriorating. An abnormal score in one observation, or a high total score across several observations, should trigger a clear response. Depending on the patient's condition, this response may range from repeating observations more frequently to urgent review by a nurse or doctor, calling an internal emergency response, or calling an ambulance. The Quality Standards MHIC as published in 2014 [**Exhibit ABC/3**] states that the policy should set out the responsibilities of nursing staff and onsite or on-call doctors, and include when the ambulance service should be called. It also refers to the recommendation of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) that when patients continue to deteriorate after reviews that are not conducted by consultants, there should be escalation of patient care to senior doctors who specialise in acute physical healthcare, and that if a decision is made not to escalate care, the reasons should be clearly recorded in the patient's clinical notes.

54. RCUK cannot confirm when the "track and trigger" policy was first introduced on mental health inpatient wards, nor can RCUK confirm when individual providers of mental health inpatient care first adopted a "track and trigger" policy as part of their internal policies. RCUK is not a statutory or regulatory body and does not hold provider-level implementation records, nor does it monitor or assure the adoption of local policies within individual organisations. Early warning scoring systems were established in wider NHS practice before the Quality Standards MHIC [**Exhibit ABC/3**] were first published. The Royal College of Physicians first produced the National Early Warning Score (NEWS) in 2012. In February 2018, following the publication of NEWS2, the Royal College of Physicians reported that NEWS2 had received formal endorsement from NHS England and NHS Improvement to become the early warning system for identifying acutely ill patients in hospitals in England[2]. The Quality Standards MHIC [**Exhibit ABC/3**], published in May 2014, applied the same broad principle to mental health inpatient care by requiring organisations to have systems for monitoring vital signs, an early warning scoring system, patient charts that enabled regular recording of early warning scores, and a clear escalation protocol for responding to deteriorating patients.

55. RCUK would therefore have expected providers of mental health inpatient care to consider and implement appropriate local arrangements from the point at which The Quality Standards MHIC [**Exhibit ABC/3**] was published in May 2014, taking account of their own service configuration and access to acute medical or ambulance support. While RCUK did not prescribe a fixed implementation date the Quality Standards MHIC [**Exhibit ABC/3**] states that an early warning scoring system "*must be in place*", and that Provider Organisations "*must*" have a charting system to support the recording of early warning scores, and that they "*must*" have a clear escalation protocol for responding to deteriorating patients.

56. The Inquiry has asked about a change to the drafting of the suggested example measures in pages 28-30 of the Appendix to 2014 published version of the Quality Standards MHIC [**Exhibit ABC/3**] when compared with pages 28-29 of the updated Quality Standards MHIC in 2020 [**Exhibit ABC/5**]. For the purposes of responding to the Inquiry's questions and the preparation of this statement, RCUK has not been able to identify a record explaining the specific reason why the reference to "*course content, lesson plans*" was removed from the suggested example measures to monitor certain parts of the standards in the updated 2020 version of the Quality Standards MHIC [**Exhibit ABC/5**]. This change

[2] Royal College of Physicians, *NHS England approves use of National Early Warning Score (NEWS) 2 to improve detection of acutely ill patients* (5 February 2018). Available at: https://www.rcp.ac.uk/news-and-media/news-and-opinion/nhs-england-approves-use-of-national-early-warning-score-news-2-to-improve-detection-of-acutely-ill-patients/

is understood to have been an editorial change to the Appendix, rather than a change to the underlying training standards. In the 2014 published Quality Standards MHIC, "*course content*" and "*lesson plans*" were listed as possible example measures for assessing adherence to certain training standards [**Exhibit ABC/3**]. In the updated Quality Standards MHIC, published in 2020, that specific wording was removed, but the Appendix continued to identify other measures for assessing training standards, including the resuscitation policy, induction programme, training records, training matrix, and competency documents [**Exhibit ABC/5**]. The underlying standards continued to require staff training at induction and regular intervals, role-appropriate training, training in the use of early warning scoring and escalation systems, training in recognising and managing deterioration, and recording of all training.

57. RCUK would agree that, in broad terms, there were no substantive changes between the Quality Standards MHIC published in May 2014 [**Exhibit ABC/3**], and the Quality Standards MHIC published in May 2020 [**Exhibit ABC/5**]. The 2020 version retained the same overall structure and materially the same standards across the document. The amendments were principally editorial and presentational, including updates to terminology, formatting, supporting information, web links, references and the suggested example measures in the Appendix. RCUK does not consider those changes to have altered the substance of the standards or the expectations placed on those providing mental health inpatient care.

58. The reference at page 2 of the Quality Standards MHIC published in 2020 [**Exhibit ABC/5**] to training selected staff "*to a higher standard than is required generally*" is intended to recognise that some mental healthcare organisations may need particular staff to have more advanced resuscitation knowledge and skills than the general staff group. The specific standard of training is not prescribed but should be determined locally, based on the organisation's patient population, service configuration, staffing model and access to acute medical or ambulance support. In practice, this may include Advanced Life Support (ALS) training, or the appropriate paediatric equivalent, for suitably qualified staff. The 2020 Quality Standards MHIC [**Exhibit ABC/5**] state that, ideally, the role of team leader in a resuscitation team should be undertaken by a current Advanced Life Support provider or someone with equivalent training, and that Immediate Life Support providers may lead while waiting for more skilled help to arrive. For units caring for children and young adolescents, the 2020 Quality Standards MHIC states that the team leader must have equivalent paediatric life support provider status. The 2020 Quality Standards MHIC also state that Resuscitation Officers should hold a current Advanced Life Support provider certificate, or equivalent, as a minimum standard, with Advanced Life Support Instructor status recommended [**Exhibit ABC/5**].

59. Where an organisation does not arrange for selected staff to be trained to a higher standard, RCUK would expect that organisation to have alternative arrangements in place to ensure that the necessary actions and cascade training can still be delivered safely. This may include using appropriately qualified internal or external trainers, or making arrangements with nearby acute healthcare services training organisations. Where a higher level of training is identified as necessary through local risk assessment or training needs analysis, RCUK would expect this to be reflected in the organisation's training plan [**Exhibit ABC/5**].

60. In Section 3 of the 2020 Quality Standards MHIC, which provides the standards for Training Staff, the terms "*healthcare staff*", "*clinical staff*", "*staff who care for patients in any mental health inpatient setting*", and "*medical, nursing and other clinical staff*" are used to describe staff with patient-facing clinical care responsibilities [**Exhibit ABC/5, pp9-13**]. These terms are not intended to create separate or mutually exclusive categories. Healthcare assistants may fall within these terms where their role includes patient-facing clinical care responsibilities or an expected response in a clinical emergency. The exception is where the standards refer to "*non-clinical staff*", which specifically refers to staff without clinical care responsibilities, such as administrative staff.

61. Standard 5 within Section 3 provides that the RCUK Immediate Life Support (ILS) course is the recommended minimum standard for staff who deliver or are involved in rapid tranquillisation, physical restraint and seclusion. RCUK would expect this to primarily apply to registered clinical staff, such as nurses and doctors, who are responsible for delivering or overseeing those interventions. However, RCUK recognises that this could also apply to healthcare assistants where their role includes involvement in those interventions, or where they are expected to provide a defined clinical response. However, RCUK considers that this should be determined locally through the organisation's training needs analysis and risk assessment.

62. The same role-based approach applies to Standard 18. Where healthcare assistants are expected to be involved in responding to special circumstances, such as children of all ages who have collapsed, patients who are secluded, subject to restraint, or who have suffered blood loss, RCUK considers they should receive training appropriate to responding to those special circumstances in the same way as is required for other medical, nursing and other clinical staff in the relevant specialities.

63. In respect of Standard 19, RCUK would expect healthcare assistants working on mental health inpatient wards to receive training in recognising, monitoring and escalating concerns about deteriorating patients, appropriate to their responsibilities.

64. RCUK does not expect all healthcare assistants working on mental health wards to have Immediate Life Support (ILS) training as a blanket requirement. Healthcare assistants can access ILS training where this is needed and appropriate for their specific role and organisational need; this decision remains with the organisation and should be informed by local risk assessment and training needs analysis.

65. In Section 4, Preventing cardiorespiratory arrest, Standard 2 provides that the organisation must have an education programme for ward staff and responding clinical personnel that is focused on preventing patients' deterioration. The term "*ward staff*" means staff working on the mental health inpatient ward who may be involved in observing, monitoring, caring for, or escalating concerns about patients. This may include registered nurses, healthcare assistants and other patient-facing staff, depending on their role. The term "*Responding clinical personnel*" means clinicians who may be called to assess or respond to a deteriorating patient, which RCUK considers would include senior nurses, doctors, resuscitation or emergency response team members, or other staff identified in local escalation arrangements. The standard therefore applies to staff whose role includes recognising, escalating or responding to patient deterioration [**Exhibit ABC/5, pp13-14**].

66. In Section 5, Resuscitation teams and/or responding personnel, Standard 4 refers to the minimum skills required for "*the staff who respond immediately*". This refers to the ward staff or other locally designated staff who are expected to provide the initial resuscitation response to a patient who has collapsed or is in cardiorespiratory arrest, before the arrival of the cardiac arrest team, ambulance clinicians or other staff trained in advanced resuscitation skills. This typically includes ward-based nurses, doctors, and, where appropriate, healthcare assistants, depending on their role, competence and local response arrangements [**Exhibit ABC/5, pp16**].

67. In Section 5, Standard 6 states that there should be a protocol in place for arranging transfers between identified units and acute hospitals where patients require ongoing acute medical care and resuscitation, and that "*the protocol is tested periodically as a rehearsal and adjusted as necessary."* A "*rehearsal*" in this context refers to testing the local transfer protocol in practice, for example, through a simulation, tabletop exercise, scenario-based drill, or joint exercise with the ambulance service or receiving acute hospital. The purpose of the rehearsal is to check that the arrangements are workable, understood by staff, and capable of supporting safe transfer of the patient. Standard 6 does not prescribe a fixed frequency for what "*periodically*" should mean in this context. RCUK considers the frequency should be determined locally, taking account of risk,

service configuration, previous incidents, changes in staffing or pathways, and learning from exercises or real transfers [**Exhibit ABC/5, pp15-16**].

68. In Section 5, Standard 10 provides that the organisation must ensure that the resuscitation team or designated responding staff are activated within 30 seconds of the call for help, and that a *"daily test call is recommended as a minimum*". The statement that a daily test call (of the emergency activation system) is "*recommended as a minimum*" denotes best practice rather than an obligatory "must" standard [**Exhibit ABC/5, p17**]. However, where an organisation relies on a call system to summon a resuscitation team, or designated responding staff, RCUK would expect the organisation to have a reliable system in place for testing that call system, monitoring failures, contingency planning and taking prompt remedial action.

69. Section 7, Resuscitation in special circumstances, [**Exhibit ABC/5, p20**] states that organisations must have policies and procedures in place for resuscitation in special circumstances, including for example, blood loss due to trauma, suffocation, application of a ligature to the neck and hanging, self-harm, seclusion and rapid tranquillisation. This standard requires organisations to identify circumstances in which resuscitation may need to be adapted to the patient or clinical situation and to plan accordingly. The Quality Standards MHIC do not set out detailed specific guidance for each example of special circumstance identified, because they are intended to set organisational expectations for local policy, training, equipment and escalation, rather than reproduce detailed clinical guidance. The supporting information listed in relation to Section 7 refers to wider clinical and medical special circumstances, including the European Resuscitation Council Guidelines for Resuscitation 3025, section 4, which provides guidance on cardiac arrest in special circumstances [**Exhibit ABC/16**]. This guidance includes circumstances such as maternal collapse, asthma and trauma, which may be relevant depending on the inpatient population and local risks of a specific organisation. Some special circumstances may require support from staff or teams with Advanced Life Support (ALS) skills, additional specialist knowledge, or urgent escalation to ambulance or acute hospital services.

70. 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.

71. The Quality Standards MHIC also set out recommendations for policies and procedures covering prevention of cardiac arrest, rapid 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.

72. 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.

73. 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**].

74. 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

75. 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.

76. 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.

77. 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.

78. 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.

79. RCUK does not maintain a formal central repository of concerns, complaints or implementation reports relating specifically to compliance with the Quality Standards MHIC. Communications to RCUK may be received by telephone, email or through RCUK's support system. Telephone calls are not routinely logged in a way that allows retrospective review. Clinical enquiries may also be sent via email to RCUK's generic Clinical Leads inbox. For the purposes of preparing this statement, RCUK has not identified archived emails from EPUT, NELFT, The Priory Group, Cygnet Group or St Andrew's Healthcare seeking clarification or informal advice about the Quality Standards MHIC. RCUK has identified a small number of relevant support system records from EPUT, The Priory Group and Cygnet Group. From review of these records for the purposes of this statement, these were not enquiries specifically about the interpretation or implementation of the Quality Standards MHIC, but they did relate to resuscitation, CPR decision-making, ReSPECT, choking management or emergency response. Where the enquiry related to a site outside Essex, this is identified below.

80. In relation to EPUT, RCUK has identified one support system enquiry dated 30 January 2023. The enquiry concerned clarification of the RCUK guidance relating to the use of pocket masks and mouth shields in mental health settings, with the enquirer noting that pocket masks appeared in the equipment list section of the Quality Standards MHIC. The record notes the advice given on this occasion was that mouth-to-mask ventilation was no longer recommended for clinical settings and that each organisation should undertake a local risk assessment to determine suitable equipment, taking account of staff training, staff willingness to use the equipment, available staff and local risks. In response to a follow up question that the position was the same for mouth shields, it was confirmed that the same general approach applied to mouth shields [**Exhibit ABC/17**]. The advice given here reflected the position at the time, following the COVID-19 pandemic, when guidance had been adapted due to the potential risk of infection transmission from rescue breaths

and face-to-face ventilation. Since then, the Quality Standards MHIC have remained as published.

81. In relation to Cygnet Group, RCUK has identified one Essex-based enquiry. On 10 February 2023, Cygnet Healthcare Colchester asked how to register interest in ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) training. In response, RCUK provided a link to the ReSPECT e-learning module [**Exhibit ABC/18**].

82. RCUK has also identified further Cygnet Group enquiries that were group-level or not specific to an Essex site. These included a February 2023 request for a copy of the ReSPECT plan for inclusion in Cygnet policies and procedures [**Exhibit ABC/24**]. In January 2024, an enquiry was received concerning choking management in obese and wheelchair-bound patients to which RCUK responded with advice and guidance [**Exhibit ABC/19**]. In October 2024, a request was made for an urgent discussion with a clinical advisor about emergency equipment at an incident, ligature rescue and resuscitation in specific circumstances. The October 2024 support record confirms that an RCUK Clinical Lead spoke with Cygnet Healthcare, but it does not contain a detailed note of the advice that was provided [**Exhibit ABC/20**].

83. In relation to The Priory Group, RCUK identified two support system enquiries, both relating to sites outside Essex. In March 2023, The Priory Hospital Hemel Hempstead asked whether the ReSPECT process had been established in the locality, and RCUK responded that it had not [**Exhibit ABC/25**]. In September 2023, Kneesworth House Hospital asked whether a ReSPECT form could be completed where a patient had refused a DNACPR decision. RCUK advised that ReSPECT is not a DNACPR form, but records personalised recommendations for emergency care and treatment, including a recommendation about CPR, and must be developed through appropriate conversation with the patient and clinician, or, where the patient lacks capacity, with the appropriate legal proxy, family member or person close to them [**Exhibit ABC/26**].

84. Within the support system records reviewed for the purposes of this statement, RCUK has not identified equivalent enquiries from NELFT or St Andrew's Healthcare. RCUK cannot exclude the possibility of other telephone contact, for the reasons explained above.

85. Patients, families or members of a patient's support network may also contact RCUK to raise concerns or ask questions about resuscitation practice, CPR decisions or related guidance. RCUK will generally offer to listen to the concern and provide general information about applicable guidance or good practice where it is able to do so.

86. Where a concern relates to an individual patient's care or treatment, RCUK makes clear that it is unable to comment on the specific case. This is because RCUK is not in

possession of the full clinical information, including the views of the clinicians involved, the relevant clinical records, or the local policies in place. RCUK cannot and would not, as it is not its role to do so, determine whether care provided by a particular organisation was appropriate or not.

87. In those circumstances, RCUK will signpost the individual to the organisation responsible for that care. This may include advising them to speak with the relevant GP, hospital clinical team, the organisation's complaints process or Patient Advice and Liaison Service, as appropriate. RCUK may also provide general information about relevant resuscitation guidance, CPR decision-making principles or best practice, but this is advisory only and not a case-specific clinical opinion.

88. Concerns or enquiries of this nature are not routinely recorded in a formal central repository and are not systematically monitored by RCUK as complaints or incidents. RCUK does not have a regulatory, investigatory or inspection role in relation to healthcare providers.

Implementation, Education and Training

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

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

91. 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.

92. 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.

93. 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.

94. The reference to "*ABC*" in the action recorded in the extract of the ILS Subcommittee produced at **Exhibit ABC/12** is a reference to me, Adam Benson Clarke. Following the February 2019 ILS Subcommittee meeting, the draft mental health ILS scenarios were piloted at existing mental health trust-based ILS course centres: North West Boroughs Healthcare NHS Foundation Trust, Oxford Health NHS Trust, and South London and Maudsley NHS Trust. RCUK has not identified a separate record setting out formal selection criteria for these locations, but the centres were existing mental health trust-based course centres with relevant experience of delivering ILS in mental health inpatient settings. The pilot was not conducted by EPUT or NELFT.

95. The outcome of the pilot was reported to the ILS Subcommittee on 15 July 2019. For the purposes of this statement, an extract of the minutes of the ILS Subcommittee from 15 July 2019 has been prepared [**Exhibit ABC/21**]. The minutes record that the pilot went well and that positive feedback was received. The subcommittee considered, but did not adopt, suggestions to reintroduce ECG/cardiac arrest heart rhythms into the scenarios, add a sepsis scenario, or remove the ligature scenario. The subcommittee considered the ligature scenario important and approved the scenarios without amendment. As is recorded in the minutes as the action arising from this item, the scenarios were then to be uploaded to the RCUK learning management system (LMS) and notified to course centres.

96. In relation to external validation of mental health course centres, no separate mental-health-specific process was adopted. The position aligned with existing ILS course centre requirements, including appropriate faculty, equipment and course delivery arrangements. Centres required access to a current RCUK Advanced Life Support (ALS) instructor to act as Course Director. ILS instructors, including those from mental health inpatient services, could form part of the faculty where they met the relevant instructor

criteria. Many mental health organisations also used private training providers registered as ILS course centres.

97. A consensus was not reached to allow experienced ILS instructors, who were not ALS instructors, to act as Course Directors for ILS courses in mental health trusts. The position remained that all ILS courses require a current ALS Instructor as Course Director, with ILS instructors able to form part of the wider faculty. This was consistent with the wider ILS course regulations and was not changed specifically for mental health trusts. The relevant subcommittees of RCUK are currently reconsidering the issue of ILS and PILS instructors acting as Course Directors.

98. In relation to the subject matter experts and clinicians referred to above, RCUK can confirm that none of those identified as contributing through the ILS Subcommittee worked for EPUT or NELFT.

99. The development of the mental health-specific ILS training was undertaken through the ILS Subcommittee. RCUK has identified the relevant Subcommittee membership as follows:

- Joyce Yeung, ILS Chair and Associate Clinical Professor in Anaesthesia and Critical Care, University of Warwick;
- [I/S] Educator and Senior Resuscitation Officer, University Hospitals Oxford NHS Trust;
- Joanna Lawrence, private provider representative and CEO of Back to Life Ltd;
- [I/S] retired Resuscitation Officer, Belfast Health and Social Care Trust;
- [I/S] trainee representative, ST6 Critical Care and Anaesthesia, Oxford;
- [I/S] community representative and Resuscitation Officer, Torbay Hospitals NHS Trust;
- Isabelle Hamilton-Bower, Clinical Lead, RCUK;
- Adam Benson Clarke, Clinical Lead, RCUK;
- Sue Hampshire, Director of Clinical and Service Development, RCUK;
- [I/S] ILS Course Coordinator, RCUK;

- [I/S] Advanced Critical Care Practitioner, University Hospitals Birmingham; and
- [I/S] Resuscitation Officer, Surrey and Sussex NHS Trust.

100. RCUK knew that [I/S] and Joanna Lawrence had experience of working with, or providing training to, mental health institutions. RCUK has not identified a separate list of additional subject matter experts or clinicians outside the ILS Subcommittee who contributed to the development of the mental health-specific ILS materials.

101. The course 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.

102. The ILS Course materials (November 2025) [**Exhibit ABC/9**] was not the first version of the ILS course materials to contain mental-health-specific scenarios. It was the third iteration of those materials.

103. Mental-health-specific ILS course materials were first developed and introduced in 2019. The development of those materials was informed by the 2015 national resuscitation guidelines. The materials were subsequently reviewed and updated following the 2021 national resuscitation guideline update, and were reviewed and updated again for the 2025 national resuscitation guideline update. **Exhibit ABC/9** is the November 2025 version of those materials.

104. The airway assessment element within the materials is dated 2016. This reflects the version of the ILS airway assessment material that was in use following publication of the 2015 guideline-based course materials. The format and delivery of the airway assessment did not change as part of the mental-health-specific scenario development, and therefore, that element retained its existing date.

105. Earlier versions of the mental-health-specific ILS course materials from 2019 and 2021 are provided as [**Exhibit ABC/22**] and [**Exhibit ABC/23**], respectively.

106. RCUK has not undertaken a formal assurance exercise to map the November 2025 mental-health-specific ILS training materials against every special circumstance listed in the Quality Standards MHIC document as updated in May 2020 [**Exhibit ABC/5**]. However, RCUK considers that the materials are appropriate for the intended purpose and scope of the ILS course.

107. ILS was developed for healthcare professionals who may have to act as the first responder in an emergency. Its purpose is to give individuals the skills to recognise deterioration, identify cardiac arrest, start immediate resuscitation, use defibrillation where appropriate, summon expert help, and manage the patient until a cardiac arrest team, ambulance clinicians, or other advanced responders arrive. It is not designed to provide comprehensive training in the definitive management of every special circumstance listed in **Exhibit ABC/5**.

108. The November 2025 materials include scenarios relevant to some of the special circumstances identified on page 20 of **Exhibit ABC/5**. The ABCDE scenarios include hypovolaemia and asphyxiation following application of a ligature to the neck. The cardiac arrest simulation teaching scenarios include blood loss in the context of self-harm, overdose, and collapse following a ligature. They do not include a dedicated scenario for every listed circumstance. For example, blood loss is included, but not specifically blood loss due to trauma, and there are no separate dedicated scenarios for every context in which suffocation, seclusion or rapid tranquillisation may arise.

109. The special circumstances listed in **Exhibit ABC/5** are matters for organisational policy, procedure, risk assessment, equipment provision, escalation planning and role-appropriate training. The ILS course supports the immediate response by teaching structured assessment using the ABCDE approach, recognition of deterioration and cardiac arrest, initial airway and breathing support, CPR, defibrillation where indicated, escalation and handover. More definitive management of some circumstances may require additional knowledge and skills, such as those held by advanced life support providers, a local resuscitation team, ambulance clinicians, or acute hospital teams.

110. RCUK therefore considers the November 2025 mental-health-specific ILS materials appropriate for preparing mental health inpatient staff to provide the immediate first response expected within the scope of ILS. They should be used alongside local policies, local training needs analysis, local simulation or emergency drills where appropriate, and clear escalation arrangements for circumstances requiring advanced resuscitation or transfer to acute hospital care.

111. RCUK has not developed mental-health-inpatient-unit-specific scenario training as part of the PILS course materials [**Exhibit ABC/11**]. The PILS materials are generic paediatric immediate life support materials which focus on recognition and management of the deteriorating child, airway management, CPR and cardiac arrest management. They include simulation practice for paediatric emergencies and allow course centres to include optional targeted training to address the specific needs of candidates and their places of work. The simulation guidance states that the simulations are generic to accommodate

candidates' different clinical backgrounds, and that instructors may adapt them to reflect the individual candidate's workplace, local systems of care and emergency response arrangements. The PILS course materials do not contain a dedicated set of mental-health-inpatient-specific scenarios.

112. Earlier versions of the PILS course materials were not substantively different from **Exhibit ABC/11**. The materials have been updated in line with changes to national resuscitation guidelines and associated course updates, but there has not been a substantive change in the nature or scope of the PILS course materials relevant to the matters addressed in this statement.

113. 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.

Monitoring and Data Collection

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

115. 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.

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

117. 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 135-136 below).

118. 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.

119. 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

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

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

122. 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.

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

124. 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

125. 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.

126. 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.

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

128. 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.

129. 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. This is because those units may need to transfer patients urgently to a higher level of acute care, and local arrangements should support timely escalation, safe transfer and effective handover.

130. The importance of such arrangements should, however, be determined by local risk assessment rather than by geography alone. Co-location with an acute hospital may make escalation easier to facilitate, particularly where there is an agreed arrangement for an acute hospital resuscitation team or other responding team to attend the mental health inpatient unit. However, co-location does not remove the need for clear local arrangements. There may still be circumstances in which ambulance support, internal transfer support, other retrieval arrangements or agreed pathways are required to move the patient safely to an emergency department, critical care area, paediatric area or another setting capable of providing a higher level of care.

131. The key requirement is that each provider has clear, tested and locally appropriate arrangements for escalation, transfer and handover. Those arrangements should reflect the practical reality of how quickly expert help can reach the patient, what support is available on site, and how the patient will be transferred safely if ongoing acute medical care is required.

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

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

134. 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.

135. 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.

136. 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.

137. Finally, as noted at paragraph 46 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: 22 June 2026