

Witness Name: Zoe Rebecca Bunting

Statement No: 1

Dated: 29 May 2026

Rule 9 reference: Zoe Bunting Rule 9 (1)

LAMPARD INQUIRY

WITNESS STATEMENT OF ZOE BUNTING

Introduction

1. My name is Zoe Rebecca Bunting. I am currently employed as a Professional Nurse Educator, a role I have held since September 2024 at Essex Partnership University Foundation Trust ("EPUT"). Prior to this, I was the Ward Manager for the Peter Bruff Assessment Unit. I have worked for EPUT for 29 years. Prior to the Trust merger I was an employee for the former North Essex Partnership Foundation Trust ("NEP").
2. I qualified as a Registered Mental Health Nurse ("RMN") in September 1997 and have worked across a range of older adult inpatient settings throughout my career.
3. Over the period relevant to this Inquiry (1 January 2000 to 31 December 2023), I held a range of clinical and managerial roles, progressing from staff nurse to Band 6 Charge Nurse and ultimately to Band 7 Ward Manager.
4. In 2016 I was Charge Nurse in Ruby Ward (Crystal Centre, Chelmsford) before becoming Ward Manager in 2017. I remained Ward Manager of Ruby Ward until November 2020. From November 2020 I moved to the Peter Bruff Unit ("PBU") in Colchester as Ward Manager initially in a secondment capacity and subsequently as Acting Matron in 2022 and 2023. I returned to PBU as Ward Manager from January 2024 to September 2024 when I took up my current role as Professional Nurse Educator.
5. For the benefit of the Inquiry, a Professional Nurse Educator ("PNE") is a role developed for experienced nurses, built upon three core principles: Education, Quality, and Support. Our aims as PNEs are to increase workforce retention, promote staff well-being, and improve the quality of patient care. In practice, this involves fostering a culture of continuous learning within ward environments, with a particular focus on supporting newly qualified nurses and internationally recruited staff in their professional development and competency acquisition.
6. Across the Trust, there are six PNEs, each responsible for a defined local area of inpatient wards.
7. PNEs are also expected to hold a Professional Nurse Advocate ("PNA") qualification, an initiative led by NHS England. I successfully completed this qualification in January 2025. The PNA role has considerable overlap with the PNE role in its focus on education

and professional development, whilst additionally placing emphasis on staff well-being. In this capacity, I am qualified to deliver Restorative Clinical Supervision (“RCS”) to nursing staff.

8. RCS is a structured, reflective process designed to provide a safe and supportive space in which nurses can process the emotional demands of clinical work. Guided by reflection and supportive challenge, it aims to mitigate burnout and compassion fatigue whilst sustaining personal resilience and clinical effectiveness. Although RCS is not currently mandatory within EPUT, it is available to any nursing staff who either require additional support or who wish to access it proactively as a means of maintaining their well-being in role.
9. This statement is made in response to the request by the Inquiry to EPUT on 18 February 2026. I have been in that letter requested to provide a formal witness statement setting out my evidence concerning mental health treatment and care in Essex.
10. I would like to begin by expressing my sincere condolences to the families and loved ones of all those patients who died or were harmed whilst in the care of services provided by EPUT. I hope that the evidence I am able to provide to this Inquiry will assist in understanding what went wrong and in preventing future harm.

Methodology

11. I am providing this statement in a personal capacity, and although this is a request addressed only to me, I have been assisted by the Trust’s solicitors Browne Jacobson in preparing this response. I have not spoken to any current or previous colleagues for the purposes of this request.
12. The contents of the statement are true to the best of my knowledge, information and belief.

Clinical assessments

13. My experience of clinical assessments is primarily from the perspective of the ward receiving patients, rather than the community teams and bed management services that conduct pre-admission assessments. I can only therefore speak to what information

arrived with the patients on admission, the quality and completeness of that information, and the ward-based assessments that followed.

14. Pre-admission assessments were the primary responsibility of the community mental health teams and bed management. These could have been undertaken by Accident and Emergency department ("A&E"), the Crisis Team, Gatekeeping, the Home Treatment Teams ("HTT" or "HFT"), First Response or the Community Mental Health Team ("CMHT"). I was not directly involved in undertaking those assessments. I cannot comment on the processes used by those services as me and my team in the inpatient areas would have been the recipient of those assessments. The level of information provided by those teams varied from patient to patient. Patients from different localities such as the south of Essex used other systems such as Mobius, instead of Paris which was used in the north. However, at the earliest opportunity the nursing team often with the support of the ward clerk, could request copies of Mobius information via bed management.
15. On admission to the ward, nursing staff used a range of assessment tools including risk assessment, falls assessment, VTE assessment, and where relevant, early warning scores, neurological observations and blood tests. The timing of these assessments was governed by Trust policy, though in practice the pressures of admission and staffing levels at night impacted the timing by which those assessments were undertaken.
16. If a proposed admission did not feel appropriate, for example, where the ward environment was not suitable for the patient's needs, it was possible to "push back" to bed management. This typically occurred via the daily sitrep calls which managed bed capacity and admissions. At PBU, there was a change in policy regarding the admission of detained patients, the detail of which I cannot fully recall.
17. Mental Health Act ("MHA") assessments could take place on the ward. They took place through the Approved Mental Health Practitioner ("AMHP") hub and the MHA office. The section paperwork was managed through established processes, rights being given, and audits conducted. Delays in completing the MHA paperwork did occur on occasion, particularly around the availability of AMHPs and second opinion doctors. Patients subject to Section 2 or Section 3 of the MHA were advised of their rights under Section 132 by the ward staff. Delays occurred on occasions with rights being read to patients within the timeframes expected for both detained and informal patients who

would have received 131 rights. MHA audits were conducted regularly, though I cannot now recall whether these were initially on paper or electronically at PBU, before later moving to the monthly "tendable" format.

18. Detention under the Mental Health Act is indicated where the relevant statutory criteria is met. This often includes when there are significant concerns about that person's safety and risks. Detention is not the immediate first step, and any alternative least restrictive options should be considered first. For detention under Sections 2 and 3 of the MHA, the application for detention must be made by one AMHP and two doctors one of whom must be section 12 approved.
19. Section 5(2) is available to doctors in the event that a voluntary patient sought to leave and there were concerns for their safety. This meant that patient could be detained for 72 hours in order to undertake an assessment. 5(2) was applied on many occasions at PBU. Section 5(4) was also available to nursing staff in the event that a voluntary patient sought to leave and there were concerns for their safety, and this gives nurses the ability to hold a patient for 6 hours in order to provide an assessment. In my experience this was rarely used.
20. It was possible for delays in assessment to occur, as a result of limited AMHP cover and availability of a section 12 approved doctor. Staff were required to contact the AMHP hub to attend for assessments, particularly when a patient had been detained under 5(2) out of hours and where it was necessary for further assessment to occur under section 2 or 3 of the MHA prior to expiry of the 5(2) powers. Peak periods for these delays were more likely to be out of hours, weekends and bank holidays. There were occasions on the PBU assessment unit when staff did not inform the AMHP hub of the detention and this had a knock-on effect, delaying AMHP attendance. There were also occasions, although few, where AMHPs did not provide assessment prior to the lapsing of 5(2) expiry, which resulted in a new 5(2) being completed for the patient, which was not best practice, as far as I recall these instances will have been reported via Datix and highlighted within the MHA office.
21. Mental Capacity Act 2005 ("MCA") principles, including capacity assessment and best interests' decision-making, were applied in practice and Independent Mental Capacity Advocate referrals could be made where appropriate for those patients who lacked capacity and had no-one suitable to act on their behalf.

22. On admission to the ward, a risk assessment was expected to be completed within four hours. Falls assessments were conducted on admission using the Paris system. VTE reminders were generated. The need for blood tests and ECGs was decided on by doctors and could be requested at any point during the admission and assessment process on the ward, Speech and Language Therapy ("SALT") access was limited or absent on Ruby Ward but may have been implemented after I left. A 72-hour care plan was expected to be completed for the initial 3 days of admission, which provided staff those 72 hours to familiarise themselves with the patient and their information before completing a more comprehensive care plan for the patient.
23. Risk assessments on the ward were undertaken through a process of information gathering. For risk assessments on admission, nursing staff utilised handover information, available information from the EPR system, any identified risks by the community team and the information provided by the referring team. The patient was clerked in by the doctor and a member of the nursing team where their views would also be gathered. Sometimes a relative, family member, or Next of Kin ("NOK") were present with the patient on admission.
24. Families would have experienced different levels of inclusion in admission and assessment processes, due to several factors including, time constraints, the activity levels on ward at the time or if it was an out of hours admission, and importantly, whether the patient consented to their information being shared if family were involved. Staff were reminded to gather information from relatives, even when there was no consent for us to share and we informed our patients that we could gather information from relatives (without sharing information about them) that might assist us in supporting them.
25. My overall view is that the design of assessment processes, the policies, templates, timescales and responsibilities was appropriate. However, the adequacy of assessments in practice was inconsistent and several recurring concerns affected the quality of assessments throughout the period.
26. Firstly, the quality of information arriving with patients on admission to the ward was variable. As an example, staff who did not have access to Mobius would not have had the fullest picture available to them, and would have needed to gather information from other sources and contact bed management to send copies of Mobius system

assessments to PBU. This placed pressure on ward staff to fill information gaps rapidly at a time when they were simultaneously managing the clinical complexity of receiving a new admission. This was particularly the case on PBU. There were times where patients arrived for admission prior to the ward team receiving a handover and without the ward anticipating their arrival. As an assessment unit it was very important to ensure the room was ready and staff had an overview of the patient's identified risks in advance to support the patient and the nursing team.

27. The assessment unit could receive 3 possibly even 4 patients in quick succession for admission. What this meant in practice was that the nursing team would usually be managing transfers or discharges of patients who had only hours sometimes vacated those bedrooms, this created a significant workload for those staff over the span of a shift and would have had an impact on the time nursing staff had available for newer admissions. As a nursing team and during my time on PBU, where we were aware of potential admissions, we would endeavour to work with the bed management team to stagger admissions in order to be able to manage this activity in a planned and paced manner. This could be problematic for the nursing team to manage if this did not go to plan and it would have no doubt had an impact on patient and Next of Kin (NOK) experiences of admissions.
28. Second, the timeliness of physical health assessments, including neurological observations, blood tests and ECG, was affected by staffing pressures and competing clinical demands. For older adult patients on Ruby Ward, physical health assessment was of particular importance given the complexity of their presentations, and delays carried a heightened risk of harm.
29. Upon admission, all patients across inpatient wards - including Ruby Ward - were subject to standardised Trust-wide admission processes. These included a physical health assessment completed by the Duty Doctor, incorporating a physical examination, and a further physical health assessment completed by nursing staff on the Paris system. Where a patient was admitted from a general hospital setting, assurance of medical fitness was sought from the clinicians responsible for their care in that setting, and a discharge summary detailing treatment given and any ongoing recommendations was requested. A medicines reconciliation was also completed by the pharmacy team to ensure that all prescribed medications were accurate and current.

30. Once admitted, patients had their vital signs recorded at least once per shift as a minimum, with increased frequency directed by medical staff, clinical observation, or the patient's specific presentation or physical health condition.
31. I am unable to comment on whether practice in relation to vital signs on Trust inpatient wards differed to general settings having not worked within general settings myself.
32. The means by which vital signs were recorded and acted upon evolved over time. For much of my career, a basic template was in use which served solely as a recording tool and provided no guidance as to whether a reading was of concern or required escalation; the responsibility for identifying abnormal readings rested entirely with the individual member of staff. Modified Early Warning Score 2 ("MEWS2") was subsequently introduced by the Trust, a tool more commonly used in general hospital settings to alert nursing staff to patient deterioration and prompt timely action. MEWS 2 was later replaced by the National Early Warning Score 2 ("NEWS2"), a standardised tool developed by the Royal College of Physicians with the aim of improving recognition of patient deterioration and standardising the approach to vital signs monitoring across health settings. NEWS 2 remains the current system in use. The tool requires vital signs to be recorded on a designated document, with each reading generating an individual score contributing to a cumulative total, alongside guidance for escalation where readings fall outside the normal range. This method of monitoring and early recognition of physical deterioration is a valuable improvement within all inpatient settings.
33. Regarding training, at the time of MEWS2's introduction, as far as I recall it was not accompanied by mandatory training; some non-mandatory training sessions were offered by the Trust, though I do not recall the level of uptake. At present, there is no mandatory training offer specifically for NEWS2, and it does not appear on the mandatory training tracker for staff. However, I understand the Trust is considering making such training mandatory. In my PNE role, I have completed the online learning available through the NEWS2 learning hub and have actively encouraged ward staff to do so. There is some exposure to NEWS 2 within the ligature awareness course and within the current Immediate Life Support ("ILS") course, though neither constitutes a dedicated mandatory training offer for the tool.
34. I do not recall SALT provision during my time on Ruby Ward so with the passage of time I cannot recall to what degree this created difficulties. Access to Tissue Viability

advice also varied greatly from ward to ward with nursing staff reaching out to the district nurse team for some patients where they had that provision at home and then at other times calling on the Trust's physical health lead for support and advice. The physical health lead was a very valuable contact but was not a provisioned service and so access was dependent on their availability.

35. The Trust had a Physical Health Lead - a senior clinician with a physical health background - who could provide advice and support to ward staff on physical health matters, most commonly, from what I recall, in relation to tissue viability matters.
36. This was not a formally commissioned service; contact was ad hoc and typically initiated by me or a member of the nursing staff when tissue viability concerns arose. The Physical Health Lead could advise remotely on wound management and dressing and would on occasion visit the ward to assess and advise directly, subject to their availability. As far as I am aware, there was no commissioned Tissue Viability Nursing ("TVN") service on any of the older adult wards I worked on in the northeast, including Ruby Ward, and access to this support was largely provided on the basis of goodwill and individual availability rather than through a structured, commissioned pathway. The Physical Health Lead was also involved, to some extent, in the rollout of both MEWS 2 and NEWS 2, though their remit extended considerably beyond this function.
37. Thirdly, the involvement of patients and families in the assessment process was not consistent. At times, time pressures and staffing limitations meant this was not always achieved in practice. In order to overcome this, Registered Nursing staff were reminded of their keyworker duties (now referred to as a Named Nurse) and the responsibility this entailed to make contact and introduce themselves to the NOK, maintaining that contact throughout admission. Where staff were falling behind with their caseload duties it was sometimes possible to allocate a caseload day, or for charge nurses a charge nurse day. However, this was not consistent and what was intended to be a protected day could often be problematic to adhere to, due to the demands of ward work, or unanticipated staff absence which then had to be covered at short notice. Patients also had the right not to share their information with family if they didn't wish to do so at that time.

38. For these reasons, whilst the framework for clinical assessments was appropriate, the delivery of assessments in practice was not consistently adequate and, on occasion, fell significantly below the required standard.

Doris Smith

39. I have been asked by the Inquiry specifically about Doris Smith who died on 14 October 2020. I was the Ward Manager of Ruby Ward at the time of Mrs Smith's admission. I would have been familiar with Mrs Smith and her daily care needs and would have had fairly regular interactions with her in my role as Ward Manager. On the morning of 9 October 2020 when I arrived on duty, it was brought to my attention by the nursing staff that Mrs Smith had sustained a fall overnight.
40. Mrs Smith had been reviewed by the duty doctor following the fall, and it was routine for the nursing team to update the regular ward doctors of any incidents as soon as they were able, so I will have anticipated for this to happen on the doctor's arrival.
41. I undertook the falls risk assessment as this was a requirement after any fall incident. The assessment used the Paris system template, which included prompts to guide the assessor through the relevant risk factors.
42. There are prompts for interventions to consider as the clinician goes through the assessment. The interventions I undertook as part of that assessment are as follows.
- a. I reviewed the Datix reporting incident form to get an understanding of the circumstances of the fall incident. In doing so I saw that the nursing staff had not recorded any reference to the Assisted Technology alerting them to movement in bedroom prior to the fall being realised and so I surmised this had not have been activated by the nursing team once Mrs Smith was settled into bed, therefore I reminded the team of the importance and need to activate Assisted Technology in patients bed space.
 - b. Applying my Duty of Candour, I contacted Mrs Smith's Next of Kin over the telephone. I informed them that Mrs Smith fell overnight. I remember making the phone call but not the conversation itself, although I did make a brief case note in Paris system.
 - c. I ensured that Level 2 observations continued.

- d. I requested a physiotherapy referral.
 - e. I reminded the nursing team that Mrs Smith's family had brought more appropriate footwear in for her to wear and to ensure that she was wearing these, to support her comfort and mobility.
43. I was aware of the requirement for neurological observations following a head injury, however I don't recall involving myself in these duties on the day and I do not recall any conversation with the Nurse in Charge regarding this on the day. It is likely that I will have checked in with the Nurse in Charge that they were undertaking neurological observations as part of our conversation about patient care on the day, however I have no memory of this.
44. In terms of my clinical rationale for Mrs Smith remaining on Level 2 observations, I was aware that Mrs Smith had not previously tolerated Level 3 observations well. From reviewing the Datix report, it was apparent that the assisted technology was not activated in the bed space in relation to Mrs Smith's fall that night and I considered this to be contributory to the fall occurring. I concluded that reminding staff of the need to ensure the assisted technology was activated in her bed space, in addition to continuing on Level 2 observations, alongside ensuring appropriate footwear and a request for physiotherapy review to take place that day, were suitable risk management measures
45. Ward huddles were not well established on the ward at the time and I do not recall the huddle on the day.
46. I left Ruby Ward in November 2020. Mrs Smith died on 14 October 2020 and the Root Cause Analysis ("RCA") report into her death was completed in June 2021. I was not in post on Ruby Ward at the time the RCA report was finalised, and I was not involved in the implementation of any recommendations arising from it on that ward.
47. I have no direct personal knowledge of what changes were made to observation practices on Ruby Ward following Mrs Smith's death, or whether the issues identified in the RCA and inquest were subsequently addressed. I am also not in a position to comment on whether similar issues arose after her death.

Admission

48. My direct experience of the admission process was primarily as the receiving ward rather than from the decision-making end. Decisions about admission to inpatient services were largely made by community teams and bed management, with the ward's primary role being to receive and care for patients once a decision to admit had been made. Ward staff and ward managers did not, in the main make the initial admission decision. Decisions about whether a patient required voluntary or involuntary admission under the Mental Health Act rested with the responsible clinician and AMHP. With that in mind my observations are as follows:
49. The design of the admission decision making process, involving AMHPs, responsible clinicians, bed management and Home Treatment Teams, was appropriate. In practice, several factors affected whether admissions were made appropriately and in a timely manner.
50. I cannot speak to the factors that influenced a decision about admission as ultimately those decisions were not made by me or the ward staff. I will say however that during my time at Ruby Ward; there were at times pressure relating to bed capacity which could affect how quickly admissions were processed and how quickly patients requiring admission were able to access a bed. The Trust used out of area placements where local capacity was insufficient but again this was not decided by me or my nursing staff.
51. Bed capacity pressure was a significant and persistent feature of both Ruby Ward and PBU. There were occasions when I was aware that patients who in my clinical judgement appeared to require inpatient admission were managed in the community for longer than was ideal due to a lack of available beds. There were also occasions when patients were admitted with minimal pre-admission information because the urgency of the situation did not allow for full preparation. Out of area placements, where local beds were unavailable were used.
52. Conversely, I was also aware at times of pressure in the opposite direction where bed management sought to move patients through the system quickly.
53. My overall view is that admission decision making was not consistently adequate. The process was heavily influenced by bed capacity constraints and systemic pressures, rather than being driven purely by clinical need. A system that is consistently under bed

pressure cannot reliably make admission decisions that are in the best clinical interests of patients.

54. These pressures were more pronounced on PBU than on the older adult wards; however, the older adult wards were not immune and at times experienced similar pressures primarily because community demand for older adult beds exceeded the number of vacant beds available on the wards.
55. Decisions to admit patients out of area were taken on the daily bed management calls, the decisions were made by the Matrons and Service Managers leading those calls. The community teams would flag that they had a patient requiring admission and the bed management team would endeavour to allocate a bed. It was ideal for a bed to be available in area. However, if there wasn't an in area bed available, bed management would look to allocate out of area, on the basis that the patient required inpatient admission. Where out of area admission looked likely (and this would be due to limited, or no bed capacity) then bed management would look in the first instance to admit to a like for like ward out of the area.
56. Where the need for admission was pressing, there were occasions where patients could for example be admitted into an organic bed when they had a functional diagnosis. These decisions were taken as a last resort, but they could be used where the need for an inpatient bed was considered to be necessary. Following on from that, local arrangements were in place to source a more appropriate ward environment for those patients, by tracking flow and transferring patients when able into more suitable ward areas. However again there could be significant delay with this also, depending on flow through wards and the list of patients waiting in the community.
57. Bed management calls take place three times a day. They could be reduced to twice daily unless there was a decision to escalate to Opel 4, I cannot recall the exact criteria which amounted to a decision to declare Opel 4, but it was generally where demand for beds far outweighed the bed capacity available in the Trust at that time.
58. This initiated a process where key decision makers such as consultants and directors were expected to attend the call, to explore how bed capacity could be created for admissions. My recollection during the early days of being a Ward Manager was that attendance on these calls was required three times a day, so that local areas could relay their bed capacity and any upcoming discharges. This system relied heavily on

discharges occurring as planned. The community team remained responsible for the patient until the point a bed became available. The bed management team were responsible for managing the patients waiting for beds, along with their identified need for admission, risks, how long they had been waiting for a bed and the provider area. From my experiences of those calls I was aware of patients waiting for significant periods for an inpatient bed and the pressure this placed on community teams to manage the patient's risks in the community. It was difficult when a planned discharge from the assessment unit didn't take place and was delayed due to the patient's clinical need, as that meant bed management had to identify another bed for the patient waiting in the community and it could extend that patient's wait.

59. In my experience on PBU the flow through the assessment unit could be slowed down as patients on the assessment unit who were waiting for treatment beds in the Trust could experience significant delays, which then impacted the assessment unit nature of PBU. As an Acting Matron the experience of the bed management calls was a learning curve for me. The bed management team and Directors and Service Managers had oversight of the list and decisions and escalations.
60. Patients and families could speak to me as the Ward Manager and nursing staff regarding their preferences in relation to transfer to an in-area ward. I could relay these concerns in several ways, either by attending the bed management calls, escalating the preference to my Matron, or contacting the bed management team via email to alert them to the request and need. If older adult patients had a family member or spouse that was had to travel a great distance to visit, this was be deemed a priority and escalated as per above.
61. Patients on PBU would often approach me regards to a preference to a specific area for a treatment bed, or also a request for an area they did not wish to go to. These requests I'm reasonably confident would have always been relayed by me to the bed management team either via email or telephone, or sometimes both.
62. Towards the end of my time as a Ward Manager the bed management calls evolved with the introduction of the flow and capacity team, I was aware of the flow and capacity lead exploring need for admission in more detail, they explored the patient's diagnosis, risk and the patient's individual factors thoroughly to help them understand the need for admission and whether or not there were alternative options to support the patient in

liaison with the community teams. This exploration was part of the Purposeful admissions model.

63. These conversations grew in complexity and involved key decision makers such as the flow and capacity lead, community staff, directors and service managers. I cannot say there was pressure not to admit, but there was a more detailed exploration of the need for admission required, to ensure purposeful admissions, so that the admission had a clear set of goals for the patients care and treatment. I haven't attended any bed management calls now for some time as it is not a requirement of my current role.
64. Overall sufficient and appropriate systems were in place to support the admission process. Towards my later time on PBU, bed capacity, patient demand, staffing and activity levels impacted the adequacy of this process and certainly patient experience of the process. Patients may not have always had a positive experience of admission to PBU. For example, in the early stages of the Covid 19 pandemic. In line with infection control guidance at the time, newly admitted patients were required to isolate as per the Trust's guidance in response to wider national government/NHS guidance. I was aware of occasions where patients found this incredibly distressing. Having been admitted to the unit in a time of need and crisis, the expectation then was that they were required to isolate in their bedspace often for prolonged periods. Whilst I appreciate the importance of this at the time in terms of infection prevention and control measures it did have a significant impact on the experiences of those patients admitted during that time.
65. This will have been further impacted by the limitations in the physical environment of PBU and the small bedrooms that patients were expected to isolate in. One patient shared his experiences via the PALS process, and learning from this was shared with the team via team meeting.

Ward environment

66. As a staff nurse early in my career, I had limited knowledge of the requirements for the ward environment, and my focus was on patient care and developing my clinical skills. As my career developed and my experience on working on older adult wards, I became aware of the need to consider wet floors, trip hazards, and report any environment issues, for example around lighting or faulty equipment and the need to communicate this effectively to colleagues in handovers.

67. The process for reporting and tracking faults started as a manual logbook and a call to the Estates department where you would be allocated a job reference number. This system is now electronic, and staff can log and track tasks. When I first became a nurse in 1997, wards were not locked and staff were required to complete an incident report where they felt there was a rationale to lock the ward. Early in my career I worked on a functional ward and do not recall as much regard for reduced ligature furniture and fittings as there is now.
68. The functional wards were carpeted and generally more homely. There was provision of handrails for older patients and nurse call bells in toilets and patient bedrooms, but there were no staff alarm systems or CCTV. There were no swipe card systems as areas were managed with keys. In the early 2000s, there was growing thought to dementia friendly environments, which considered colours, layout, signage and recognisable furniture and fittings for a dementia cohort of patients which continues to this day.
69. There have been significant changes to ward areas and considerations to the environment in relation to the patient demographic during my career. With acute settings considering reduced ligature furniture and fittings and these being managed via ligature inspections, ligature audits and hotspots systems on wards as well as daily environmental checks. I cannot recall infection control auditing methods in my earlier days, however generally more consideration has been given over the years to the types of material and surfaces on the wards to ensure they can be cleaned as per requirements. As an example, carpets are no longer on wards and furniture is now nonporous and therefore easier to clean.
70. Older adult wards have sophisticated systems of assisted technology in patient bed spaces, I recall in the early 2000s and 2010s, sensor mats became available, these were secured under the patient's mattress and would alert staff to movement in bed. The standards applied to those wards depend on the patient demographic, with dementia assessment wards applying dementia principles, functional wards applying principles which are guided by the Trust and monitored via the ligature inspection process. Older adult wards also consider factors in relation to frailty and falls risk, with the provision of handrails and assisted technology and provision of assisted baths and shower areas. This is where my main experience lies and so I cannot speak to other factors unless they were present on the wards that I mainly worked on.

71. The effectiveness of the assisted technology in reducing falls risk was dependent on correct activation by staff, in the same way that any technology of this nature requires correct use to function as intended. This applied to both the falls sensor mats and the assisted technology bedrooms. When activated correctly, they provided an effective and less intrusive means of monitoring patients at risk of falls.
72. On Ruby Ward, the assisted technology rooms were activated by a key located outside the patient bedroom, once the patient had settled into bed. This required communication between the Nurse in Charge and the member of staff supporting the patient to bed, as part of the standard handover and care process. The system was, as I recall, provided by Aquarius Alarm Systems, with instructions for its use held in the nursing office.
73. I do not recall the specific audit arrangements that were in place for the bedroom falls sensors on Ruby Ward, nor am I able to speak to what processes may have existed on previous older adult wards. I am aware that other safety systems on the ward, such as the anti-ligature door top alarms, were subject to regular testing, and I regularly participated in that process. I cannot confirm what equivalent arrangements, if any, were in place for the fall's technology during the relevant period, and I would not wish to speculate beyond my own recollection.
74. I do not recall any instances of the fall's sensors malfunctioning during my time on Ruby Ward. Had any fault been identified, the appropriate course of action would have been to escalate to Estates or to Aquarius, and to communicate this to the relevant team members and senior colleagues in line with standard practice. I am not aware of any occasions on which this was necessary, though I acknowledge that I cannot speak with certainty to every eventuality across the period in question.
75. I have only worked in acute areas for a relatively short time of my career and while there is focus on reduced ligature furniture and associated risks, there seems to have been limited provision for facilities for those acute patients who may need larger bedrooms, for use of mobility aids and space for staff to support them. The assessment unit on PBU had one bariatric room with a bariatric bed, which had an ensuite which allowed for the space needed for mobility aids and staff support.
76. The facilities team managed a cleaning schedule for patient and non-patient areas such as the kitchen. Nursing staff conducted a daily environment checklist, and patients could bring their concerns to the attention of the nursing team or me and we would flag these

with the facilities lead/team for them to address. Nursing staff were responsible for clinical areas and clean stickers were used for staff to label when a clinical area had been cleaned. The infection control team conducted audits, which focused on the cleanliness of patient and clinical areas.

77. I do not recall concerns around cleanliness being brought to my attention on Ruby Ward, and the same system was in place regarding the ward cleaning schedule. The only key difference that I am aware of that may have influenced the degree of cleanliness was patient flow and overall activity on PBU in that it was far greater than that of Ruby Ward. The PBU assessment unit was smaller than Ruby Ward and there were a limited number of options for patients who did not wish to use the busier communal areas. Patients who wished to occupy less busy areas, had the option of two quiet rooms on PBU, which doubled up as consultation rooms for private meetings with patients. PBU was small and did not lend itself to being a therapeutic environment. Towards the end of my time on PBU, I was able to get agreed funds for the provision of some murals for those quiet rooms the lounge and the corridor and all were carefully chosen to create a more relaxing aesthetic in those areas.
78. A beverage bay was installed before I left PBU, so that patients could have ready access to refreshments, rather than needing to ask staff and potentially wait for them to be provided. PBU did have an activity timetable however, in reality this could be impacted by the availability (or not) of Occupational Therapy ("OT") staff and therefore the need to share cover with other wards. I always noted a significantly improved atmosphere on the ward when the activity program was fulfilled and for example it was always incredibly valuable when the therapy dogs visited the wards.
79. Ruby Ward in comparison was spacious and had more choice for patients with regards to where on the ward they could choose to spend their time, there were ample quiet spaces and separate side lounges, a large dining room and TV room and each of the smaller quiet rooms as far as I recall also had a TV. Patients had ensuite toilet and shower facilities for each of the bedrooms, there was a fixed positioned seat in each of the bedrooms on Ruby Ward, and as far as I recall each bedroom had a very good view to garden areas. On PBU the rooms were small and could be dark; the bedroom windows were obscured due to the need to ensure privacy from outside areas, that were accessible to others. I did make enquiries with Estates regarding one way privacy windows; however, I do not remember what came of this.

80. Ruby Ward had the support of at least one senior Occupational Therapist, available during core hours of 9.00am to 5.00pm, Monday to Friday. As far as I can recall, this senior cover was shared across other wards within the Trust. The senior Occupational Therapist was supported by at least two Occupational Therapy Assistants ("OTA"), though similarly, this resource was also shared with other wards. PBU had similar OT cover arrangements.
81. Activity provision for patients was at times affected by both sickness absence and the demands of shared cover arrangements. On such occasions, patients could have limited or no access to planned activities unless nursing staff could provide cover themselves. However, the acuity of the ward and the demands of the nursing workload frequently made this difficult in practice. I am unable to recall with any precision how often sickness absence or shared cover arrangements affected activity provision during the relevant period.

Ruby Ward, Chelmsford

82. Ruby Ward was an older adult inpatient mental health ward. It cared for patients who were frail, elderly and who presented with complex physical and mental health comorbidities. The environment and staffing model needed to respond to both physical risks (falls etc) and mental health risk simultaneously.
83. Overall, the environment was spacious and well equipped for physical health needs as described earlier it was spacious and consideration was given to handrails in communal areas and corridors. However, a later decision was made (I cannot recall when) to remove the handrails from ensuite bathrooms in patient bedrooms, which was not taken by me and nor do I recall being consulted prior to their removal. In my view this was an error in decision making. As far as I can recall this decision was taken for all inpatient areas within the Ligature Risk Reduction Group ("LRRG") work stream for functional ward areas. As I was not consulted, I am not aware of any consideration given to mitigating falls risks in those areas. The same applies to the removal of fixed soap and towel dispenses and the installation of collapsible replacements.
84. EPUT organised and scheduled environmental ligature risk inspections, coordinated by the risk team. These inspections brought together representatives from the risk team, Estates, and either the Matron or the Ward Manager. The purpose of these inspections

was to systematically identify ligature risks within the ward environment on a regular basis, to record them, and to ensure they were appropriately addressed.

85. I cannot recall whether any specific adaptation was made to the ligature risk inspection process for older adult wards to account for the interaction between ligature risk and falls risk. I would not wish to assert whether such an adaptation was made; any contemporaneous documentation would provide a more reliable account than my recollection alone.
86. Separately, EPUT provided a Falls Policy and associated guidance, informed by best practice as set out by NICE at the relevant time.
87. Ruby Ward had a functional ward operational policy, but this did not contain specific guidance on managing the interaction between ligature risk and falls risk for older adult inpatients. I cannot recall whether the Trust made available any external guidance applicable to managing these dual risks in an inpatient setting. However, I would not wish to assert that no such guidance existed.
88. I do not recall the Trust providing any specific training provided for staff on Functional wards, with regards to managing these dual risks
89. I cannot recall a process by which ligature risk and falls risk were considered together within a single combined review for older adult wards. I want to be clear that this reflects the limits of my personal recollection, and I would not wish to suggest that no such process existed; it is entirely possible that arrangements were in place that I cannot speak to with confidence. I would defer to any documentary evidence that may assist the Inquiry in clarifying this point.
90. I do not have a clear recollection of the specific means by which I raised concerns in relation to the balancing of ligature and falls risks on older patient wards. Falls were discussed at local falls meetings, overseen by Matrons for their respective wards, and it is possible that I raised concerns in that forum. I may also have raised matters of concern with my Matron through supervision sessions and day-to-day conversations, though I am not able to recall the specifics of any such discussions with them.
91. On reflection, the Datix incident reporting system would have been an available mechanism through which concerns regarding the handrail removal could have been

formally recorded, though I have no clear recollection of whether I utilised it in this instance.

92. Access to specialist input, including Speech and Language Therapy ("SALT"), tissue viability, Allied Health Professionals ("AHP") and Occupational Therapy ("OT") was important but not always consistent. Dietician input was available and nursing staff could make referrals, and the dietician would generally visit referred patients once a week to review their, weight, progress, diet and fluid chart. Although not based on site I recall dietician input to be responsive and present when needed. OT input varied dependent on cover arrangements across the Trust's site. When I was on Ruby Ward, we recruited an activity support worker who worked twilight shifts and the provision of an activity support worker worked really well supporting activities and engagement for patients during between the hours of 4.30pm and 11.00pm.
93. Subject to the concerns above and during the time I was a Ward Manager there, I consider that overall, Ruby Ward was fit for purpose. Patient bed areas were large and spacious, each of which had its own private ensuite toilet and shower area; the bed space and ensuite areas had nurse call bells. There were between four and six assisted technology bedrooms for those patients deemed to be at a high risk of falls. Although there were fairly long corridors, each of them had seating installed within the corridor and each corridor had a separate quiet space/tv lounge and a large spacious shower area, designed for patients that required mobility equipment and staff support hence requiring floor space to navigate that support and assistance.
94. Each corridor had an assisted bathroom with a manual hoist to support patients in and out of the bath if this was needed. There were activity rooms for group sessions with OTs, nursing staff could use this area to support patients with activities.
95. There was a large physical health room with an examination couch, weighing scales and physical health equipment directly adjoining the communal area; patients were invited into this area for weekly weight ins and any tests or examinations that they required. The garden area adjoined the dining room which was large with high windows allowing plenty of natural light. All of which supported a therapeutic environment whilst our patient's received assessment and care.

Peter Bruff Unit ("PBU") – Colchester

96. PBU presented a more significant set of environmental challenges. The unit had a "swing" area comprising of 3 bedrooms that could either be swung to 3 females or swung to 3 males depending on demand. During periods of high bed demand and limited capacity across the Trust, decisions were on occasions made on bed management calls by Directors and Senior Management to admit a patient of the opposite sex into that area, this always caused concern for me and the nursing team, but we were able to mitigate any risks associated with mixed sex areas by placing a nurse in that swing zone for the duration of the breach or allocating a nurse on the hour as part of shift set up and in the same way that patient observations were allocated.
97. Datix incident reports were completed, and all efforts were made to resolve any gender breach as swiftly as possible by transferring the patient into a vacant bed on the appropriate male or female area as soon as a bed became available as a result of a discharge or transfer.
98. Repairs and estates issues were a recurring feature of the unit, and the fabric of the building presented challenges for both therapeutic care and safety management. The unit was old and wear and tear was present. The unit was previously an older adult ward which was adapted for use as an assessment unit. In terms of aesthetics, the skirting boards and door frames looked old and they were a little more difficult to clean due to the material and age. This was not assisted by the heavy use of the ward.
99. Damage could occur as a result of patient vandalism, this included holes in the walls from kicking or punching and this happened frequently. Nursing staff reported this to Estates. Other than the installation of the beverage bay, the installation of the murals and the occasional repainting of some areas, no significant funds were available for the appearance or improvement of the unit as far as I am aware. This always surprised me given the importance of the assessment unit in relation to flow and capacity through the Trust. this being said I acknowledge that any major changes to the layout of the unit would have been incredibly difficult and complex to manage alongside the busy nature of the assessment unit.
100. Vision panels into patient rooms were an issue. Each bedroom door has a vision panel which is an observation window, which is a glazed window set within the door frame, which provides a view into the patient's bedspace. The vision panels were fitted with a

privacy blind that could only be lifted manually by a member of staff using a key, allowing staff to observe a patient from outside the room without the need to enter.

101. As per the Vision Panel meeting of 2 February 2022, I am aware that vision panels in at least seven bedrooms at PBU did not give an adequate view of patients when they were in bed. I exhibit the meeting notes as **ZB Exhibit 1**.
102. To be clear it was only following Mr Steel's death that I became aware of an issue affecting seven of the bedrooms on the PBU, including Mr Steel's room. The vision panels in those rooms did not provide a comprehensive view of the patient or of the head of the bed. On becoming aware of the issue with Room 7, where Mr Steel's death occurred, I took it upon myself to check all of the bedrooms on the unit for similar layout concerns and found that the same issue affected a number of other bedspaces. In those rooms, the positioning of the beds obscured the view of the patient through the vision panel. As the beds were fixed-base units, they could not simply be repositioned. Furthermore, the bed positions were aligned with the Oxehealth camera system installed in each room, meaning that any reconfiguration would need to be progressed through Estates, risk management, senior management, and Oxehealth. I was not involved in the design and layout of the bedrooms during the refurbishment, as I was posted elsewhere at that time. When I took on the secondment position, I was not provided with a handover that addressed these factors. Prior to Mr Steel's death, I had not considered how these individual factors interacted with one another.
103. Upon realisation of these interacting factors, I raised the matter with my Matron, who advised me to arrange a vision panel meeting. I believe I may also have completed a Datix incident report, though I cannot be entirely certain of this. I also asked my Matron to add this risk to the ward's risk register. I had a number of conversations about this issue with both my Matron and my Service Manager, and whilst I cannot recall the specific detail of those conversations, I am clear that they took place.
104. Mirrors were considered as an alternative by estates and risk team in the interim and whilst the matter was being escalated to senior management and the Risk team for their attention. However I expressed my view that these were not a reliable contingency at night when the room's lights were turned off. I took steps to mitigate the risk as far as possible but the doors to bedrooms were heavy and noisy, meaning that repeated entry by staff for observation purposes could significantly disturb patients' sleep. I alerted

nursing staff to the issue and reminded them that where they were unable to obtain a comprehensive view of a patient through the bedroom door vision panel, they were required to enter the room to satisfy themselves as to the patient's wellbeing when completing their assigned observation checks.

105. My overall view is that PBU was not fit for purpose. The combination of environmental factors, including the sightline issues, the mixed sex area, the state of repair of the building, and the layout challenges for observation meant the environment did not meet the standards required for safe, therapeutic inpatient care.

Treatment

106. Treatment decisions at both Ruby Ward and PBU were made within a multidisciplinary framework. Ward reviews took place regularly, with input from the responsible clinician, nursing staff, and where available allied health professionals. Patients were invited to participate in their ward reviews. Families were not expected to attend every review and on PBU and Ruby Ward they did not attend routinely but could be invited or could request to attend. The consultant and his PA would then be made aware of such requests. Patients on admission were encouraged to complete a My Care My Recovery document. As far as I can recall families sometimes completed these for older adult patients who were not able to do this themselves.
107. Forming relationships with family members was easier on Ruby Ward since the flow and length of stay on the ward was longer. Named nurses were allocated on admission and the expectation was that the named nurse should contact the relatives as early on in admission as possible.
108. The turnover on PBU impacted staff ability to create relationships, largely nursing staff and the medical team would consult the patient but relationships with family or NOK was uncommon. This was in part due to the informal nature of most of the admissions onto PBU and the patient's capacity to include their NOK as per their own wishes and the busy nature of the unit. During reviews, patients were asked whether nursing staff and or doctors could speak with their NOK and whether or not they could be invited into reviews. The patients would also ask if their relatives could attend their review and or meet with the doctor, but this also varied dependant on the patient, family or NOK's willingness to do so.

109. On Ruby Ward, reviews involved a member of nursing staff, the consultant and their juniors and often allied health professionals. The community team were invited to attend in the lead up to any key decisions particularly in relation to treatment, discharge or best interest meetings. Families were permitted to attend and were invited however families were not required to attend every review.
110. In situations where patients or families disagreed with the treatment decisions, mechanisms were available to them and these included PALS and local resolution processes. The complaints process at the time advocated local resolution as a first step.
111. The effectiveness of these routes depended on patients and families being made aware of them. Band 7 staff were encouraged to manage disputes locally in the first instance and I always tried to contact family as soon as I was aware of concerns. This involved me as the Ward Manager contacting the patient or their family to apologise for their experience and have a discussion with them to explore what their concerns were and how we as a team could resolve them. I made patients and family aware of the process, so they were aware of the options available to them.
112. From what I recall more often than not, where I was able to pick up the phone and swiftly contact a relative regarding any concern, we were usually able to come to a solution together with regards to how to address their concerns.
113. Co-morbidities such as Alzheimer's, dementia, pneumonia, cancer, diabetes, frailty and nutritional issues were addressed and integrated into a patient's care plan. An initial physical health examination took place on admission where the patient was assessed and examined by the admitting doctor. A nurse was also present throughout this assessment. The GP summaries were requested the same time as the medicine reconciliation was requested via the patient's GP. This action on admission supported the prompt identification of the patient's physical health history and diagnosis. A set of baseline physical health observations were taken on admission and the monitoring of vital signs continued throughout admission; the frequency of which varied vary depending on the patient's circumstances, the instruction of the medical team, or the judgement of the Nurse in Charge through observations.
114. Admission risk assessments included Falls, Venous Thromboembolism ("VTE"), Malnutrition Universal Screening Tool ("MUST"), WATERLOW and a general risk

assessment which included assessment of mental health related risks as well as risk of neglect or hazards and the considerations of physical factors.

115. Functional assessments were undertaken throughout the admission and included a physiotherapy provision to cover mobility assessments exercise to maintain ability and strength. Occupational therapy assessments to assess the patient's physical abilities and their independent living skills were also undertaken.
116. Nursing staff were responsible for devising care plans for specific domains and conditions. In doing so it was necessary to consult with specialists such as dieticians, TVN specialists, and diabetes specialists to seek their input into the care plan. Prescriptions of medications were reviewed weekly by the consultant within the ward review and the pharmacy team had oversight of prescriptions and along with any omissions or dates for review.
117. Nursing staff observed a patient's presentation throughout their shift and any concerns regarding their physical health were escalated to the medical team, who assessed the patient to provide medical support and guidance. Doctors consulted the general hospital and relevant specialisms whereby they had any questions relating to a particular condition and management of the same.
118. Diagnosis and treatment were led by the medical team, there was a range of pharmacological treatment available including antidepressants, antipsychotics, anxiolytics and mood stabilisers. If prescribed these were kept under review by the consultant the medical team, this was supported by pharmacy oversight and monitoring through processes of audit and in ward reviews.
119. The wards had access to a psychologist and staff could refer on to them. Psychologists were in attendance frequently in ward reviews, I am unable to recall the range of treatments they offered but we could make referrals to them. There was also provision of therapeutic activities and groups, such as relaxation, reminiscence, current affairs, art and music therapy but I cannot recall how regularly these were timetabled. Electro convulsive therapy was accessible if a patient met the criteria for this through a process of assessments and as a last resort treatment.
120. Access to Allied Health Professionals ("AHP"), including OT, physiotherapy, SALT, and psychology, was important for holistic treatment, particularly in older adult patients with

complex physical and mental health needs. In my experience, AHP input was not always consistently available or timely, and this was a gap that affected the quality of care. For example where OT provision was impacted by OT cover (or the lack of it) this meant scheduled activities would not run. Where my team could not access timely tissue viability support, nursing staff were required to use their own sometimes limited wound assessment and dressing skills to cover the period whilst awaiting input.

121. In my view SALT provision is essential for all older adult wards but I cannot remember whether SALT was commissioned for the Ruby Ward during the time I worked there.
122. Both Ruby Ward and PBU had access to physiotherapists, they were not based on site and covered several areas. Staff could refer patients to them. For those patients who were diabetic, Mid Essex was covered by EPUT's Diabetes specialists, the North East was supported by the Suffolk team or East Suffolk and North Essex Foundation Trust. The Wards could contact or make referrals to them to attend and/or advise.
123. Baseline weights were taken on admission. Patients who refused food and fluid on Ruby Ward were monitored through a process of completing diet and fluid charts to monitor intake. Issues were escalated to doctors and a dietician where necessary. Refusal was discussed in ward reviews for medical oversight and solutions (or the monitoring of those solutions) and patients underwent regular weighing.
124. In addition to this, the medical team assessed the patient's hydration level. Patients could be prescribed supplements drinks by the dietitian where indicated. The Dietician assessed patients referred for their weekly caseload and reviewed diet and fluid charts, they met with the patient, reviewed their weight charts and gave advice to the nursing team and medical team with regards to ongoing management.
125. In my view treatment was appropriate sometimes but some it was not given the concerns I have outlined above. Whilst wards did have access to the psychologist team, in my opinion therapy-based treatments were limited and dependent on cover within that team. As far as I recall patients would not access psychological interventions more than once a week, and there was limited access to engagement with talking therapies and therapeutic groups.

Medication

126. Medicine assessments took place on admission to the ward, with pharmacists reviewing the patient's medication charts and nursing staff administering the medication according to the prescription. Patients sometimes came in with their own medication, particularly older adults and this would be reconciled between doctors and the Trust pharmacy team. Reconciliation involved contacting the GP surgery to ensure medications prescribed were accurate in terms of forms of medicine and doses.
127. The age of the patient, any contraindications and side effects were considered by the pharmacy team at point of reconciliation, they were reaffirmed by doctors within the ward reviews. Nursing staff were responsible for observing for any potential side effects. If they noted any this was fed back to both the doctors and the pharmacy team with a reassessment of medication where this was indicated. All observations and changes were recorded on the medication chart. The consultants reviewed medication cards in the weekly ward review.
128. Difficulty with swallowing could be an issue on Ruby Ward given the demographic of the inpatients but I cannot recall any specific examples. These issues were flagged at handovers amongst the nursing team and with doctors either in ward reviews or on the day with doctors who were on the ward. Solutions were provided, and the pharmacy could advise an alternative form of medication, such as a dissolvable or liquid medication, over a tablet which needed to be swallowed.
129. Nursing staff received training in medication administration, and there were processes for managing refusals, lack of capacity, covert medication administration, and PRN medication.
130. If a patient refused medication and had capacity to make this decision, this was their prerogative to do so, subject to any decision by the responsible clinician to provide treatment without consent which is possible for patients formally admitted under section 2 or section 3. Ward staff would further explore the reasons behind any refusal, ensuring the patient had as much information as possible regarding the treatment in order for them to make an informed decision. Staff would also discuss the alternatives if appropriate and risk assess the presenting symptoms during their ward review.

131. Where capacity was uncertain or doubted by the staff then a determination would need to be made regarding capacity and capacity assessments were completed. Capacity decisions were documented on a Mental Capacity Act 2 document. Where a patient was assessed as lacking capacity under the MCA the consultant and nursing team followed the MCA best interest's pathway. MCA guidance was available and the doctors would complete the necessary documentation, consult the safeguarding team and ensure that all copies of MCA forms were shared with the safeguarding team scanned to Paris.
132. Best interest decisions were made with the contribution of family, relatives, NOK or any appointed persons to inform the decision. This process was more common on older adult wards.
133. Second opinions were sought for detained patients, to support with the legal requirements of completing the T2 and T3 process after the first three months of their detention. When a patient is detained under the Mental Health Act there are special rules about giving medication for their mental health. A T2 is used where a detained patient agrees with the prescribed treatment and has capacity to do so. T3 is where a patient does not agree, or does not have the capacity to agree to the treatment prescribed. The rules for each patient help protect detained patients' rights and make sure treatment is lawful and appropriate.
134. The second opinion doctor was not a doctor based on the ward or unit. T2 and T3 authorisations under the Mental Health Act were sought where required and kept with the medication cards for the awareness of the administering nurse.
135. On older adult wards, clear covert medication guidance was available, although I have no clear recollection of how this developed and changed over time. If a patient was on covert medication within their food, staff were required to observe the patient whilst they were eating to reduce the risk of another person inadvertently picking this up and consuming it. Staff were also required to be mindful that the covert plan didn't have an impact on putting patients off their food, if they became suspicious about its contents. These processes were documented using the covert guidance available and conversations in ward reviews, following pharmacy guidance and updating progress notes.

136. I do not believe there was a practice or culture of over medication on the wards. Prescribe when needed medication ("PRN") was prescribed by doctors, and usage was regularly reviewed by the consultant and medical team, through ward reviews often with a view to consider whether that particular medication was still required or whether it could be discontinued or if needed, transferred onto a regular prescription.
137. There was a practice within both PBU and Ruby Ward of administering as required medications proactively for some patients where indicated. In the presence of an escalating presentation or agitation, as a proactive approach, PRN was offered to prevent the patient's agitation/distress increasing further, which may result in harm to themselves or others. This proactive approach was considered alongside de-escalation techniques.
138. As far back as I can remember if patients refused medication, every effort would be made to encourage acceptance of medication orally before considering any restrictive methods of administration such as intramuscular ("IM") alternatives or using Therapeutic and Safe Interventions ("TASI") which are Trust approved physical interventions to assist in the management of acutely disturbed patients where there is a risk to harm to themselves or others
139. These decisions were discussed with the team and doctors through ward reviews and Multi-Disciplinary Team ("MDT") meetings. Thereafter prescriptions could be in place for nursing staff to utilise out of hours when assessed as required for the patient and often in liaison with the out of hours Duty Doctor. I cannot recall how far back this guidance goes; however, guidelines are and were in place setting out the pharmacological management of the acutely disturbed patient.
140. Pharmacological interventions include oral and IM medication and can be prescribed for administration in cases of agitation, aggression and violence, and severe distress, where urgent intervention is required to keep the patient and others safe. The guidance sets out that use is to be proportionate and as a last resort. It also sets out the monitoring requirements post administration. It is a last resort intervention where de-escalation has not proved effective and or where the patient not receiving their treatment will be detrimental to their treatment and recovery. Nursing staff would be required to raise Datix reports whereby any instances of Restrictive practice occurred and these instances would be highlighted to the Doctors for discussion in MDT and ward reviews.

141. Prescriptions were completed by doctors under the review of the responsible clinician and the pharmacy team, and consideration was given to patient specific factors such as their age, physical health and pregnancy. Trust guidance regarding the use of pharmacological interventions in these circumstances has recently been revised in 2024, in particular, to strengthen guidance regarding physical health monitoring post administration. I cannot recall how comprehensive earlier guidance was and how and when this has evolved in the relevant 23-year period.
142. Trust training around physical interventions to safely support this process has evolved over the years from "control and restraint" training to the now known TASI training.
143. When I started working for the Trust in 1997, the training in place was referred to as Control and Restraint training. On reflection, Control and Restraint training was predominantly focused on the management of violent incidents and equipped trained nursing staff with a range of physical techniques that could be applied in response to violence or escalating aggression from patients. The emphasis of that training was therefore reactive in nature and was centred around physical intervention once a situation had already escalated.
144. TASI refers to Therapeutic and Safe Interventions. It is a training programme designed to equip staff with the skills to support patients who are experiencing escalating distress or agitation. TASI incorporates fewer physical techniques and holds than its predecessor; however, it does continue to provide staff with guidance on how to safely manage a situation where physical intervention is necessary.
145. I do not know the precise date on which the transition from Control and Restraint training to TASI took place but it was many years ago now and I do remember that the change was made in response to evolving best practice guidelines at the relevant time. The rationale behind TASI is the adoption of a more trauma-informed approach to patient care and recognising the distress that physical interventions can cause to patients and therefore shifting the intervention to a more patient-centred approach to support individuals in crisis.
146. "Do not disturb" tabards were introduced to minimise interruptions during medication rounds to protect medication rounds on Ruby Ward. Administration of medication was recorded on the medication chart and nurses could enter a code in instances where the patient refused or the medication was omitted for any reason. The pharmacy team also

monitored missing doses and if appropriate a Datix was raised if a critical medicine was missed or not recorded as having been administered. Datixes were also raised if a medication error was made. These were escalated to the doctor and physical health monitoring took place in instances where errors occurred. This was followed by the Duty of Candour process to NOK and/or relatives.

147. I believe the prescribing and administering processes were adequate, processes were always followed regards to medicines reconciliation and pharmacy input.

Care management and raising concerns

148. Patients and families had access to PALS services, an advocacy drop-in, local resolution, and formal complaints processes. Complaints handling followed Trust procedures. I cannot recall any patient or family views on the process.
149. In addition to this, leaflets and posters were displayed on the wards, highlighting how patients and families could access these services. They were also able to approach staff, or me as the Ward Manager either through speaking with me, or in writing.
150. On PBU an advocacy service provided by the Rethink advocacy service was rolled out. This was a non-statutory service available to patients on the ward. It included a drop in each week on a Thursday, where the patient could meet privately with advocacy volunteers from that service. Patients could feed concerns or queries via this service. Posters and leaflets were available for patients and displayed in the ward notice boards.
151. Staff had routes for raising concerns about colleagues, including through the Matron, HR, Datix reporting and Freedom To Speak Up. Capability and conduct processes existed for managing staff performance and behaviour issues. I felt confident in reporting any concerns to my line manager, HR or through raising a Datix.
152. I was not aware of any particular thresholds for referral to professional bodies, but any concern I had I will have been escalated via my senior management structure for guidance and advice and their involvement, along with HR advice and advice from the clinical lead if appropriate. On PBU we also had a NMC Clinical Lead who could be called on to give advice.
153. Where I was responsible for a person's line management, I would discuss those concerns with that member of staff, so they had awareness of the concerns made about

them and have a right to reply. I would also inform them of the need to address those concerns, how they were expected to do that and how we could support them in doing this. These conversations whether with the formal input of HR or not, took place supervision reviews or I would complete a file note, for their personnel file. I found this to be an effective mechanism in allowing that member of staff to understand the concerns and allow them to have the opportunity to take action to address them.

Clinical records

154. Clinical records evolved during the period of my service from paper-based systems to electronic patient records ("EPR") using CareBase and then Paris in 2013.
155. Prior to this, paper Nursing Kardex files were kept separately to the doctors set of paper notes, kept in a blue file and stored in the filing cabinet on ward.
156. The evolution from paper to digital records brought some advantages in terms of accessibility and audit, but it also introduced challenges. The electronic care planning modules, for example, were less conducive to collaborative care planning with patients and families than the previous paper-based tools had been.
157. Audit dashboards and the Trust's governance oversight improved with the EPR systems, though this was not without difficulties in terms of data entry burden and system usability. Ward and shift handovers evolved from purely verbal to incorporating electronic handover tools.
158. Patients are now allocated a named nurse on admission who is responsible for overseeing the creation, updates, completion and review of their nursing documentation. More recently acuity levels and demands on staff time has resulted in little to no protected time for staff to complete these tasks on the ward and particularly completion of and review of patients' care plans with them has been made challenging. During my time on PBU there was little time or space for nursing staff to do this to the desirable standard.
159. The governance of completion of these assessments and documentation more recently has moved over to live dashboard audit style system, which is RAG rated, i.e. it indicates green for completion and red where these have not been completed. Prior to

this completion audits were documented on a paper format audit form, or a shared spreadsheet, completed by the Ward Manager, Charge Nurse or Staff Nurse.

160. For the majority of my career, handovers were undertaken using paper forms. At the turn of the century, there was no template for a handover and as a new nurse I would follow the example of my senior nurses, with regards to how I received and recorded handover onto paper. I used the notes I made as a prompt for how I coordinated the shift and any prioritise or risks I needed to be aware of and any particular tasks that I needed to action, this handwritten handover supported my handover to the next shift and I summarise any actions completed, any new concerns, the patient's presentation through my shift and any outstanding tasks or issues the nursing team needed to be aware of.
161. As I recall these notes were not stored, but in the early to mid-2000s, we utilised handover files where handover notes could be filed and I believe handover templates were created. The templates differed depending on the ward you worked on, being produced locally by the team rather than a standard template.
162. Handover during these times included vital information such as the patient's risks assessed at that time, their presentation on that shift, their diet and fluid intake, their medication concordance, any incidents, and their observation levels. Recent changes to handover process have included changes to template used, move over to a dashboard system where the patient's case notes are available to review and refer to during handovers.
163. I do feel that the move over to electronic systems for all things, although to an extent unavoidable, it has and does at times complicate processes and adds in a time factor. It has led in my view to the deskilling of nurses and their ability to coordinate a shift and handover skilfully. Any persistent concerns regarding a nurse's ability to effectively coordinate their shift is discussed with them in supervision and a supportive plan put in place to help the nurse develop those skills
164. This reflects my personal view, informed by the fact that I was not required to use these systems when developing my own skills as a newly qualified nurse. At the time of my qualification, nurses were expected to swiftly develop skills in shift coordination and prioritisation, cultivate personal organisational attributes, create memory-prompting tools to help navigate their shift, and deliver clear handovers covering the pertinent

details of each individual patient's care - all without reference to electronic dashboards. These were considered important skills to foster in a nurse's early career. Care planning was also paper-based, and care plans could readily be drawn up with patients without any need to duplicate information into an EPR once the plan had been agreed. The current My Care My Recovery document is a hard-copy paper document that forms the foundation of the patient's care plan.

165. The patient can either complete this on their own or with the support of nursing staff. Patients sometimes do not want to complete these documents straight away or they may not be able to straight away due to the nature of their admission, and their levels of distress.
166. The 72-hour care plan needs to be transferred onto the EPR. There will therefore be situations where the nurse is required to start the care plan on the EPR with or without the involvement of the patient at that stage or the system will flag it as overdue. The absence of a shared interface that staff can work together with the patient can add a barrier to more skilled collaborative care. Nurses cannot simply open a care plan in front of the patient as they are required to ensure data protection of patient records. The duplication required can be impacted by acuity and time constraints on shift. It is my personal opinion that care planning should be a collaborative formulation and where EPR systems are used, then staff need an interface where they can sit with their patients and complete care plans together, without creating any access to records breaches. This would allow nursing staff to develop their collaborative care planning skills more easily, rather than trying to do so in the fragmented manner described above, which requires duplication of information and is more easily disrupted when ward acuity is high.
167. I understand most wards were issued with guest passwords for electronic systems (but I cannot say precisely when) which could be used by temporary bank and agency staff.

Care plans

168. Care plans are intended to be collaborative tools. They are formulated with input from patients, families and professionals, reviewed regularly, and used as living clinical documents to guide care.

169. At the very start of my nursing career; very early on in my time in the Trust, care plans in my view, used to be less complex and more relevant to patient specific, person-centred needs. It was a collaborative and devised agreement between the Nurse or Keyworker and the patient which held considerable value for the patient.
170. Care plans have now evolved into long documents, kept in electronic systems which in my view has lessened in value. This is attributable to factors such as: KPI requirements, audit requirements which pull through to central dashboards to demonstrate compliance and subsequently justify ongoing funds and resources for specific KPIs, for example smoking cessation, which does not lend itself to a person-centred approach.
171. The Trust currently utilises the My Care My Recovery approach document. The intention behind this document is for staff sit with the patient and complete this together as early on in the admission as possible so that this can then feed into and lead the care plan. Acuity on the wards impacts staff ability to do this reliably, patients are often at a point of crisis when they are admitted and therefore not in a position to complete this until either a few days later, by which time the 72-hour care plan has already been completed electronically. If completed separately then My Care My Recovery requires inputting into Paris.
172. As set out above having an EPR interface which allows My Care My Recovery documents to be completed by the patient alongside the nurse would be an improvement in the process as it would remove the need for duplication, or completion of a care plan via two separate mechanisms or systems.
173. For older adults, additional documents feed into the care plan, and this includes My Care My Recovery and My Care My Support. The latter is for those with cognitive impairment; they can be completed by relatives on the patient's behalf to ensure the ward has all of the relevant information to formulate a care plan individual to their needs.
174. On both PBU and Ruby Ward, the nursing care plans followed a similar format within the Paris system with essential domains covering observation levels, reason for admission, status (informal or detained), physical health and additional considerations for older adults, such as manual handling needs, falls risks and tissue viability. This is not to say that some younger people do not also have those needs and those sections can be completed in Paris if relevant to that patient.

175. My overall view (and this is a recent view) is that I do not feel care plans were adequately formulated, shared or reviewed. As described above in my experience, the introduction of EPR systems has added layers of difficulty with the process of collaborative care planning and the need for 72-hour care plans and inpatient care plans to turn “green” on Compliance Dashboards, i.e. completed, within a certain timeframe. Where the dashboard goes green this means the care plan is complete and the ward is considered compliant, however the system turning green provides no indication of the quality of this care plan.
176. That said I refer back to my opinion set out earlier that my skills were not initially developed using electronic record keeping and so this is very much a personal view given the way I was trained when I qualified.
177. My Care My Recovery is a good starting point, and I prefer the paper document as it lends itself to sitting with the patient and working on it with them collaboratively and the ability to revisit this with them. It is supported by a booklet which lends itself to collaborative formulation.
178. Time is also a significant factor, particularly on PBU which is an assessment unit with a high patient turnover. Although I am no longer in a managerial role, this remains my view on how reliably the My Care My Recovery documents are used in practice
179. In my experience, care planning formulation for patients on the ward rarely involved inclusion of the relative in that process. Staffing levels, Time constraints, the difficulties with formulating care plans collaboratively directly into an electronic interface all contributed to this. Patient wishes also needed to be respected where there was a wish to maintain the privacy of their care and treatment.
180. Patients had a physical health domain in their care plan within the Paris system, setting out any co-morbidities and plans for the treatment if the same. The care plans drew in specialisms where necessary to support, for example, a Diabetes Nurse. Sometimes patient physical health needs were formulated in separate care plan domains within the Paris system, this depended on the individual nurses approach to care planning and as far as I’m aware still does. Registered staff up until relatively recently were predominantly mental health trained with an occasional member of staff that may be dual trained and hold a Registered General Nurse Qualification. Care plans for co-morbidities were historically limited with regards to interventions and guidance but more

recently wards have seen recruitment of significant numbers of Registered General nurses as part of the international recruitment.

181. I recall very little specific training geared towards supporting staff with care planning. My early skills of care planning were gathered over time and on the job. I referred to care plans completed by more experienced colleagues and gradually improving my skills. I can remember the introduction of paper-based audits to oversee quality, which created a guide for staff to refer to in terms of what was expected to be included in a patient's care plan. Initially these audits were helpful and supportive to clinicians auditing their own caseloads. However as referred to elsewhere in my statement, in my view the transition to electronic style dashboards increasingly led to these becoming more of a tick box exercise and ensuring dashboards turned green to indicate compliance to KPIs and the care plans lost their value as a collaborative tool to aid treatment.
182. In my own role now, much emphasis is placed on the My Care My Recovery document being completed with the patient and this informing the care plan from there. However in my view issues persist with how reliably this is done. There remains a need for duplication of the completed My Care My Recovery document into the EPR system, in that it needs to be manually inputted by the nurse.

Therapeutic engagement and supportive observation

183. The process for decisions relating to observations are outlined in the Engagement and Supportive Observation Procedure, I do not know how far back this guidance goes. On admission, the patient is seen and assessed by the doctor, or duty doctor, if out of hours along with a nurse. The patient's presentation and mental state would be assessed. The nurse and doctor reference information available to them from the patient, the carer or NOK or family, if present, information available to them via the referring clinician and any referral documents.
184. The admission process considers the reason for the referral, the person's background and presenting risks and on admission patients are placed on Level 2 observations for no less than 24 hours. If the admission assessment indicates a higher level of observations is required, then this is recorded and undertaken. This process goes as far back as I can recall, and I do not think it has changed.

185. Observations levels are revisited in ward reviews with consideration given to any incidents a patient may have had, be it self-harm, violence and aggression, falls, patient vulnerability or physical health needs. Observations levels are highlighted at each handover at commencement of shift, where nursing can discuss any incidents and views on appropriateness of the observation levels at that time.
186. The minimum level of observation for patients on an inpatient ward is Level 1. Ideally prior to a patient being discharged or taking leave, the patient would be on Level 1 observations, to satisfy and support that they are consistently able to keep themselves safe over an assessed period.
187. Having said that, more recent changes with regards to informal patient leave from the assessment unit did impact this. When I commenced on PBU informal patients who were admitted were required to remain on the ward for 72 hours for a period of assessment, prior to being permitted to take leave. This was within the PBU operational policy at the time and also, I understand the result of a patient safety incident which occurred prior to commencing on PBU. Having worked on PBU for some time, I recall but cannot remember the date, where there were changes to informal patient leave following a CQC inspection. This meant that informal patients were entitled to leave whenever they requested owing to their voluntary status. Guidance followed from the Trust, and the operational policy was revised and included guidance around managing informal patient leave, the requirements around leave risk assessments prior to any episode of leave and the escalation process if the nursing staff had concerns that leave was not appropriate and potentially unsafe for the patient. The team needed to adjust to these new guidelines very quickly and this frequently resulted in newly admitted patients requesting and taking leave very soon after admission. Pending a leave risk assessment this means that at times some patients were monitored on a Level 2 on the ward, owing to their newly admitted position whilst also requesting and being risk assessed for short leave periods.
188. Decisions on observations are revisited in ward reviews, handovers and huddles. PBU had a daily MDT. Nursing staff would not automatically increase observations post incident, it would depend on the nature of the incident itself, engagement with the patient, effectiveness of any 1:1 support and more recently considerations for least restrictive practice and an awareness of the dependency this can sometimes create and the potential delay in progress towards a person's recovery. There was and remains an

expectation that risk assessments are updated following each incident. Whilst the nursing staff made great efforts, I cannot confidently say that this was the case following each incident, due the frequency of incidents in the span of one shift particularly on the assessment unit, combined with other activity on the ward, staffing and time constraints.

189. Safety plans and observation reduction plans were sometimes used, as an example, on PBU, observation reduction plans and safety plans were done on paper with patients, so they were more meaningful and collaborative. The safety plan within the EPR system of Paris were drawn up separately on paper as an agreement between patient and staff, and then case noted into Paris with the patient given a copy. This was communicated in MDT and ward reviews.
190. Observation reduction plans were used on PBU with patients who were generally deemed as a higher risk and may have been on Level 3 or 4 observations for some time but were requesting a reduction. As a team we would want to support this to encourage a therapeutic relationship and least restrictive practice, in a managed and collaborative way. Observation reduction plans included using communal spaces for a period where observation would be reduced to Level 2 but for a limited period of time, this could be increased gradually if the limited time went well and was incident free. The patient would be on a Level 3 at all other times, but this was used as technique to be built upon, with a view to gradually moving away from higher levels of observation.
191. A reduction can only be indicated if clinically reviewed by a doctor, whereas nurses have always been able to increase observations where this is indicated. More recently a Band 6 nurse or above has been able to review and reduce observation levels as part of an assessment of the patient and their own clinical judgement.
192. Staffing constraints had a direct impact on the ability to deliver observations as prescribed. Managing staffing levels and resources across the Trust has always been a challenge, particularly when wards are required to manage high levels of observations. I cannot recall how far back the aforementioned guidance goes, however for the most part the guidance was that wards would absorb Level 3 or 4 observations into their established or required ward staff numbers per patient with additional 1 staff being placed onto roster for each additional patient that required Level 3 or 4 observations. That being said, securing additional staff was challenging when changes to observation levels were made without much notice.

193. Overall decisions relating to observation levels were in my experience clinically driven and to overcome this a variety of actions can be taken:
- a. Mixed observation levels – for example, as mentioned above, the patient may be deemed to need a Level 3 bed space but could be assessed as requiring Level 2 observation in communal spaces. This was practiced on older adult wards but also used in relatively short time working in acute / the assessment units.
 - b. The allocation of communal nurses and corridor nurses are a method of supervision that have been practiced over the years particularly on older adult wards. It is difficult to recall exact timelines, but I would say certainly for the last fifteen or so years there has been an expectation on older adult wards that a communal nurse is available for the hour to supervise patients within the communal area, with all other Level 1, 2, 3 and 4 observations, delegated to specific nurses on the hour, at the commencement of shift.
194. I am aware of instances where staff fell asleep whilst on Level 3 (constant) observations. Where this occurred and was identified, steps were taken including incident reporting, investigation, and in some cases formal performance management. Trust guidance existed prohibiting this, but the reality of long night shifts, often with only one registered nurse on duty and heavy reliance on bank and agency staff, meant enforcement was challenging.
195. I personally became aware of issues with staff falling asleep on Level 3 observations when I was in post as a Ward Manager. Concerns were brought to my attention in several ways. Patients sometimes approached me directly, staff sometimes informed me and I would receive Datix notifications.
196. As soon as I was aware I ensured a Datix was raised so that senior management also became aware, sometimes I would speak with the patient affected to gain their account of the situation and apologise. I recall the issues lay mostly with temporary staff, in which case I ensured this was raised with the bank office and I completed bank office and complete a temporary worker concern form before removing them from the roster.
197. I took steps to remind the team of their duty of vigilance; expectations placed upon them and the process of reporting any instances they witnessed themselves.

198. Trust level guidance was available and circulated in the form of a flow chart, steps to take if staff were found sleeping on observations, or reports made. Posters were displayed in the office area and shared via email. This guidance included steps that the Nurse in Charge should take to ensure staff welfare on duty, which included staff signing a fit to work log at the start of their shift, and ensuring allotted breaks for staff.
199. The Service Managers and Matrons monitored sleeping on duty incidents, I would say these incidents were more common when needing to rely on bank or agency staff to cover shifts. Site Officers would visit wards to undertake spot checks on request, particularly in out of hours periods.
200. I am no longer within a managerial role, so it is more difficult for me to comment on whether these issues persist and how widely. Agency staff bookings are significantly restricted now and less commonly used due to budget reasons and so this has potentially seen a reduction in these types of instances. Staff sleeping on duty incidents are reported via the Datix system.
201. My overall view is that engagement and supportive observation was not adequate during the period in question. The reasons that I can recall include:
- a. Staff falling asleep on Level 3 observations as above.
 - b. Delays in meeting patient gender preferences; gender preference could not always be facilitated or could be delayed. For example, a patient needing to request a gender swap in order to use the toilet facilities or tend to their personal care needs may need to wait for that to be facilitated which can be restrictive and feel undignified.
 - c. Other issues include patients being kept on observations for prolonged periods.
 - d. Documentation challenges when staff were required to observe high numbers of patients allocated to them in an hour, challenges observing those patients, engaging and documenting the information for each allocated patient.
 - e. Reliance on temporary staff who were not always familiar with patients or Trust policies, and limitations in bank shift planning. Bank staff would not always have an established rapport with the patient, unless they regularly picked up

shifts. On both PBU and Ruby, restrictions were introduced on how far in advance shifts could be offered to bank and agency staff. Previously, ward managers had been encouraged to complete rosters in advance and plan bank cover accordingly. Advance rostering was still encouraged, but the window within which bank and agency shifts could be booked was progressively reduced. My understanding is that this was driven by budgetary pressures and changes to ward staffing establishments. In my view, putting shifts out in advance is beneficial. Where a shortfall in cover can be identified ahead of time, planning in advance increases the likelihood of that shift being filled by bank staff who are already familiar with the ward and its patients. Bank staff generally prefer to plan their availability in advance, meaning that shifts offered at short notice are less likely to be picked up by regular bank staff, who may already have committed elsewhere. This in risks the shift being covered by agency staff, which is both more expensive and does not provide the same consistency of care for patients.

- f. On PBU during the Covid pandemic the senior management produced a system logging cover for each site over several days to identify any shortfall in cover which was highlighted in red on a staffing table. During the pandemic the staffing table was dominated by the colour red, which gives an idea of the difficulties of ensuring staffing cover on wards during this time. Staff were be redeployed to ensure as best as possible cover across all wards and the Matron and Service Manager held oversight of this staffing table to ensure cover was arranged.

Mrs Smith's observations

- 202. In my view, confusion around observation levels in the case of Mrs Smith arose in part because of wording used by physiotherapy staff. For example, there was no reference to prescribed levels of observations either Levels 1, 2, 3 or 4 within the written recommendations. This meant the recommendations were open to interpretation by me and nursing staff with regards to how the guidance provided by the physiotherapist could be achieved. Within the RCA report the physiotherapist has stated that their recommendations were intended as Level 3 when mobilising and level 2 at all other times and that they communicated this verbally to the team. Whilst I have no recollection of this now given the passage of time, I accept that this was likely the case. I will

therefore have needed to consider how to apply those recommendations in practice, given that they specified different levels of observation depending on the activity.

203. On receipt of the recommendations at around midday, I advised the Nurse in Charge, that in addition to Level 2 observations that were already in place for Mrs Smith, they were to encourage her to use the communal areas during the daytime (in order staff could intervene and support mobility as required). In my experience of older adults wards it was common practice to allocate a communal nurse to manage and observe small groups of patients in communal areas in the daytime. This was a practice I was personally familiar with working as a staff nurse and a charge nurse across different older adult wards both functional and organic. It offered a more discreet means of observing a patient which was less intrusive.
204. At the time of the incident the observation policy in place allowed for communal or “zonal” nursing of patients. The zonal method of management had been promoted by our Matron at the time on Ruby Ward as a means in which observation of patients could be managed.
205. Mrs Smith remained on Level 2 observations with a separate nurse allocation. This further contributed to gaps in communication and oversight, as although the nurse in charge was aware of this advice it is apparent now that other members of the team may not have been informed and hence allowed Mrs Smith into her bed space where the subsequent fall occurred.
206. Huddles were not well established at the time, they came into place with the introduction of the long working day on the merger of the Trust which is a 7.00am to 7.30pm working shift. Prior to this arrangement we worked on an early shift and late shift system. An early shift was 7.00am to 2.30pm and a late shift was 1.30pm to 9.00pm, which gave a whole hour at shift change to handover, hold team meetings and provide staff with reflective space. I understand the long working day was introduced post-merger Trust wide, and I do not know the rationale behind this change.
207. Huddles were intended to be a short 10-to-15-minute discussion of patient risks. The challenges presented by activity levels, accommodating staff breaks and facilitating huddles which were free from disruption was problematic and from what I remember we never got to a place where these were well established. Doctors very rarely attended

if at all. The lack of huddles may have impacted communication on the ward. I am not sure what could be used in place of a huddle.

208. Training in assistive technology had been provided on installation of the technology prior to my arrival on Ruby Ward and was provided after that by nursing staff to each other, with instructions in the nurses' office to support. The RCA report states that neurological observation training had low uptake and had been offered only on an ad hoc basis to the Ruby Ward team by the Falls lead. It was not listed as a mandatory training for staff.
209. Falls risk assessments were completed by nursing staff and mobility assessments were completed separately by the Physiotherapist. Some time prior to Mrs Smith's incident I suggested that the Ward Physiotherapist should support with the completion and monitoring of falls risk assessments for patients on the ward. I cannot recall the date I did so, or why this suggestion wasn't considered further or taken on board.
210. COVID pressures during this period also affected staffing, activity levels and the ability to maintain close oversight of all patients albeit the ward did have an additional two staff over the established staffing levels for the ward on the day.
211. As set out above, I left Ruby Ward about a month or so after Mrs Smith died and so I cannot say if challenges with observations remained, or what changes were made to observation practices after her death or following any investigation by the Trust.

Adam Steel

212. Staff are required to complete Oxevision mandatory eLearning and a staff Oxehealth competence checklist, which registered and unregistered staff need to complete alongside Observation and Engagement learning. The training addresses:
 - a. That Oxevision is not CCTV.
 - b. How to share information about the Oxevision system and its use with patients, relatives and carers, including supporting any concerns and objections to the use of the Oxevision system and consent.
 - c. How to use Oxevision and Oxevision Observations to conduct observation rounds, periodic observations and managing observations levels.

- d. The ward level of the application of the system, alerts and notifications, and functionalities.
213. On a local ward level, I would have personally issued reminders of face-to-face checks being required for Level 1 and level 2 observations and not to use the Oxehealth screen in the nursing office. Staff were reminded at daily huddles and at the team meeting that they should reassure themselves, and document clearly on the observation record, that they had observed the patient was breathing and exhibiting natural movement. Where breathing and natural movement could be seen properly through the vision panel on the bedroom door, this was acceptable. However, where it was not possible to see the patient through the vision panel or if there was any doubt about the visible signs of breathing, then staff were reminded that entry into the room to undertake the observation was expected, even where opening the door might rouse the patient.
214. This learning was reinforced when the Patient Safety Incident Review ("PSIR") report was finalised and shared with the staff on PBU where it was revisited and discussed at the team meeting.
215. Although I don't recall any specific incidents of staff using Oxehealth technology to complete Level 1 or 2 checks on PBU, I do vaguely recall issuing reminders following Mr Steel's death to nursing staff that if anyone was observed using the Oxehealth screen in office they were to be reminded to complete their patient checks face to face.
216. The Oxehealth system at the time of the incident was accessible via the screen in the office, tablets, as part of the E-Observation roll out some time later, I cannot recall the date, but I think it may be around the spring or summer of 2022. As far as I recall, prior to this staff will have only had access to one Oxehealth TV type screen in the nursing office. I recall once the tablets arrived, Oxehealth training was provided across several shifts directly by the Oxehealth team.
217. Although I cannot remember specific examples, I do remember that staff did on occasions need to be reminded not to use the tablets and that checks should be face to face, however I am unable to provide any clear recollections or specific examples.
218. In my opinion, human factors and room ergonomics/layout particularly on PBU increased the likelihood of staff using Oxevision as a substitute. The vision panels on 7

out of the 18 of the bedroom doors in PBU did not provide a view of the head of the bed and the bedroom doors were heavy and noisy to open, combining this with the availability of an alternative option, i.e. Oxehealth, further combining this with staff not wanting to disturb patients sleep, which was particularly relevant at night time.

219. I have some recollection of the initial Oxehealth promotion materials, specifically promoting Oxehealth as a tool on which patients sleep hygiene could be improved, due to less disturbances for the patient.
220. The Patient Safety Incident Review into Mr Steel's death concluded that although he was on Level 2 observations, requiring four random checks per hour, he was not physically checked face-to-face overnight. Instead, staff relied on Oxehealth technology rather than conducting in-person checks, contrary to policy. Documentation was simply recorded as "observed." On reflection I agree that a culture of recording less information might have existed but as far as I can recall I was not aware of this at the time and this combination of factors did not become apparent to me until after Mr Steel's death when I took steps to address this. This included reminders to the nursing team in discussions and team meetings, and escalation of the room layout issue via the vision panel meetings, discussed above.
221. Following Mr Steel's death, the layout of Room 7 was changed as the bed could not clearly be seen from the observation window. Room 7 houses a bariatric bed which was removed for repair. The bed was returned to the ward after repair and consideration was given to repositioning the bed and the Oxehealth equipment so that the bed could be viewed from the vision panel on bedroom door. The bed was changed to a fixed based bariatric bed and positioned centrally in the room to allow for improved view via the vision panel on bedroom door. I undertook the Vision Panel meeting following advice from my matron having approached him with my concerns regarding room layout after the incident. My hope from the meeting was to highlight at organisation level the circumstances affecting those 7 bedrooms.
222. I understand that the remaining rooms could not be changed because of the limitations in the physical environment, in addition to other adverse implications such as loss of the use of a busy, needed and functioning ward for a significant period, and cost implications needed significant funding. Mitigation measures were put in place, such as reinforced mandatory training on patient observations and Oxehealth with all

conversations within team meetings having a particular emphasis on its use as an additional tool and not a substitute for inpatient observations.

- 223. All inpatient qualified and unqualified staff are required to complete mandatory training on Therapeutic Engagement and Supportive Observations. The training is completed online every three years and addresses methodology as well as the importance of engaging and observing patients to reduce risk.
- 224. Observation recording was partially addressed by the roll out of e-obs, as this provides an electronic time stamp of the time the observation was entered, with observations being recorded contemporaneously. Tab options to select the whereabouts of the patient, i.e. lounge, corridor, garden, and narrative boxes for staff to record their engagement with the patient and interventions. I am not certain this has adequately addressed issues with quality of observation documentation. I do not personally see any benefit to e-obs on patient care as I feel it adds a barrier to engagement, with staff concentrating on recording using the device, rather than enhancing engagement with our patients.
- 225. I did complete a review of Henneage ward by walking around the ward personally and confirming with the Ward Manager that all the bedroom door vision panels on Henneage ward provided a good view of each bed. With the beds being situated directly in front of the vision panels.
- 226. I did not review any other wards. Henneage and PBU are the only wards on the Kingswood site.

Discharge

- 227. Discharge planning starts on admission where an expected discharge date is identified if appropriate, the identification of a discharge date from the outset is a process which has been in place for the last ten or so years of my career. Discharge processes involved an assessment of readiness communication between the treating doctor, nurses, with community teams and carers
- 228. Decisions relating to discharge were discussed during the period of admission, in reviews and MDTs, in consultation with the patient, and decisions were made by reference to an assessment of their treatment progress and presentation. Ward reviews

on Ruby Ward took place weekly, but more frequently when the patient's need arose. On PBU all patients were discussed daily in morning MDTs. The MDTs comprised, doctors, nursing staff, OT, psychologists, junior doctors, pharmacy and the North East HFT. Sometimes AHP attended.

229. The discharge review process consisted of a handover from the nursing team to the doctors, with regards to the patient's presentation, whether they were involved in any incidents, the patient's mood, how they had spent their time on the ward, their level of engagement in ward activities, concordance with medication, any use of as required medications, their diet and fluid intake, any physical health concerns including review of their vital signs, their sleep pattern and any leave periods. The patient would then be invited in to partake in that discussion, and they were always asked for their views on progress. A ward review template was completed within the Paris system by the junior doctor (on PBU) or the doctor's PA (on Ruby). Where relatives were attending discharge planning, a meeting between professionals would take place prior to the family being invited in, at which point they would be provided with an update and invited to share their view.
230. Families were invited to meetings relating to discharge planning and particularly, where there was a need to gain more collateral information. Some families were involved but the extent to which they were involved varied, this was dependant on the relationship between the patient and their family, if they had any. It was common for families to be involved with discharge planning for those patients on older adult wards.
231. Discharge plans were communicated by the ward, to the care coordinator, or social worker if allocated and the HFT. Each patient had a crisis, or discharge domain within their care plan. The HFT also undertook their own assessments of patients prior to being accepted into their service, prior to Discharge. OT assessments were provided as part of discharge planning where this was required.
232. At PBU specifically, the geographic complexity of covering multiple areas added an additional layer of challenge for discharge. Attendance at discharge meetings by HFT was variable. The arrangements for PBU HFT were set out in the PBU Operational Policy at the time. The standard set out in the policy dictated that The North East HFT would attend daily MDT both to cover their own provider area and to provide in reach for patients who were admitted from out of the area. North East HFT were expected to

attend the daily meetings however, particularly during the latter part of my time on PBU, attendance could be impacted by cover within that team. This was an issue I escalated more than once to my Matron who in turn escalated this to the Matron for that service.

233. Having said that when there wasn't attendance at MDT, the nursing team could still request that a member of that team to come and assess patients as required on any given day. Where this was necessary prior to discharge, the member of the HFT team would meet with the patient and complete their own assessment and also hand over to the HFT team within that patient's local area. There were issues at times with referrals to community teams out of area, with each community team having a slightly different referral processes which could be difficult for the PBU Nursing team to navigate particularly at short notice, and I recall Datixes being raised by one team in particular regarding the quality of referrals being completed by PBU.
234. There were some factors that impacted on discharge. A prominent factor I recall relates to PBU. For example, on PBU, patient accommodation issues were a frequent cause for discharge delay. Patients with no fixed abode or those who had been served notice from their accommodation once they had been admitted could face delays whilst they and the discharge coordinator liaised with the local authority to source the provision of accommodation. Where a patient was ready for discharge and had no accommodation, they were sometimes temporarily placed in bed and breakfast hotel style accommodation funded by EPUT, for a temporary period. The discharge coordinator was responsible for oversight of this process, liaising with the local authority and updating the MDT with regards to accommodation delays and process. This arrangement as far as I recall was always run by the consultant to ensure they considered this an appropriate discharge arrangement.
235. Prescriptions were prepared for discharge by the Pharmacy team who would supply To Take Away ("TTA") medication for discharges. A process of Self Administration Monitoring was available, which allowed a period of assessment of self-administration on the ward by the patient prior to discharge. This was used more regularly on Ruby Ward for older adults approaching discharge, although it was not routinely undertaken for every discharge. Where the process was used the patient's ability to self-administer was documented. I don't recall Self Administration Monitoring being used much, if at all on PBU.

236. The patient's discharge prescription would be sent to their GP, via the 24-hour discharge summary; the ward would retain one copy, with another copy being sent to the GP and one to be retained by the patient. The recording of discharge decisions and plans were documented in ward review updates.
237. Overnight leave was used to test discharge arrangements for some patients. On Ruby Ward, overnight leave was utilised frequently enabling the team to test whether discharge would be successful, as well as provide the patient with the opportunity to test discharge themselves. This was particularly useful for the patient, if they had been in hospital for some time and where they had some natural apprehension about returning home after a long period in hospital. On Ruby Ward, leave could be granted for up to two weeks and I believe in some cases, longer.
238. We could arrange for their community nurse to visit whilst they were home, and we could also arrange to contact them via telephone during this time to see how they were getting on and provide them with some assurance we were on the end of a phone call if they needed. Patients would then return to the ward to be reviewed by the consultant, where generally if all had gone well, they would either be discharged or placed on a further week's leave, if the consultant required further time to review their progress. Sometimes the patient would get on so well at home that they wouldn't want to return to the ward, so they would be discharged with follow up by the community teams.
239. On occasion, if a patient was on leave, their bed might be used for an admission for the period of their leave. Where this was contraindicated, the bed was ringfenced for the patient on leave to return.
240. Leave was generally not permitted on PBU due to the assessment nature of the unit. During my time on PBU periods of leave did become a little more common at the discretion of the responsible consultant. Those patients waiting for treatment beds who were reviewed, showed progress and expressed a wish to have leave were permitted leave on assessment to test their progress and enhance their recovery. The period was limited and short in nature, usually one or two nights but no more.
241. I did at times feel that there was an overall pressure to discharge patients, this was the case especially on PBU, to the extent that we were expected to work towards the expected discharge date. The expected discharge date would be amended where if on assessment, a patient wasn't ready to be discharged, this could include for example,

changes in their presentation, their response to treatment or accommodation. The patient would be discussed at MDT to review and change date to allow for further assessments or for accommodation for example to be sourced.

242. The pressure generally was from a place of needing to create flow within PBU as an assessment unit, but this did not prevent discharge dates being put back for patients where required.
243. There were some barriers to the discharge process on Ruby Ward. The older adults would require care packages if they returned to their own home, or we would need to identify appropriate placements in residential or nursing homes taking into account their mental health, physical, or nursing care needs and their social care requirements, such as Care Coordinators etc. This would all be determined through an MDT or a Panel meeting to discuss the care and funding required and the process could take considerable time, particularly where funding needed approval. To combat this Matrons held delayed discharge meetings, attended weekly by the Ward Manager, Discharge Coordinator and Social Workers and Care Coordinators, to try and identify reasons for those delays and how they could be overcome.

Engagement

244. Nursing staff engaged and communicated with patients every shift. Communication relating to treatment decisions were processed through ward reviews and patients would often have questions about their care or treatment, where the nursing staff could support with answering themselves, they did. Where they could not, they would flag this with the doctor.
245. I would say that communication with family members could vary. For example, on older adult wards where admission was generally a longer length of stay, it was more common to engage with family members and include them in reviews and updates. Although family members were included in ward reviews for many patients on PBU they were consulted less regularly, particularly where a patient was informal and able to update, or where they wished update family members themselves. The intention was for communication with patients and families to be regular and collaborative, with family members being invited to ward reviews and consulted about care where the patient consented. However the extent to which this was achieved varied and largely depended on patient consent, as well as ward acuity, and handover communication

246. MDTs and ward reviews took place daily and PBU was established for three registered nurses per long day shift. Staffing pressures elsewhere on site however frequently resulted in the Registered Nurses on PBU being redeployed to other wards, leaving sometimes only one or two nurses to manage the workload of the assessment unit. These activity levels meant that routine communication with each patient's family member simply wasn't possible and so what tended to happen was that family engagement was reactive rather than proactive. As a team we responded to family queries as and when they contacted the ward, or where it was determined that the family needed to be contacted. Despite this during my time on PBU, I recall vividly speaking with many family members, as did the nursing staff, during the course of our daily duties and I always respond to a family member's request to speak with me.
247. Confidentiality and consent processes existed and consent to share information was sought and documented on admission by the admitting nurse on the Electronic Patient Record ("EPR") system. It was kept under review and revisited regularly with the patient when there was a need to share, or gain information and permission was sought to invite family members to ward reviews. I have mentioned earlier in my statement that family input was variable, and this was dependant on the family's wish to participate, or the patient's wish to share that information with their family if they had any.
248. The sharing of information with family was also dependent on consent to share. Some patients might wish to share certain information about their care, treatment or progress but omit other pieces of relevant information. Where patients did not want staff to share information with their relatives, they were reminded by me that we were still able to receive information from them that may be helpful to us in supporting the patient.
249. Where families did participate, their input was documented in ward reviews and the doctor's case note entries which recorded subsequent information gathered from the relative. This information was considered and could be used to assist or inform decisions on care and treatment.
250. Where patients had capacity, they had a right to have their confidentiality maintained, however instances where significant concerns may arise regarding their level of risk, particularly in the case of a risk to their life, information about them could be shared without their consent. As an example, limited information could be shared with the police. Nursing staff undertook best interest discussions within MDT or with the

consultant or doctors of the MDT and had access to safeguarding teams for proactive support. I have no recollections of having been required to override a patient's wishes not to share information as a result of escalating risk

251. If I became aware that a family member was dissatisfied with communication from the nursing team, I raised this with the nursing team in team meetings to highlight the need for more effective and supportive communication with family members. I reminded allocated named nurses to contact family members early on in admission. Where complaints were raised I shared the findings of investigations with the nursing team. When concerns were raised, I would scope the nature of the concern to attempt to establish how this could be rectified by us as a nursing team and outline my expectations to the team, if not in a team meeting then by way of circulating an email to the team and conversations with my charge nurses for their support with the matter moving forward.
252. I recall some occasions where the patient's first language was not English, I recall particularly a patient on Ruby Ward however I do not recall their nationality. I was able to secure translation services for the patient, and the interpreter was able to meet privately with the patient and also support their communication to the nursing team. I do not recall how frequently they met with the patient or how easily we were able to source their input as this was some time ago.
253. More recently on PBU, I vaguely recall some challenges accessing timely translation services for a patient. My team needed to make enquiries which spanned over several days if I recall correctly – I do not recall how successful our enquiries were and whether or not we were able to source the adequate support. My memory is not clear however I recall some challenge.
254. Following serious incidents and near misses such as a ligature attempt, headbanging, self-cutting or other methods of self-harm, patients were supported through immediate clinical intervention to address any harm they sustained physically, along with emotional reassurance and 1:1 support. Incidents were documented in the case notes and logged as an incident on Datix. I recall Datix reports to review on PBU where I saw no reference to 1:1 provision post incident within the incident narrative. On those occasions I reminded the team via a Datix memo to offer and record the provision of 1:1 support and document this within the Datix narrative and follow up with risk planning. This will

have also been highlighted in team meetings. Therefore overall, the quality and consistency of this support varied.

255. Incidents or harm sustained during my time on Ruby Ward was routinely shared with the NOK. For example, if a patient had a fall or where they needed to be transferred to the general hospital, nursing staff contacted family or NOK over the telephone. I recall this less so on PBU. At times this was because patients did not want this information to be shared. There were some occasions where acuity was a factor and instances where it is likely that the need to do so was unintentionally overlooked.
256. In my experience of notifying families of a patient's death, the process was extremely difficult and emotionally demanding, and there were gaps in training.
257. I don't ever recall receiving any comprehensive training regarding the delivery of bad news. There is some reference to this in the Duty of Candour e-learning and these soft skills are picked up over time. My own development in this regard was attributable to on-the-job learning; I observed senior staff when handling challenging news and undertaking difficult conversations. I don't recall any written material, such as leaflets available to patients relatives in the event of receiving such news, which may be of benefit to them in terms of important contact numbers and support mechanisms both provided within and outside of the Trust such as bereavement support or information on next steps, and cover arrangements for NOK support. This role was often performed by the Ward Manager, who might have limited training or support for what was a highly sensitive and complex task.
258. Regarding absconsions, the Trust has a missing persons policy and alongside other immediate actions, one is contacting the NOK to inform them of the absconsion itself and to determine whether their loved one has been in contact with them.
259. My view is that engagement with patients and families was not consistently appropriate or adequate during the period in question. There were individual staff members who communicated exceptionally well with patients and families, and who went to considerable lengths to involve them in care. With hindsight, the overall standard of engagement was too dependent on individual initiative and varied across different staff members, shifts and wards.

260. Structural and systemic factors contributed to this variability. Staffing levels and workload pressures reduced the time available for meaningful engagement. The absence of consistent training in communicating with families particularly in relation to serious incidents and death, meant that staff were not always equipped to carry out this role to the standard required. The processes for obtaining and documenting consent, and for managing the tension between confidentiality and appropriate family involvement, were not always applied consistently for these reasons.
261. Structurally a system that worked for a longer stay treatment ward such as Ruby Ward did not necessarily work well within a busy assessment unit such as PBU where turnover of patients and demands for daily MDT and review were far higher, particularly in cases where staffing resources were pulled from the assessment area to cover other units staffing challenges. Whilst the baseline registered nursing establishment for the assessment unit was set at three registered nurses per shift, this was frequently not the case due to unanticipated sickness or redeployment of PBU staff to cover other wards. This impacted skill mix shift to shift and impacted the quality of communication and engagement.
262. The experience of Adam Steel's family, where the family liaison officer was not allocated until four days after his death and did not make initial contact until thirteen days after his death, is illustrative of the gap between the intended standard of family engagement and what was delivered in practice.
263. Intentions were good, but in practice the quality of engagement was variable and depended heavily on the individual commitment and skill of staff members and on the availability of time and resources. My recommendation is that engagement with patients and families must be treated as a clinical and organisational priority, with dedicated resource, consistent training, and clear accountability.

Safety

264. Safety was managed in several ways and included safety for the patient through risk assessments and ligature audits and safety within the environment.
265. To safeguard patients from self-harm, ligature audits and environment inspections were conducted routinely at both Ruby Ward and PBU. The process involved the Ward Manager, Matron, Estates, and Risk Team representatives. A template was used to

guide the inspection, and action points were identified and tracked. "Door-top drills" were also carried out. As Ward Manager, I participated in these audits and was responsible for implementing and monitoring actions. My overall view is that the process was adequate, though prior to around 2017 there was an over-reliance on the Ward Manager to initiate and drive the process. To overcome this Estates took more of a lead, with raising and monitoring completion of any repairs or tasks identified within ligature inspections. This meant as Ward Manager I could focus on more clinical aspects such as sharing the report or any other learning and updated hotspots with the team.

266. Audits and inspections were carried out on the ward to assess the safety of the ward layout and the environment the patients were in during their admission. The audits and inspections would have identified the risks presented by the environment to patients on the ward. Along with the audits, both Ruby Ward and PBU had the red tabbed ligature wallets. These contained hot spots which was a floor plan setting out where the potential ligature points were, they had photographs of the hot spot areas amongst other items such as ligature cutters. On PBU each shift also had an allocated environment nurse who checked the ward daily using a check list. I cannot recall the contents of the list in its entirety, but it included a check of each patient's bedroom, and all patient areas as well as clinical areas, to check for any environmental damage, defects, or faults that caused concern from an environmental perspective. These were then raised and flagged with Estates or action taken by the nursing team. I do not recall if a similar daily checklist existed on Ruby Ward.
267. In addition to ligature audits and environmental inspections, patients were individually risk assessed on admission. The risks noted in their assessments were taken into account in ward reviews and when determining treatment and/or therapy. They also assisted with determining for example the personal items they could have with them. Patients could be reassessed during their admission for example after an incident.
268. Both Ruby Ward and PBU had systems in place if a patient had ligatured. The wards contained ligature pouches containing a selection of ligature cutters and scissors, to ensure different methods of cutting and removing the different types of materials that might have been used. The pouch was kept in the nursing office and clearly signposted for easy access. In the event of an alarm being raised, nursing staff would grab the pouches and respond to the alarm. Sometimes if the ligature was not tightly tied it was possible to untie this by hand, where this was not possible and where there was a need

to remove this quickly staff utilised the appropriate cutters. If the patient resisted this and tried to prevent staff from removing the ligature, nursing staff were required to utilise TASI holds to allow other staff to complete removal of the ligature. We received mandatory training in the use of TASI.

269. Following a patient ligature incident, the patient was to be supported with their immediate physical needs and a check of their vital signs. The nursing team would assess the item that was used and if possible, this would be removed. Nursing staff offered 1:1 support, the degree of which could vary. Where Datix reports didn't include reference to this post incident the team were reminded of the importance of the provision of emotional support post incident. Where patients used clothing to ligature, it was not possible to remove all potential ligature risks and so on risk assessment the patient's observation level was considered by the nurse in charge and increased if required.
270. Reduced ligature clothing and bedding was provided by the Trust for use with patients where clothing was repeatedly used for ligature attempts, it was set out in policy. Wards had limited numbers of reduced ligature clothing and bedding provision and could sometimes source this from other wards if needed. Reduced ligature clothing was a very restrictive option and could impact patient dignity and comfort and the use of it is guided by policy. I was only ever familiar with reduced ligature clothing during my time working on PBU and I had no experience of using this on older adult wards.
271. I do not recall ever witnessing a ligature incident taking place on Ruby Ward. Ligature incidents were frequent on PBU. Observation levels were not always increased following every incident and nursing staff endeavoured to utilise the least restrictive practice as this assisted with the patient's therapeutic intervention. Patients were encouraged to talk with nursing staff and inform them if they were struggling in order staff could intervene and support prior to an incident in addition to the observation levels prescribed for that patient. In the presence of continued attempts, the patient's observation levels was discussed and reviewed in MDT and ward reviews and in the presence of repeated attempts levels were increased. This was not the only way to manage ligature attempts, nursing staff were aware of the importance of working in the least restrictive way, they were aware of the intrusive nature of Level 3 and 4 observations and mindful that enhanced Level 3 and 4 observations could be difficult to move away from and can create an unhelpful dependency. This can subsequently

impair or delay the patient's ability to keep themselves safe and obstruct their progress towards recovery. All nursing staff completed Ligature Awareness and Preventing Suicide by Ligature training (e-learning). All ligature attempts were highlighted in the daily MDT and ward reviews for MDT oversight.

272. Older adult wards presented particular safety challenges because the patient group was at risk of both falls and ligature. The environment needed to be designed and managed through a dual-purpose lens that addressed both risks. Although ligature inspections were in place, I remember less clearly the process regarding environmental considerations for falls risks. Consideration was paid to the physical environment through handrails, assisted technology and assisted shower and bath facilities, as well as signage and nurse call bells. Handrails were removed as a ligature reduction measure in the ensuite areas of Ruby Ward and this created new falls risks. I do not recall dates these were removed, nor do I recall any prior notice that they were to be removed.
273. Sexual safety issues arose at PBU and involved a range of scenarios including boundary breaches between patients and staff, staff conduct allegations requiring investigation and inappropriate patient relationships. I do not recall any incidents of this nature of Ruby Ward.
274. The mixed sex nature of PBU could present difficult dynamics. Staff always intervened and reminded patients of appropriate conduct between themselves and towards others and reminded patients of their vulnerabilities and the vulnerability of others on the unit. My memory of specific incidents is limited due to the passage of time and the volume of incidents managed over the period.
275. I have a vague recollection of family members at times, expressing concern over the mixed sex nature of PBU and requesting for their loved one to be moved to single sex female ward. I remember one family member who had this concern along with concerns about their loved one's physical mobility needs on PBU. I spoke with this patient and their family member on many occasions in response to these concerns in an attempt to be responsive and supportive. If I recall correctly this was processed via the PALS process and with the input of the complaints team. I will have spoken to many family members during my time on both wards and I am unable to recall any more specific

details of safety concerns shared by family members due to the passage of time and volume of conversations I had.

276. I have been asked specifically about whether I felt safe on ward. I have no recollection of ever feeling unsafe on Ruby Ward.
277. Conversely, on PBU there were many incidents where I felt my personal safety and that of the team was under threat, some of the incidents include an ex-patient making multiple attempts to contact our then Charge Nurse. Contact was made through the ward phone, arriving at the unit on several occasions, or waiting within the car park area. There was no clinical reason for this contact which was persistent and so this was reported to the police, who attended and undertook the police process going forward.
278. I recall another incident where two female student nurses raised concerns regarding the conduct of a male Healthcare Assistant ("HCA") towards them whilst on duty. I recall this included asking for their telephone contacts and making inappropriate advances and comments towards them. I can't remember how I became aware of these concerns, but once I became aware I spoke with the student nurses, I believe both of them separately contacted their university so they could be further supported. I also escalated this to my line manager for their awareness and spoke with HR for advice, before speaking with the male member of staff themselves.
279. After getting advice I spoke with the staff member, informed him of the concerns raised and placed him on leave whilst an investigation took place. The investigation as far as I recall was allocated to a member of staff external to PBU team. I do not recall what the findings were and I am unable to recall with any certainty whether the staff member worked on the ward again –as far as I recall the staff member resigned but remained on the Trust staff bank.
280. There were many occasions where the nursing team and I were subjected to verbal abuse, patients shouting and gesticulating in such a way that gave the impression physical harm could potentially be imminent. These incidents were managed via de-escalation techniques as far as possible. Within mental health settings there is always an acknowledgement that patients may struggle to self-regulate and manage their behaviour. These types of incidents are managed as professionally and sensitively as possible, with all focus on de-escalation of the incident in the moment. The incident was then discussed with the MDT and in review with the patient, to highlight the Trust's

expectations of their behaviour whilst on the ward. Zero tolerance letters could be issued, sometimes this could have a positive effect, but conversely at other times it could inflame the situation. We worked as a team and supported one another, but this was difficult. The nursing team had personal attack alarms and a supply of bank and agency stock alarms. Handovers also include the communication of any such incidents, and we could call on the security staff based at the Lakes to support us. PBU also did have some security cover which varied, but this did not prevent us from calling on security support during the day, where we felt there was a threat of escalating behaviour that could result in harm to staff. But certainly, at times I felt vulnerable to the risk of physical harm. There were some occasions where the threat of harm was such that the Police were called and their assistance required.

281. For a considerable period of my time on PBU, we had a Police Liaison link, who visited the ward weekly and more often if requested. The Police link officer, who was an experienced officer within Essex Police attended the ward to support staff and patients, usually informally by way of a presence and familiar face, and at times attended patient/staff community meetings. The Trust's safeguarding team were also available to support in relation to the referrals processes and deadlines for completion of referrals.
282. PBU also had a domestic abuse link worker who provided drop ins weekly on Thursdays. The Police link officer and safeguarding team were available for support and advice on request.
283. The Trust's Patient Safety Incident Response Framework ("PSIRF") was introduced in May 2021. My direct experience of PSIRF investigations is limited to one case (Christopher Nichols). Prior to PSIRF, I had only been involved in RCAs relating to investigations.
284. Having only completed one PSIRF report I cannot say I have an experienced view on whether PSIRF has had an impact on the response to patient safety incidents. There was a significant time gap of around a few years between my requirement to complete an RCA and then being asked to complete a PSIR. The RCA investigations I completed related specifically to falls incidents; the PSIRF investigation was into a death by suicide and so I cannot draw any comparisons between the two types of investigations. Both investigation templates provide an overview and investigation into the care provided

and both have an action plan with recommendations. Both also have an expectation for local learning within the service concerned.

285. The Learning Lessons Team disseminate learning from investigations via the Trust intranet, newsletters shared by email, and governance processes. The effectiveness of this dissemination to frontline staff was limited and I would say remains limited. Frontline staff are time-pressured, email communications are and were voluminous and cannot always be read thoroughly or digested, and team meetings did not always provide sufficient time or opportunity for meaningful reflection and embedding of learning. There is little to no protected time for staff to attend undisturbed meetings due to the busy nature of ward activities. My suggestions for improvement include better support for the Ward Manager role in leading learning and the provision of protected time for staff to engage with learning.

Technology

286. During my career at EPUT, the use of technology in inpatient settings evolved considerably. In the earlier part of my career, clinical records were paper-based, observation records were completed by hand, and there was minimal use of assistive technology on the wards. Over time, this changed significantly, with the introduction of electronic patient records, mobile devices, body-worn cameras, CCTV, and patient monitoring technology. I cannot recall all of the technology that was available. The specific ones I have been asked about include the following:
287. Mobile devices for recording observations – moving from paper-based observation charts to electronic recording was a positive development. Electronic recording allowed for real-time data entry, reduced the scope for retrospective completion of records, and made data more readily available for audit purposes. However, the transition required adequate training, and I recall that there were periods when staff were not sufficiently confident or consistent in using the new systems.
288. Body-worn cameras were introduced for staff safety purposes, primarily to be used in situations where there was a risk of aggression or violence. Their use was subject to policy and required activation in specified circumstances. Staff were expected to notify patients when a camera was activated.

289. An allocated member of the nursing team was expected to wear a body worn camera per shift. Those cameras not in use were kept in the office in a docking station to ensure they were always charged. I do not recall if there was a process displayed for staff to follow in the event of needing to activate a camera. BWCs were rolled out whilst I worked at PBU, I am unable to recall with any certainty the training provided, I believe these were initially delivered to the wards by the VAPR team, who provided some initial instruction on their use and a written guide to their use, which was circulated to the nursing team by me via email and then displayed in a BWC file in the nursing office. In terms of securing and access to footage of incidents, I believe this was enabled by contacting the BWC team who could access any uploaded footage from off site and secure it. The use of body worn cameras was highlighted on entrance to PBU via a poster format. I don't recall any written information being available for patients regarding BWCs, nor am I at all certain on how long information was stored for. In terms of the impact on the therapeutic relationship between staff and patients. I'm not confident they had any positive impact in terms of improving staff safety and my view is that it could at times be viewed by patients as an antagonist rather than a method of improving safety.
290. CCTV was not in use on Ruby Ward, but it was in use in communal areas of PBU. Patients were made aware of CCTV through notices displayed on the ward. CCTV footage was retained for a set period and could be accessed for incident investigation purposes via the CCTV team.
291. I can recall that footage had to be requested as soon as possible after any incident by completing a request form and submitting this to the CCTV team who could then isolate the footage and store. I cannot remember the retention period. Matrons or higher level senior staff could view the footage. I am unable to remember what information was given to patients regarding the use of CCTV. As a safety tool, it was useful in the event of an incident which required further exploration, for example if a staff member was alleged to have been asleep, the footage could be accessed to assist HR processes. If there was an incident requiring escalation to police, police could request access to the footage again via the CCTV team. The footage was only accessed on a strict need to access basis and via the CCTV team application process, and so I view any impact on patient dignity to have been minimal, given the strict process for accessing footage, and footage only being stored and shared on a strict need to know basis as governed by the CCTV team.

Oxevision/Oxeobs for remote monitoring of patients

292. I used Oxehealth whilst I was a Ward Manager at PBU. Oxehealth technology was deployed at PBU to monitor patients remotely. The system operated using cameras installed in patient bedrooms, which were capable of detecting movement and monitoring vital signs, including heart rate and respiratory rate, without physical contact with the patient.
293. The system could monitor vital signs but required staff to actively press a button to activate this function. The CCTV footage provided by the system lacked clarity and sound. I don't know how long the recordings were retained for.
294. The intended purpose of the technology was to support observations particularly overnight in a less intrusive way, by allowing staff to monitor patients without repeatedly entering their bedrooms and disturbing their sleep. In principle, this was a positive development, particularly given the tension between maintaining safe observations and preserving patients' sleep quality. The heavy and noisy bedroom doors at PBU meant that repeated physical entry for observations could cause significant sleep disruption, and Oxevision was intended to offer an alternative means of monitoring
295. However, in practice, the deployment of Oxevision at PBU was associated with significant concerns. The system required staff to actively navigate to a patient's room on the monitoring screen and, where vital sign monitoring was required, to press a button to activate that function. This was not an automatic process. The monitoring station was located at the nursing station, meaning that staff needed to be at the station actively viewing the system for it to provide meaningful oversight.
296. When I joined PBU the Oxehealth system was completely new to me and I took it on myself to familiarise myself with its use by asking colleagues. This involved understanding its layout, how to take vital signs using the technology and how to interpret alerts. I do not recall what formal Oxehealth training was available to me at the time by way of mandatory training, but I know that it was not immediately available. My first recollection of the formal in person training being made available was as part of the roll out of e-observations. This involved documenting observations using handheld the devices. Members of the Oxehealth team attended the unit for a 24-hour period over several weeks to ensure they captured as many staff as possible regarding its use.

297. I recall carefully rostering staff familiar with its use for many weeks to allow those not captured or later captured by Oxehealth's team to catch up on training. I cannot recall when the formal Oxehealth e-learning became available as a mandatory training and how and if this has changed. Some younger staff are also more naturally adept at using this type of technology than staff of my own age group and older, who will be more familiar and at ease with paper-based systems. Once training was available this was in the form of an e-learning via the Oxehealth website and once staff successfully completed the e-learning (which included a test covering functionality and use of the system), they were provided with a certificate. The roll out of e-observations included the Oxehealth team being based on site rotating onto both day and night shifts to support the roll out. In my view the staff member's level of skill and ability to adapt to recording using a device rather than paper recording will vary from individual to individual, with some staff being more adept to using technology more generally and some staff needing more time and tuition to adapt.
298. When I arrived on PBU there was little in the way of guidelines available to staff and patients regarding Oxehealth in bedrooms and its functionality. I cannot say with any confidence that all patients will have been aware of its presence and its use on admission and throughout their stay. During my time at PBU increasing emphasis was placed on informing patients of its presence and its use as part of the admission process and patients were expected to have an Oxehealth care plan in place detailing the information they had been given regarding its use and whether any patient concerns arose. During my time on PBU a Oxehealth flow chart became available and was shared and circulated to the nursing team. This would be referred to where a patient requested it be switched off, and the guidance would be referred to by the MDT to determine a decision. This happened only on a few occasions, and it was not common that patients asked to have this switched off. This guidance came from a Trust wide approach part way through my time on PBU, I do not recall the provision of such detailed guidance when I first commenced work on PBU.
299. In my personal and professional view the only benefit I see to the use of Oxehealth is the timestamping of entries reducing the scope for retrospective entries. I have not personally been able to see any therapeutic benefit to patients but equally I do not think it hinders the provision of mental health treatment either. The installation of CCTV and Oxehealth does provide the ability to access footage when required and via the correct

access process, which can support investigations or allow a method of exploration where concerns are raised

Staffing arrangements, training and support

300. As Ward manager on Ruby Ward, I completed rosters no less than 6 weeks in advance. Each ward had a designated staffing establishment for each shift; this was dictated by the Trust and not the Ward Manager. Establishment reviews did take place, but I cannot remember how regularly. I recall working with the safe care staffing tool and MHOST (Mental Health Optimal Staffing Tool) as key data collection tools to inform future staffing reviews by the Trust.
301. I paid consideration to the skill mix when completing rosters selecting Registered nurses (substantive or bank) that were familiar with the ward. Rosters by their very nature are changeable due to unanticipated sickness, special leave, and redeployment to another ward. These instances were to be escalated to the Service Manager and Matron with a request made for site officer to either base themselves on the ward or provide regular contact to check in on patients and staff for support and leadership purposes.
302. I remember there were establishment vacancies on Ruby Ward, and I vaguely remember recruitment activity was led by the Matron. I gained some early experience of the recruitment and interviewing process during my time on Ruby Ward. I recall during my time on Ruby Ward that there were consistent registered nurse establishment vacancies and a high turnover of staff.
303. Concerns raised in relation to agency staff members was fed back to the staff bank and a feedback form was completed. Where those concerns were substantiated, the worker could be blocked from working on the ward again and the agency informed. Concerns regarding bank staff followed a similar process and the Trust would be required to carry out investigation or further inquiries I do recall blocking some bank workers due to concerns.
304. As far as I can recall some of the substantive team had flexible working arrangements, which allowed them to work set shifts. These arrangements were processed through the flexible working policy. I cannot recall specifically if any substantive staff elected to only work nights, I do recall having fairly permanent bank staff that elected to work nights rather than the days. Having permanent bank staff, was an advantage due to the

fact that they were familiar with the ward processes and patients, and this offered some consistency to the care provided to patients.

305. Where there were establishment vacancies, wards were required to utilise bank staff to cover the shifts and it was better to plan for bank staff known to the wards in advance, rather than needing to go to agency staff who may not know the ward or patients so well.
306. Staff were required to request annual leave well in advance and no more than two registered nurses were permitted could take leave at any one time. During busy or difficult periods, I recall this being reduced to one registered nurse. Training days would also be booked in advance wherever possible.
307. Short notice sickness was always problematic as this left no capacity to plan for that short fall.
308. Both Ruby Ward and PBU operated within an agreed ward establishment setting out the number and grade of staff required on each shift. In my experience, the planned establishment was inconsistently achieved in practice, particularly on night shifts, due to a combination of sickness absence, vacancies, and the difficulty of securing bank or agency cover at short notice. Escalation processes existed for reporting staffing concerns via line management structures and bed management calls and staff could sometimes be redeployed but in practice Ward Managers often had to either arrange for additional staff by enquiring with staff directly, personally cover shifts or rely on bank and agency staff, which affected the continuity of care and the quality of ward reviews.
309. In practice, the skill mix was not always adequate. There were periods when shifts ran with fewer registered nurses than establishment required, with bank and agency staff filling gaps. Bank and agency staff, whilst sometimes very competent, were not always familiar with individual patients, ward policies, or the specific clinical needs of older adult mental health patients. I can say that one knock on effect would be that substantive staff had fewer staff to share the responsibilities of completing ward reviews and care planning with, as bank and agency staff tended not to complete these duties.
310. A shift could not be staffed without a female member of staff. At times, in short notice circumstances, female staff were required to move to another ward ensure female cover.

311. Bank and agency staff were a significant component of the staffing model at both sites throughout the period in question. The use of bank and agency staff carries inherent risks in terms of continuity, familiarity with patients, and adherence to local policies and procedures. Efforts were made to manage these risks, through ward orientation for new bank staff and preferences for repeat bookings with the same individuals. However, these measures were not always effective in practice. Agency use is now blocked, and bank shifts are published at very short notice, i.e. 24 hours before, I believe due to budget concerns, however I do not manage or oversee rosters in my current role.
312. Caps on agency usage existed as part of Trust financial management, but the reality of staffing vacancies and sickness meant that agency use persisted. The booking process for bank and agency staff was sometimes cumbersome and did not always result in confirmation of cover until close to the start of the shift.
313. Safe care assessment tools including MHOST were available and were supposed to be used to assess whether staffing levels were safe on each shift. In practice, the use of these tools was not always consistent, and there were occasions when assessments were not completed or were completed after the fact.
314. In relation to the night Adam Steel died there was one registered nurse, three senior HCAs and two HCAs on duty: one registered nurse fewer than the planned establishment due to sickness, cancellations and vacancies.
315. Where staffing levels fell below safe levels, Ward Managers were expected to escalate through the site manager and on-call management structure. In practice, I found that escalation processes were not always effective. There was a culture, which I experienced, in which Ward Managers were expected to solve staffing problems themselves, and in which requests for additional resource were not always met with a practical response.
316. I was aware that other Ward Managers shared this experience. The effect was that Ward Managers bore disproportionate personal responsibility for covering gaps, including by working clinical shifts themselves, which reduced their capacity to fulfil their management and governance responsibilities and contributed to burnout and turnover at Ward Manager level.

317. Medical staffing at both sites was provided through consultant psychiatrists and junior doctors (including trainees). The availability and responsiveness of medical staff, particularly out of hours, was a persistent concern. Out-of-hours medical cover was provided on a rota basis, and the response time from on-call medical staff varied.
318. I have been asked about support from consultants and ward doctors and their availability. I did not have oversight of the doctor rosters, and I was not responsible for rostering or cover arrangements for consultant, or medical cover.
319. PBU for a significant portion of my time had only one consultant to cover the unit, supported by junior doctors. I know the consultant continually raised this with his own line management. There was a longstanding vacancy for a second consultant for the most part of my time on PBU. Locum cover was sourced for periods of annual leave taken by the main consultant and the ward always had seven day a week medical cover on the assessment unit. For a short period of time PBU did receive a second consultant during my time there and I believe may have subsequently left or was redeployed shortly after.
320. A particular challenge at both Ruby and PBU was the requirement to ensure female staffing cover on all shifts, both for the delivery of observations for female patients and for personal care. This was difficult, particularly on night shifts and when relying on bank or agency staff. On the whole this was achievable, even if it meant only one female staff member was on duty, which was less than desirable, but the lowest standard to which the shift could work in terms of female cover. Efforts were made to also secure a twilight shift female member of staff and escalate to the site officer for support, if site cover was available.
321. The Trust undertook a number of initiatives during the period in question to address recruitment and retention challenges. These included international recruitment drives, the introduction of flexible working options, and long-service recognition schemes. However, in my observation, these initiatives were only partially effective.
322. The international recruitment initiative brought new staff into the workforce, and in many cases these staff were dedicated, skilled and valuable. However, the transition for internationally recruited nurses arriving in a new country, adapting to the NHS and to UK mental health legislation, and working in a high-pressure inpatient environment was not always well supported. I am certain having supported new international recruits

myself that their early experiences were difficult, they received variable degrees of induction prior to arriving on the wards, many of them were recruited and it is my understanding that posts were not swiftly sourced for them, resulting in many experienced significant waits once here before they were deployed to wards. This time did not appear to have been utilised effectively by the Trust as once they arrived on the ward, many of them had not completed their mandatory training, and some had little to no experience of working within a mental health setting.

323. This time could have been more effectively utilised by the Trust to support those staff in acclimatising, and in completing their mandatory training and provision of a comprehensive induction preparing them for the ward. Flexible working options were available however in practice any one ward area could only reasonably support a limited number of flexible working patterns as service provision had to come first. Whilst there was focus on recruitment, inpatient areas faced difficulty retaining newer registered staff that they had invested time in, supporting them through preceptorship, however once the initial experience was gained many of the newly qualified staff found the pull to a community Band 6 role, of which there are many and more desirable than gaining ward experience where there were only limited numbers of Band 6 roles compared to the community. Long serving and experienced staff myself included often saw and continue to see little to no recognition of their long service.
324. Retention remained a significant challenge. The pressures of inpatient mental health nursing, including shift work, exposure to distressing situations, physical risks, and the emotional burden of working with patients in acute mental health crisis, were significant factors in staff choosing to leave. In my experience, staff who left the Trust identified workload, management culture, and lack of support as key reasons for their departure, but I am aware this is a nationwide issue with the NHS.
325. My experience working within a Band 7 role and particularly holding a Band 7 role on the assessment unit, is that the workload burden and impact of those experiences is not sustainable over a long period of time, it has an cumulative impact on one's own wellbeing in the long term and was key in my own decision to look for alternatives roles.
326. Sickness absence was managed through the Trust's absence management policy, with occupational health involvement. However, the culture around sickness absence was not always supportive, and I observed instances where staff who were genuinely unwell

felt pressured to return to work before they were ready, which in turn led to further absence.

327. Low staffing levels were sometimes reported via the Datix reporting system by individual nurses and more recently, where the MHOST tool indicated low staffing levels a Datix would be raised by a different Trust department. I cannot remember the name of that department. Either way these Datixes would come back to the Ward Manager to review, who will have already been aware of the situation and had either been required to cover the shortfall themselves where possible or had already made significant effort to cover the shortfall in the first instance. This was an unhelpful process of escalation that ultimately looped around back to the Ward Manager to review the Datix.
328. The Inquiry has asked me specifically whether or not I raised any concerns regarding staffing whilst I was the manager for Ruby Ward. I did raise concerns regarding staffing levels on Ruby Ward several times with my Matron and Service Managers. Particularly gaps in registered nurse cover. On occasions I cancelled my own training and cancelled my own leave. I also covered gaps in the roster myself either staying on late to meet the night staff and handover to them or parking my managerial duties in order I could cover nursing duties. Parking managerial duties was often difficult to impossible, and the duties would simply wait until I had time to get around to them.
329. During the summer of 2018, I informed the consultant psychiatrist, Matron and Service Manager. That owing to staffing levels for a temporary period the nursing staff would not be able to cover the three allocated ward review days, as we simply did not have the staff. I flagged my concerns at this time, that whilst covering shifts, I would still be viewed in a managerial capacity by staff, MDT and relatives, placing a great deal of pressure on myself. The situation at the time was compounded by the wards two charge nurses leaving within a week of one another for new posts. Ward Managers were also rostered onto bleep rota, which means that manager is holding site cover for the day. At one point during this period, I could cover less than half of the registered shifts across a week. I managed this through a combination of escalating to senior management to get bank and agency authorisation for registered cover.
330. I do not believe that this situation was unique to Ruby Ward and other ward managers within EPUT will have had similar experiences. As described separately in another part of my statement. I was also prevented by my Matron from taking up a secondment

position I had successfully gained owing to the registered staffing shortfall on the ward at the time, I believe this would have been 2019 or 2020.

331. I have been asked whether there were any instances where I was required to manage Ruby Ward without safe staffing levels and whether this was raised with management. I recall one instance, although it is a vague memory, when I arrived on duty, and only one substantive HCA and one bank HCA were on duty. I really can't recall any more specifics than that, this was likely the result of short sickness absence and bank cancelations and although I don't recall, I imagine either the night Registered Nurse or Site Officer will have remained on the ward to wait for my arrival in order they could leave. Naturally I managed the shift and supported the patients and team rather than completing my managerial work. I have no recollection of how effectively I was able to escalate this situation via seniors and what support was provided, but our numbers remained limited for the duration of that shift.

Training

332. New starters at both Ruby Ward and PBU completed a Trust wide induction programme followed by ward level induction. The quality of ward level induction was variable and depended significantly on the time and resource available to deliver it. There were periods when ward level induction was curtailed due to staffing pressures, with new starters moved to work clinical shifts before their induction was complete. The ward induction for substantive staff was two or three pages containing a very detailed list of information and practices which had to be reviewed and ticked for completion. On reflection what started as well intended, in the first day to few weeks, the remainder of the induction document often sat incomplete, due to lack of time to get around to this.
333. Mandatory training requirements existed covering a range of topics including moving and handling, basic life support, mental health legislation, safeguarding, infection control, and medicines management. Compliance with mandatory training was monitored at ward and Trust level. However, protected time for training was compromised by staffing pressures. Staff were sometimes pulled off training sessions to cover clinical shifts, and this was a recurring and damaging pattern.
334. Personally, I found training more valuable where there was a classroom element which incorporated scenarios and particular challenges that one might experience practice. The list of mandatory training modules grew larger and larger, and it didn't appear as

though the Trust paid much regard to which modules could potentially be removed, were duplicative or whether or not the content of that training was up to date. Some training which previously spanned a day, or a morning were reduced to a few hours, as a Band 7 this made rostering of staff challenging. The most effective form of mandatory training I have personally experienced has been TASI and Life Support Training both of which are face to face, engaging and scenario-based trainings delivered by experienced clinicians with the skill and practical experience associated with the content. It has been evident to me in attending these sessions over the years that the content has been continually reviewed to ensure up to date practice guidance is covered.

335. Beyond mandatory training, there are specialist training needs specific to the patient groups and ward environments at Ruby and PBU. For Ruby Ward, relevant specialist training includes dementia care, neurological observations, falls prevention and management, and physical health management in the context of mental health conditions.
336. For PBU, relevant specialist training includes de-escalation, management of acutely disturbed behaviour, Prevention and Management of Violence and Aggression, and physical health monitoring.
337. I also observed a broader gap in training for specific professional scenarios. Training in how to deliver bad news to families, how to communicate with a family after a patient's death, how to support a patient through a serious incident, and how to conduct or engage with a PSIRF investigation, was either absent or inadequate. These are not peripheral skills for Ward Managers and senior nurses on inpatient mental health wards, they are central to the role, and the absence of training in these areas left staff ill-equipped and unsupported. It took time to process my own experiences in relation to these for the purposes of this statement.
338. My overall view is that the training offer at EPUT was not adequate to meet the needs of staff working in inpatient mental health settings during the period in question. The gap between mandatory training compliance (which was monitored) and genuinely useful, meaningful, role-specific training (which was not consistently available) was significant. Protected time for training must be treated as non-negotiable, and its erosion due to staffing pressures must be addressed as a matter of patient safety.

Support

339. During my time on Ruby Ward and PBU support was available to me through my line managers. I experienced varying degrees of support from different line managers over the years.
340. I became aware particularly that there was an expectation from my line management regarding the ability to be resilient within the Band 7 role in particular. Both of my interview asked questions with regards to how I recognise and manage stress in myself and others and as such I did have my own sense of needing to maintain resilience and there were times on both wards where this was tested.
341. On Ruby Ward I did not feel comfortable challenging my Matron's approach which at times, I and others staff, found to be intimidating and disrespectful, however I did feel able to approach them for example if I needed some support or guidance regarding a particular situation and how it could best be managed.
342. On PBU I was comfortable speaking to my line manager and requesting guidance on the management of particular scenarios. I found generally that my line manager on PBU had more of an open-door policy where I could approach them and simply have a conversation about the activity on the ward, offload stressors and gain more peer support.
343. External staff support at both sites is provided through a range of mechanisms, including the Employee Assistance Programme ("EAP"), the "Here for You" service, occupational health, and clinical supervision. These resources were available to all staff and are voluntary. I often suggested these to staff and encouraged their use. Access to occupational health assessments were available and could be arranged via a management referral. They were used to support sickness absence management, phased returns to work or provide recommendations to support staff at work with personal circumstances.
344. Clinical supervision was supposed to be provided on a regular basis, but in practice supervision was often the first thing to be cancelled when staffing pressures required prioritisation of clinical activity. This was deeply counterproductive. Inpatient mental health nursing is emotionally demanding, and staff who do not receive adequate supervision are at increased risk of stress, burnout, compassion fatigue and, ultimately,

patient harm. As Ward manager I was under considerable pressure to complete as much supervision of staff myself both to ensure compliance with Trust requirements and to satisfy myself that my team had access to regular supervision.

345. The wards have a dedicated supervision tree with senior staff being allocated staff to supervise. I made great efforts to ensure all staff received supervision. During extremely busy periods I achieved this through group supervisions and team meetings with the proviso that staff should approach me personally should they wish to have any 1:1 or discuss anything privately.
346. I have most certainly experienced work-related trauma and stress on many occasions over the years and which has become apparent to me after reflecting on my career for the purposes of this statement. I firmly believe there is a pressure on nurses and an expectation of resilience. There is an almost inevitable impact on emotional wellbeing; the busy nature of front-line health care means that this impact will not be addressed at the time and there is an accumulative impact of the work, which can sometimes take time to fully present itself.
347. This being said I do not think this is unique to EPUT although I have no experience of working outside of EPUT or its predecessor.
348. The impact of traumatic incidents on staff was not consistently well managed. Following incidents such as patient deaths, serious self-harm, or violent episodes, staff were not always offered timely and adequate debriefing or psychological support. The expectation that staff would continue to work through traumatic events, relying on their own resilience, was not sustainable.
349. If a serious incident occurred or staff were assaulted by patients, staff were entitled to sick pay. Entitlement to sick pay depends on length of service, so a substantive member of staff's entitlement to sick pay varies in terms of how the duration of leave that can be taken. One week must be self-certified and any additional absences require a GP sick note.
350. I recall some instances of bank staff being injured, although not the specific circumstances and staff bank would contact me or I would contact them as soon as possible to make arrangements for staff to be honoured for shifts booked in advance, if

they hadn't been able to work as a result of that incident so their pay was honoured for a period.

351. Leadership visibility was inconsistent. Some managers were highly visible, approachable and supportive. Others were less accessible, and staff on those wards felt unsupported and isolated. The ability of staff to approach their managers with concerns depended significantly on individual management style.

Culture

352. EPUT articulates a set of values and a commitment to a positive, open, compassionate and learning culture. In principle, staff were encouraged to raise concerns, to speak up about poor practice, and to contribute to continuous improvement. Dignity and respect for patients and for each other were expressed core values.
353. My experience of the culture at Ruby Ward and PBU was mixed. At times there was good support and a collaborative atmosphere. At other times, there were instances of behaviour that were not supportive and that created a difficult working environment.
354. The culture I experienced in practice was more complex and variable than this description suggests. There were teams and individuals who genuinely embodied these values, and who created environments in which good care was delivered and staff felt supported and respected. However, there were also significant problems that, in my experience, affected the quality of care and the wellbeing of staff.
355. Workload burden and time constraints were an issue. As I have set out earlier in my statement (paragraphs 24, 167, 172 and 189), staff ability to offer engagement to patients could be incredibly limited due to workload burden, but failure to do so was often viewed as a personal failure or result of a badly organised shift rather than a reflection of the demands on staff time and their workload. This was felt particularly during the pandemic when only the nursing and medical staff were front facing meaning that other supporting staff such as physiotherapists and Ots were not available because of the national restrictions.
356. This absence of any protected staff time often under extremely pressured circumstances could have an impact on staff morale.
357. Staff team building days were either completely absent or infrequent.

Speaking Up and Raising Concerns

358. In my experience, the culture of speaking up was not consistently safe or effective. Staff are encouraged to raise concerns through formal channels including Datix, Freedom to Speak Up, and whistleblowing processes. In practice, I observed a culture in which staff feared the consequences of speaking up, particularly where concerns involved senior clinicians or managers. I personally experienced a situation around 2019 or 2020 in which I felt intimidated and humiliated by a Matron. I didn't feel able to challenge this at the time and only later reflected on the situation when I was at home. I took the decision to speak with my Service Manager the next morning who was supportive and sensitive to my distress. That experience had a lasting effect on my confidence and reinforced the understanding that challenging those in more senior positions carried personal and professional risk.
359. The Freedom to Speak Up Guardian role existed within the Trust, but in my experience, awareness of this role and confidence in its independence and effectiveness were not universal.
360. The Inquiry has asked me about bullying and discrimination. I did not personally experience any bullying or discrimination towards me. I was however in a managerial role and there were occasions when staff raised concerns with me regarding the behaviour or conduct of another member of staff towards them. It was my role to facilitate a resolution or escalate this. I offered the staff involved the opportunity to meet with me in an attempt to agree a suitable resolution and remind each party of expectations regarding their conduct. This was noted in their supervision record. If issues could not be resolved satisfactorily or the member of staff complaining did not agree the resolution, they had the option to raise a formal grievance through the HR process. This was not common during my time on the ward. I can recall one occasion on Ruby and one occasion on PBU where a grievance route was initiated by a staff member. The fact-finding investigations for these instances as far as I recall were led by an external investigator.
361. I also recall in one instance on PBU a junior colleague informally approached me and informed me of some concerns amongst bank and agency staff that worked on the ward, that there was a concern of racism within the team. This staff member approached me in confidence and did not share the identity of the staff members concerned. I was very

concerned to hear this and recall I enlisted the support of our Charge Nurse who was a person of ethnic minority background and discussed this with them to enlist their support.

362. They were a point of contact and support for staff should any such situations arise, if this assisted them in way with aid them in feeling more able to open up and share their experiences and gain some support. Given the time that has lapsed and my subsequently taking up a new role, it is difficult for me to recall if this had any benefit. We had a diverse team on PBU which was an asset and there was certainly in my view a presence of good working relationships within this diverse setting. I do not believe discrimination was present and opportunities were present for all. Equality and Diversity was and remains part of the Trust's mandatory e-learning.
363. Long established practices resistant to change - I observed, particularly in older and more established teams, a resistance to change and a tendency to perpetuate practices that had been in place for many years, regardless of whether those practices reflected current evidence or policy. Challenging entrenched practices was difficult, and the response from staff was sometimes defensive or dismissive. There were at times a cultural barrier to the adoption of safer practices and the embedding of learning from incidents. An example that comes to mind is an instance where swift changes were needed to manage informal leave from the assessment unit, and patients being able to access the garden area at all times, required the need to supervise the garden area on allocation. This was initially met with some resistance from staff, although these changes did take place reasonably swiftly.
364. Compassion fatigue and desensitisation - working in inpatient mental health care over a sustained period exposes staff to high levels of distress, risk and, at times, tragedy. In my experience, compassion fatigue and desensitisation to poor care or to distress were real risks in these environments. I observed staff whose responses to patients in crisis had become mechanical rather than empathetic, and whose engagement with patients had diminished over time. This was not a reflection of bad character but of the absence of adequate support, supervision and management to recognise and address these signs before they affected patient care.
365. I do not recall any circumstances where patients received differences in treatment as a result of these characteristics.

366. I do recall at least one occasion on PBU where the team had to step in following transgender patient being incorrectly listed as the wrong sex on the bed management list, i.e. they were in error listed as female when in fact they identified as male. This was flagged with the bed management team before any distress occurred to the patient by way of being admitted into the wrong gender zone of ward. This was an unintentional error, but it had potential to cause distress to the patient.
367. Information is available to staff and patients regarding protected characteristics and staff receive mandatory Equality and Diversity.
368. Patients with a dual diagnosis were often admitted to the assessment unit. I do not believe that stereotyping was present, however my relatively recent and limited experiences in acute services have given rise to my own awareness and understanding of these challenges. Although dual diagnosis training is mandatory there was limited support for patients who experiencing these challenges both on the ward and within the community settings. There was a tendency for these dual challenges to be viewed as separate issues, with patients needing to engage in drug or alcohol services separately to their mental health care and treatment but I cannot speak to the position today.
369. The absence of protected time for reflection, meaningful supervision, and genuine team development meant that there were few structural mechanisms to counteract the effects of sustained exposure to distressing work.
370. My view is that cultural failings, including a reluctance to speak up, resistance to change, and insufficient recognition and management of compassion fatigue had a direct impact on the quality of patient care. Patients who were cared for by staff who felt unable to raise concerns, who were desensitised to risk, or who were perpetuating outdated practices, were at greater risk of harm. The cases of Mrs Smith and Mr Steel both illustrate, in different ways, the consequences of practice that had drifted from the required standard and had not been challenged or corrected. I have addressed these earlier in my statement.

Quality of investigations

371. During my time in post, I was involved in or aware of a range of investigation types, including internal incident reviews, Serious Incident investigations, Root Cause Analysis

("RCA") processes, coroner's inquests, and, from 2021, Patient Safety Incident Response Framework ("PSIRF") investigations.

372. My direct experience as an investigator was limited. I led one PSIRF investigation into the death of Christopher Nichols and was involved to a lesser extent in the process following Adam Steel's death. I was not involved in the Nadia Wyatt investigation and cannot comment on that process.
373. My recollection of being consulted during the Mrs Smith's RCA is limited, though I note that the RCA was finalised in June 2021, by which time I had already left Ruby Ward.
374. I was asked to lead the PSIRF investigation into the death of Christopher Nichols without having received training in the PSIRF methodology prior to being asked to undertake it. I found this extremely challenging. I was required to navigate a new and complex framework, meet tight timescales, and engage with distressing material, without the preparation or support I needed.
375. I did not speak to the patient safety team about my concerns and in retrospect having thought about this for the response to this request, I feel as though I should have done so. I did express an initial concern to my line manager about the task and my lack of experience within the service. I cannot now remember the exact response, but I do recall being given the impression that the task fell within my expected duties as an Acting Matron and there was a limited number of other staff to whom this could have been delegated.
376. I conducted the investigation to the best of my abilities and with what I considered to be due diligence with the best information that was available to me at that time.
377. However after presenting the report at inquest and the subsequent criticism from the coroner I was left with a profound sense of having let the family down with the quality of my report and also having let the assessing clinician and family down by not being able to come to the investigation with the relevant experience, or presenting its conclusion with an acceptable level of confidence in my findings. I accept I could have pushed back on undertaking the review, for the reasons I have outlined above, however I only came to this realisation after the inquest when I had time to evaluate and reflect on my experience.

378. In terms of family engagement: contact with Mr Nichols' family during the investigation was managed through a Family Liaison Officer rather than directly by me as investigator. I did not speak directly with the family during the investigation process. I understand the reasons for this approach, but I am not confident that it always results in families feeling genuinely heard or meaningfully involved.
379. During the investigation process, I was required to prepare draft findings, which were reviewed and amended before the final report was produced. as far as I can recall, these were minor layout changes and not an adjustment of my findings in any way.
380. My understanding was and remains that learning was shared by the Operational Matron for that service with the team and that many of the recommendations within my report were taken on board, implemented and monitored by the Operational Matron for that service.
381. Doris Smith - My recollection of being directly consulted as part of the RCA process is limited. I recall being aware that an investigation was underway, but I do not have a clear recollection of providing a formal statement or being interviewed as part of the process. As Ward Manager at the time of Mrs Smith's fall and death, I would have expected to be a central witness in any investigation. It is apparent that I was consulted as my answers to some questions are contained within the completed RCA, but my involvement must have been extremely limited as I have no recollection of any interactions with the authors.
382. Adam Steel - I recall having some engagement with the investigation process following Adam Steel's death. The Patient Safety Incident Review identified a number of concerns about the care Adam Steel received, including the reliance on Oxehealth rather than face-to-face observations, the sightline deficiencies in his bedroom, the staffing position on the night of his death, medication administration issues, and the delayed family liaison.
383. The nature of my involvement in Mr Steel's investigation was as a result of my role as Ward Manager at the time of his death. I was contacted by the allocated investigator who visited the ward and who I met with over Microsoft Teams on at least one occasion. During these interactions I was asked questions, I do not recall what those questions were or how many questions I was asked. The investigators were not PBU staff, they

were concerned with establishing timelines, exploring the ward and room layout, they also met with other ward staff.

384. There were two recommendations, one of which related to observation documentation and the other with regards to room layout. Those recommendations were left with me as Ward manager to monitor and track and I have spoken to how these recommendations were implemented and the action I took to achieve a higher level of escalation within the Trust regarding the Room layout in not only room 7 but other bedrooms on the ward.
385. Nadia Wyatt – I did not meet Nadia, nor did I have any involvement in decisions relating to her care and treatment whilst she was on PBU. I was not the Ward Manager at the time of this incident, and I had no involvement in investigations or reports into her death, so I am unable to comment.
386. My experience of the culture surrounding investigations is limited and I can only speak to my personal experience from the time. My personal experience was that allocation to a suitable investigator was not well planned. Staff were delegated investigations in addition to their operational role and in practice had to balance their main duties alongside the important work of completing the investigation. Little regard was given to that person's degree of experience in completing investigations, and in my case allocated to me whilst I was in an Acting Matron. In sending my report to the patient safety team, the feedback I recall receiving was with regards to a few minor layout changes rather than any constructive feedback regarding the quality of the investigation, which was subsequently criticised at the inquest. This had a profound impact on my sense of failed duty towards the family. There was limited follow up support from my seniors and the Trust following this experience. I cannot say whether this is the case right now given that I have only undertaken the one.
387. The Duty of Candour obligation to be open and transparent with patients and families when something had gone wrong was understood in principle but was not in my experience, always applied consistently or promptly by all staff. This was as a result of time constraints, lack of staff skill or confidence in doing so, or an assumption that other staff would action.
388. On Ruby Ward I introduced a communication sheet which was a tool I had been familiar with on previous wards, as a method in which to support handover and communication

between staff regarding duties and tasks for completion, this remained in place to the point at which I left. I received positive feedback from staff regarding its use during my time on Ruby Ward. Similarly, PBU used a diary to aid communication between staff but it was not always reliably used and so the team were reminded in conversations and team meetings of the importance of its use as an additional measure to aid communication between staff and to oncoming shifts regarding outstanding tasks.

Examples of good practice

- 389. During my time with the Trust, I can recall many examples of good practice. At the time of writing, the following come to mind.
- 390. Staff in PBU – the nursing team exhaust their efforts to avoid restrictive practices, nursing staff work tirelessly to developing therapeutic relationships with patients, they are good at de-escalation and building rapport with patients quickly on admission.
- 391. On Ruby Ward "Do Not Disturb" Tabards during medication rounds - the introduction of "do not disturb" tabards worn by nurses during medication rounds was a straightforward but effective safety measure that reduced the risk of medication errors caused by interruption. This was a positive example of a low-cost intervention with a measurable patient safety benefit.
- 392. Activity coordinators on older adult wards - the use of dedicated activity coordinators on Ruby Ward provided meaningful therapeutic engagement for patients, including those with dementia or reduced cognitive function, who were not always able to benefit from more traditional talking therapies. This was an example of a resource that had a direct positive impact on the quality of life of patients during what were often prolonged admissions. The risk was that this role was seen as non-essential and was therefore vulnerable to cost-cutting pressures
- 393. Sensory rooms - the provision of sensory rooms on inpatient wards, where they were available, offered a therapeutic and calming environment for patients in distress. This was a good example of an environmental intervention that was consistent with a trauma-informed approach to care and that could reduce the need for more restrictive interventions.

394. Advocacy Drop-In Services - the availability of an advocacy drop-in service on PBU allowed patients to access independent advice and support in a way that did not require them to navigate formal processes or rely on staff who were employed by the same organisation whose decisions they might wish to challenge. This was an important safeguard, and the drop-in model made it more accessible than a purely referral-based system.
395. Vision Panel meeting process - the Vision Panel meeting process at PBU — despite the concerning findings it produced — was itself an example of good practice in that it brought together a multidisciplinary group to examine the physical environment of the ward and identify safety concerns. The willingness to scrutinise the environment in this structured way, and to act on what was found, represented a positive model for safety governance, even if the findings themselves revealed significant shortcomings
396. Huddles and safety briefings - where huddles and Handovers were consistently embedded well, they represented good practice in terms of communication, situational awareness, and the prompt identification of changes in patient risk. Their effectiveness depended on the consistency with which they were held, MDT attendance and the quality of the information shared.
397. Ongoing work to recognise when patients are deteriorating - there has been a focus on physical care and registered general nurses have been recruited into most inpatient settings.
398. COVID – work during the COVID pandemic was exceptionally difficult, it placed a strain on staff, their families and their physical and emotional wellbeing. Staff were incredibly resilient and provided the best level of care they could with the resources they had.

Examples of poor practice

399. I have already described in detail, within earlier sections of this statement, the poor practice that occurred in the cases of Doris Smith and Adam Steel. I wish to address those cases specifically in this section, alongside other examples of poor practice that I observed.
400. Doris Smith — Ruby Ward, October 2020 - The care of Mrs Smith on Ruby Ward represents an example of poor practice resulting in death. Mrs Smith fell and sustained

a head injury. Following this fall, neurological observations were not undertaken as required. Confusion and error arose regarding observation levels, in part due to wording used within physiotherapy recommendations. Those recommendations were applied to patient care inadequately. The huddle process was not well established or attended by the MDT at the time resulting in this being an inefficient forum for discussion of risk and shared decision making as it was intended to be. The plan for communal nurse supervision was inadequate and had not been effectively communicated amongst the team on duty. Mrs Smith remained on Level 2 observations when Level 3 should have been implemented. These were systemic failures as well as individual ones, and they occurred in the context of COVID pressures that were placing additional strain on all ward functions.

401. Adam Steel — Peter Bruff Unit, October 2021 - The care of Mr Adam Steel at PBU in October 2021 represents an example of poor practice resulting in death. Mr Steel was admitted to PBU on 13 October 2021. On the night of his admission, he was not physically checked face-to-face, contrary to the Level 2 observation policy requiring four random checks per hour. Staff relied on Oxehealth monitoring rather than conducting in-person checks. Mr Steel was in Room 7, where the bed was not visible through the vision panel on bedroom door, and there is no evidence that staff entered his room overnight. His medication administration on admission was associated with gaps and errors. Staffing was below planned establishment. The sightline deficiencies in his bedroom should have been identified through the vision panel process and ward inspections but were only escalated after Mr Steel's death. These were failures relating to the ward environment, the Oxehealth deployment without adequate safeguards, staffing, and the culture around observation practice as well as individual ones.
402. Reliance on technology as a substitute for face-to-face contact - this is a misunderstanding of both the purpose and the limitations of monitoring technology, and it represents poor practice wherever it occurs.
403. Inconsistent neurological observation practice - the failure to undertake neurological observations following a head injury, as occurred in the case of Mrs Smith, reflected a broader concern about the inconsistency of neurological observation practice on older adult wards. This was not simply a matter of one individual failing to follow a protocol; it reflected inadequate training uptake, unclear documentation, and the absence of robust

clinical governance to ensure compliance with this important and time-sensitive intervention.

404. Inadequate care planning as a clinical tool - I have already described my view that care planning became increasingly administrative, and compliance driven during the later part of my time as a Ward Manager. This represents poor practice because care plans that are not genuinely used as clinical tools do not protect patients. A care plan that exists to satisfy an audit requirement but does not reflect the patient's current presentation, needs and risks provides a false assurance of safety.

Illustrative cases

405. I note that Adam Steel, Doris Smith and Christopher Nichols appear on the illustrative cases list, and I have provided detailed evidence about these cases throughout this statement. My reading of the list has not prompted immediate recognition of the names on the list, but this reflects the volume of patients and incidents managed over my time at the Trust and the time that has elapsed

Recommendations

406. My recommendations for improving the safety and quality of inpatient mental health care are as follows:
407. Staffing: Safe staffing levels must be maintained at all times, with adequate skill mix and sufficient registered nurse cover on every shift. Reliance on bank and agency staff should be minimised through improved recruitment and retention. Ward Managers should not be required to cover clinical shifts routinely.
408. Observation practice: The distinction between in-person observation and technology-assisted monitoring must be clear in policy, training and documentation. Technology should support, not replace, face-to-face contact with patients. Observation levels must be subject to regular clinical review and escalated promptly where indicated.
409. Ward environment: Inpatient environments must be fit for purpose, with adequate sightlines from observation windows, safe and therapeutic spaces, and designs that meet the needs of the patient group (including older adults with physical health needs). Mixed-sex accommodation breaches must be eliminated.

410. Training: Mandatory training must be protected, accessible and appropriate to role. Specialist training (including neurological observations, dementia care, physical health management) must be mandatory available and encouraged. PSIRF investigators must receive training before being asked to lead investigations and receive support thereafter.
411. Allied health professional input: Timely access to SALT, occupational therapy, physiotherapy, tissue viability, psychology and other AHP services is essential and should be available on a shift-cover basis, not office hours only.
412. Care planning: Care planning must be genuinely collaborative, patient-centred, and used as a living clinical tool, not merely a compliance exercise
413. Culture: A culture of openness, learning, support and respect must be actively promoted and modelled by leaders at all levels. Bullying, intimidation and discriminatory behaviours must be challenged and addressed promptly.
414. Learning from incidents: Learning from investigations must be effectively disseminated, with protected time for staff to engage with it, and Ward Managers supported to lead this process. Families must be meaningfully involved in investigations and their questions answered.
415. Family engagement: Communication with families must be timely, compassionate and transparent. Ward Managers and other staff notifying families of death or serious harm must receive training and support for this role.
416. Technology: my view is that technology, used appropriately and with thought to staff to patient ratio, has the potential to improve safety and to make observations less intrusive and more therapeutic. However, technology must supplement rather than replace face-to-face contact with patients. Where technology is introduced, it must be accompanied by robust training, clear policy, regular audit, and a culture in which staff understand both its capabilities and its limitations. At PBU, the deployment of Oxevision was not accompanied by adequate safeguards to ensure that staff used it as intended, and this contributed to a culture in which technology monitoring was treated as an equivalent to physical observation. It was not, and the consequences of that misunderstanding were potentially fatal.

417. In closing this statement, it is with a heavy heart. I would like to convey my heartfelt sympathies to the families and all those affected, for their loss and experiences. The pain and devastation that they will have experienced has never been far from my thoughts. A long career in mental health nursing and recalling such tragic events has been an emotional process, and an important one for me both personally and professionally. The courage that families will have needed during the Inquiry process themselves has been very much in my thoughts in the process of providing my statement.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed:

[I/S]

Dated: 29 May 2026