

1. Preliminaries

2. I, Louise Borton, am employed by Essex Partnership University NHS Foundation Trust (EPUT) in the role of Matron. I have held this position since February 2021.

3. Background and Experience

4. My professional qualification is BSc (Hons) Nursing (Mental Health).
5. From September 2013 to September 2016, I trained as a Student Nurse at Anglia Ruskin University, undertaking clinical placements within South Essex Partnership University NHS Foundation Trust.
6. My subsequent employment history is as follows:
7. 01/09/16 – 16/10/18 Senior Support Worker awaiting Nursing and Midwifery Council (NMC) Pin, Cedar Ward
South Essex Partnership University NHS Foundation Trust
8. 17/10/16 – 14/01/18 Staff Nurse, Cedar Ward, Rochford Hospital
South Essex Partnership University NHS Foundation Trust
9. 15/01/18 – 24/06/18 Interim Deputy Ward Manager, Cedar Ward, Rochford Hospital
Essex Partnership University NHS Foundation Trust
10. 25/06/18 – 06/03/19 Deputy Ward Manager, Grangewaters Ward, Basildon Mental Health Unit
Essex Partnership University NHS Foundation Trust
11. 07/03/19 – 07/02/21 Ward Manager, Grangewaters Ward, Basildon Mental Health Unit
Essex Partnership University NHS Foundation Trust
12. 08/02/21 – 07/21 Matron, Assessment Unit – Grangewaters and Health Based Place of Safety (HBPoS), Basildon Mental Health Unit and Topaz Ward, The Crystal Centre, Chelmsford.
13. 07/21 – 03/22 Matron, Assessment Unit – Grangewaters and Health Based Place of Safety (HBPoS) at Basildon Mental Health Unit, Christopher Unit at The Linden Centre and Topaz Ward at The Crystal Centre, Chelmsford. I was

covering in the absence of the Matron for Hadleigh Unit, Grangewaters Ward and Thorpe Ward, Basildon Mental Health Unit whilst waiting for the Matron to be released into this post.

14. 03/22 – present Matron, Assessment Unit – Grangewaters and Mental Health Urgent Care Department, Basildon Mental Health Unit
Essex Partnership University NHS Foundation Trust

15. Safe and Therapeutic Inpatient Care

16. Clinical Assessments

17. My practice within the scope of this inquiry was exclusively within inpatient mental health settings. I undertook clinical risk assessments and oversaw the completion of other clinical assessments. I am only able to speak to my own practice and experiences, and not those of other practitioners.

18. Staff completed clinical risk assessments using the *Initial Assessment of Needs and Risk* form within Mobius. Mobius is the Electronic Patient Record (EPR) system used in the South of the Trust. This was a structured assessment tool designed for use by nurses to complete a comprehensive biopsychosocial assessment, intended to establish a person's presenting difficulties, current stressors, and immediate risks, as described by the patient and, where appropriate, their carer. The assessment included consideration of past psychiatric history, personal and family history, mental state at the time of assessment, physical health, current medication, substance use, forensic history, and premorbid personality. It also explored social circumstances, relationships, and spiritual, dietary, and physical needs, as well as any required reasonable adjustments.

19. In addition, the assessment incorporated an evaluation of capacity, assessed risks to self, others, and from others, and drew on information from relatives or carers where available. The findings were summarised in an initial formulation, which should be discussed with the patient and/or carer to identify needs, risks, patient views, and goals. Completing these assessments was both a legal and professional responsibility.

20. The purpose of inpatient risk assessments was to form a professional judgement about the likelihood or probability of adverse or harmful outcomes, such as self-harm, suicide, neglect, vulnerability, or violence, occurring because of mental illness, distress, or associated behaviour, to inform initial management and care planning.
21. Risk assessments commenced on admission to the ward. The Trust had a Key Performance Indicator (KPI) requiring completion within four hours, and as a result admission risk assessments were generally completed in a timely manner. Inpatient risk assessments were expected to adopt a collaborative approach, involving both patients and carers to ensure a holistic understanding of risk. However, due to the volume of admissions and discharges, staffing pressures, and competing demands, it was not always routine practice to involve patients and carers directly. In such cases, assessments relied more heavily on reviews of existing clinical records. Consequently, patients' own language was not consistently used, despite this being prompted within the risk assessment form.
22. The Mobius risk assessment was a "trending" document, meaning that previous risk assessments could be reviewed and updated. In practice, this resulted in some staff relying heavily on existing information rather than conducting a full reassessment of current risk.
23. The Mobius form used a risk stratification system to indicate risk; high/medium/low risk. There was no clear guidance or training to support decision making regarding how to assess risk or apply the risk stratification. Staff therefore often relied on informal discussions with colleagues to support clinical judgement. It has since been acknowledged that this system is a poor indicator of risk, and the Trust is currently moving away from risk stratification rated risk assessments.
24. NHS England guidance emphasises that services should not focus on predicting risk through categorisation, but rather on understanding the individual, their current presentation, and their immediate safety needs, recognising that static factors do not reliably capture fluctuating risk.

25. Similarly, National Institute for Health and Care Excellence (NICE) guidance advises against the use of risk assessment tools and scales to predict future harm or determine care. Instead, it promotes a focus on the individual's needs and safety, supported by a structured, narrative clinical formulation. This formulation provides a clinically reasoned understanding of why a person may be at risk at a particular time, considering their vulnerabilities, protective factors, and wider psychosocial context, rather than assigning a fixed rating.
26. The Trust is supporting this transition through the delivery of STORM Skills Training in Self-harm and Suicide Prevention, which is consistent with NHS England and NICE guidance. This training promotes compassionate and collaborative engagement, psychosocial assessment, shared formulation and the co-production of safety plans, alongside involvement of the individual's support network and ongoing review.
27. However, whilst this direction of travel is clear and aligned with national best practice, it is recognised that the *Initial Assessment of Needs and Risk* form within Mobius continues to reflect a risk stratification model. Work is ongoing within the Trust with the implementation of a unified EPR, Nova, which has the capability to align documentation with NHS England and NICE guidance and enable the shift away from risk stratification.
28. Nursing risk assessments were completed separately from medical risk assessments, and nursing assessments were not routinely updated during medical ward rounds. Family and relatives' views were not consistently included within risk assessments; where relevant, these views were more commonly recorded in continuation notes within the electronic patient records rather than within the assessment itself. More recently, under the Therapeutic Acute Inpatient Operating Model for Adults and Older Adults, wards introduced Family and Carer Ambassador roles. At Basildon Mental Health Unit, this role includes updating the family and carer section of the risk assessment following contact.
29. Families were not routinely consulted as part of risk assessments, nor were they regularly informed of the outcomes. Staff frequently reviewed existing community documentation to understand the views of community

professionals previously involved in the patient's care. Outside of ward rounds, engagement with families and carers was largely reactive, with relatives initiating contact with wards.

30. In addition to assessment on admission, inpatient risk assessments were expected to be updated during admission at a minimum frequency of weekly, following incidents and prior to discharge. In practice, updates following incidents or at discharge were not always completed in a timely manner, largely due to staffing issues and time pressures. While there was a KPI for completion of risk assessments on admission, there was no equivalent KPI for updating assessments on discharge.
31. In my experience, substance misuse, including addiction to prescribed medications, illicit drugs, and/or alcohol, significantly impacted referral pathways. There was a lack of appropriate services for individuals with comorbid mental health and substance misuse needs, particularly in relation to dedicated integrated dual diagnosis services.
32. In addition, there was evident fragmentation between mental health services with the Trust and external substance misuse services. The Trust relied heavily on joint working arrangements with partner organisations, however this approach did not always provide a consistently coordinated or integrated approach to care. As a result, individuals with complex needs could experience difficulties in accessing support.
33. Physical health needs, such as mobility issues, were assessed by Physiotherapy and Occupational Therapy teams following referral. There were delays in accessing Speech and Language Therapy (SALT) and Tissue Viability services. At Basildon Mental Health Unit, physical health needs were poorly managed due to a lack of manual handling equipment.
34. Nursing staff completed falls risk assessments, while Venous Thromboembolism (VTE) risk assessments were undertaken by the medical team. I am aware of delays in some physical health risk assessments, including VTE assessments. The Trust uses a clinical dashboard to monitor compliance, although variation in compliance across wards remains.

35. On the wards, assessments for detention under the Mental Health Act 1983 and capacity assessments were rarely delayed. I am not aware of any barriers to ensuring observation levels were assessed when initiated, nor am I aware of delays in assessing ligature risks.

36. Ward Environment

37. Consideration of ward environments was primarily focused on safety, particularly in relation to ligature risk assessments and observation lines of sight. Environmental safety was a consistent priority, and ligature assessments and observation lines of sight were routinely reviewed in line with Trust policy. Known environmental risks, such as blind spots and security weaknesses, were recognised and actively considered by ward teams.

38. Historically, however, the therapeutic suitability of ward environments was not prioritised to the same extent. Wards were largely designed for containment rather than therapy, with limited opportunities for meaningful therapeutic activity. Environmental factors such as noise, lack of privacy, and limited space for therapeutic work did not consistently promote recovery. Until 2023, psychology input at Basildon Mental Health Unit was limited due to sustained recruitment difficulties, restricting access to specialist psychological expertise for both staff and patients and constraining the therapeutic model of care.

39. When I first qualified, Cedar Ward operated as a 24-bedded mixed sex ward. Following my transfer to Basildon Mental Health Unit, most adult treatment wards consisted predominantly of dormitory accommodation, with only a small number of side rooms available. The Assessment Unit and the Psychiatric Intensive Care Unit (PICU) were exceptions, as patients on these wards had their own rooms. Dormitory arrangements were neither safe nor therapeutic. Persistent noise, disturbance, and shared sleeping spaces contributed to patient agitation and conflict. Patients regularly reported feeling frightened when sharing dormitories with acutely unwell patients, particularly as privacy was limited to a curtain between beds. This frequently resulted in disturbed sleep, increased anxiety, and heightened distress. Patient dignity was compromised due to limited privacy and shared sleeping areas.

40. Although efforts were made to prioritise side rooms for the most acutely unwell patients or those with specific vulnerabilities, availability was limited. As a result, staff often relied on increased therapeutic engagement, enhanced observation levels, and de-escalation strategies to manage risk within environments that were not well suited to patient needs.
41. Over time, there was increasing recognition that ward environments impacted patient safety, dignity, and recovery, and wards underwent significant transformation. The Care Quality Commission raised concerns about the environment at Basildon Mental Health Unit during inspections. In response, substantial refurbishment work took place, including the elimination of dormitory accommodation. All wards were converted to single rooms with ensuite facilities. The move to single ensuite rooms led to significant improvements in privacy, dignity, safety, and respect for personal space, which better supported recovery. Despite these improvements, the Assessment Unit remains the only mixed sex ward at Basildon Mental Health Unit. I am aware that Topaz Ward operates as a mixed sex adult ward, that the Christopher Unit is a mixed sex Psychiatric Intensive Care Unit, and that older adult wards are also mixed sex.
42. When I became Deputy Ward Manager on Grangewaters Ward, it was a 28-bedded mixed sex ward. At that time, we frequently experienced high numbers of patients on home leave and the use of leave beds. During my time as Ward Manager, the responsible Consultant and I raised concerns regarding the safe management of the ward. As a result, the ward was subsequently reduced to 24 beds to improve safety and oversight.
43. While wards were generally maintained to a clean standard, the physical state of repair varied. Older buildings and infrastructure issues contributed to environments that felt institutional. These issues related to the age, layout, and overall physical condition of inpatient ward environments. Fixtures and fittings at Basildon Mental Health Unit were dated, and the overall environment felt austere, contributing to an atmosphere that was more institutional than therapeutic.
44. Although refurbishment improved aspects of the environment, underlying design limitations remained. Environmental design continued to present

challenges in meeting the needs of diverse patient groups, including those with varying levels of acuity, neurodiversity, and trauma-related needs. Specific issues included a lack of quiet or low-stimulus spaces for patients sensitive to noise, and ward layouts that remained inflexible, with insufficient provision for therapeutic activities. This limited the ability to adapt spaces to different clinical needs and to consistently provide a calm, therapeutic, and personalised care environment.

45. Factors such as sex, age, neurodiversity, learning disability, dementia, co-existing physical health conditions, substance misuse, and known patient sensitivities were largely managed through risk assessments, observation levels, and care planning rather than through tailored environmental design. The management of patients with learning disabilities and neurodivergent presentations presented ongoing challenges. Although staff awareness and understanding of neurodiversity improved over time, wards were not designed to minimise sensory overload. Environments were, and remain, loud, busy, and unpredictable, which could exacerbate distress for neurodivergent patients. In-reach support from Learning Disability services was limited, restricting specialist input and guidance for staff.
46. Patients with substance misuse difficulties, including drug and alcohol dependence, were frequently managed on inpatient wards, despite the therapeutic benefit of admission not always being clear and despite the impact such presentations could have on behaviour, risk, and ward dynamics.
47. Physical health considerations also posed challenges. The risk of falls among older adult patients was primarily managed through nursing falls risk assessments and increased observation levels. At Basildon Mental Health Unit there was no manual handling equipment, and environmental adaptations were limited. As a result, reliance was placed on staff presence rather than ward design to mitigate falls risk.
48. Treatment
49. During my practice in inpatient mental health settings, treatment decisions were predominantly made using a medical model, with overall responsibility held by the Consultant Psychiatrist. This was consistent across wards and

remained the primary approach for most of my career. Treatment decisions were usually made during ward rounds, which functioned as the formal forum for review and care planning.

50. Although wards were described as having Multidisciplinary Teams (MDT), prior to the implementation of the Therapeutic Acute Inpatient Operating Model for Adults and Older Adults, attendance from wider MDT members was historically limited. As a result, ward rounds were often medically led and primarily focused on medication. Treatment discussions typically involved the Consultant Psychiatrist, junior medical staff, and nursing staff, with input from other MDT members such as psychology and occupational therapy only where available.
51. Historically, involvement from allied health professionals (AHPs) was limited and inconsistent. The current position has improved, with a greater emphasis in recent years on MDT working and increased recognition of the role of AHPs in supporting recovery-focused care. The introduction of the Time to Care staffing model and the Therapeutic Acute Inpatient Operating Model for Adults and Older Adults has supported a more therapeutic and holistic model of care, which includes greater AHP contribution. This has resulted in improved access to occupational therapy input, structured activity programmes, and psychologically informed approaches.
52. However, whilst the position has improved, challenges persist in relation to workforce capacity and recruitment, as well as the ability to provide a consistent, seven-day therapeutic offer from allied health professionals. As a result, involvement remains variable across services.
53. Patients were generally involved in treatment discussions during ward rounds, and their preferences were considered wherever possible. The extent of involvement varied depending on the patient's mental state, capacity, and legal status. With patient consent, family members and carers were invited to ward rounds and their views were considered. Community mental health professionals involved prior to admission were regularly consulted, particularly during admission and discharge planning, and their perspectives were given

appropriate weighting, although this was more challenging on the Assessment Unit due to shortened lengths of stay.

54. Where disputes arose regarding treatment decisions, the Consultant Psychiatrist could request a second opinion from a medical colleague. If patients declined medication, their legal status was reviewed to determine whether treatment could be provided under the relevant legislation.
55. Over time, there was a gradual shift away from a purely medical model. Attendance from wider MDT members improved, and there was an increased emphasis on least restrictive practice and non-pharmacological interventions. Psychological input at Basildon Mental Health Unit increased from around 2023 onwards, which positively influenced treatment planning and care delivery.
56. Risk was assessed using formal risk assessment tools and observation levels. Historically, the predominance of the medical model, combined with limited psychology provision, contributed to a reliance on restrictive practices. Following the introduction of the Deputy Directors of Quality and Safety, staff increasingly challenged decisions and worked more consistently within a least restrictive practice framework. There was a deliberate move away from observation-based management towards therapeutic engagement, although this shift was constrained by staffing levels and skill mix.
57. Pharmacological treatments, including antidepressants and antipsychotics, were routinely available. For much of my practice, however, access to psychological therapies was limited due to staffing shortages, and National Institute for Health and Care Excellence (NICE) recommended psychological interventions were not consistently available. From around 2023 onwards, psychology provision improved, having been previously been limited. Alongside Clinical Psychologists, an Art Psychotherapist, Trainee Psychologists and Clinical Associate Psychologists were introduced. Psychology staff provided bespoke training and facilitated reflective practice for ward staff, which had a positive impact on care delivery and clinical decision-making.

58. Incidents of aggression were managed using verbal de-escalation as a first-line approach. When this was insufficient to maintain safety, management strategies included the administration of medication and increased observation levels, physical restraint, transfer to a Psychiatric Intensive Care Unit and consideration of use of long-term segregation, or seclusion, depending on risk and clinical presentation. Personal Behaviour Support Plans were not always completed with patients, and post-incident debriefs were not consistently undertaken with either patients or staff. Over time, the management of aggression improved following changes to the delivery of the Trust's Therapeutic and Safe Interventions and De-escalation (TASID) training, which placed greater emphasis on therapeutic relationships, trauma-informed care, and de-escalation. The introduction of Safewards also represented a shift towards evidence-based approaches aimed at reducing conflict and containment.
59. Incidents of self-harm were managed through verbal de-escalation, supportive engagement, and supportive observation levels. Where necessary, medication and physical restraint were used, alongside one-to-one therapeutic engagement to reduce risk and support the patient. Personal Behaviour Support Plans were not always completed. Patients reported that staff were not always aware of the language used when discussing self-harm, which was sometimes experienced as stigmatising. Trauma-informed care improved with increased psychological input.
60. Episodes of delirium or acute confusion were managed medically. This often involved referral to Accident and Emergency for further investigation, assessment, and treatment where a physical health cause was suspected or required exclusion. Comorbid mental and physical health conditions were considered but were not always optimally managed due to service limitations. Physical health needs were addressed alongside mental health treatment, with medical input and referral to acute services when necessary. Patients with physical frailty were often managed in ward environments that were not well suited to their needs.
61. I was aware of the risk of diagnostic overshadowing; whereby physical health problems may be misattributed to mental illness. As a clinical leader, I actively raised concerns where I felt this risk existed, and I believe awareness of this

issue was shared among staff. Formal training and structured safeguards to prevent diagnostic overshadowing were limited, and mitigation relied primarily on clinical vigilance, leadership challenge, and escalation to medical review when concerns arose.

62. Wards had limited access to allied health professionals such as Diabetic Nurse Specialists, Tissue Viability Nurses, Physiotherapists, and Speech and Language Therapists. These services were usually accessed via email or telephone referral rather than through routine MDT involvement. I experienced particular and ongoing difficulties in accessing Speech and Language Therapy services.
63. Patients with substance misuse involving prescribed medication, illicit drugs, and/or alcohol presented significant treatment challenges. Barriers included fragmentation between mental health and addiction services, which were commissioned and delivered separately, and limited access to inpatient detoxification pathways. As a result, wards frequently managed complex clinical and safety risks without specialist addiction input, which negatively affected treatment effectiveness and patient outcomes.
64. Patients diagnosed with Emotionally Unstable Personality Disorder (EUPD) presented difficulties within inpatient settings. These challenges were largely related to limited access to ward-based psychologists, the absence of consistent psychological formulation to guide care, and the lack of a dedicated inpatient treatment pathway. National Institute for Health and Care Excellence (NICE) guidelines for this patient group were not consistently followed. Staff had also experienced patient safety incidents involving individuals with these diagnoses, which heightened concern about the risk of recurrence and influenced care approaches. Staff reported emotional fatigue and anxiety when managing this patient group, particularly in the absence of structured guidance and specialist psychological support, which impacted staff confidence and wellbeing. For much of my practice, psychology provision on inpatient wards was insufficient to support trauma-informed care for these patients. Although provision improved from around 2023 onwards, the Trust did not have an effective inpatient pathway or comprehensive guidance for the management of patients with EUPD.

65. The Trust referred to a EUPD pathway; however, this did not operate effectively in practice and was not experienced by inpatient ward staff as a clear or usable framework. There was not a clearly embedded, approved, and consistently applied policy, procedure or Standard Operating Procedure (SOP) that defined how the pathway should operate within inpatient settings. Although a Personality Disorder and Complex Needs MDT SOP was developed in 2023, this was not fully approved, implemented or reviewed and therefore did not provide a robust or consistently applied structure for clinical practice.
66. Whilst the SOP outlined general principles of care, referral processes, and access to specialist support, the model relied primarily on consultative input from specialist teams, rather than being fully integrated within inpatient multidisciplinary teams. There was limited alignment between the pathway and routine ward processes, including care planning, risk management, and day-to-day clinical decision making. As a result, the pathway was not consistently embedded in practice.
67. In addition, the pathway model emphasised short-term admission for crisis containment, safety planning, and discharge to community services. However, this was not always achievable within the realities of inpatient care, where patients often presented with complex and enduring needs requiring more consistent therapeutic input.
68. It is also important to recognise the wider operating context and culture within which staff were working. Staff were acutely aware of scrutiny arising from Coroners' inquests and the ongoing Lampard Inquiry, which heightened concerns about risk, accountability, and decision-making. This environment could contribute to defensive practice, with staff prioritising risk containment and immediate safety over the relational and psychologically informed approaches underpinning the pathway.
69. Overall, staff did not experience the pathway as clearly defined, accessible, or practically applicable within the inpatient setting. This gap between the pathway as described at a strategic level and its implementation in ward-based

practice contributed to variability in care and supports the conclusion that the pathway was not operating effectively.

70. There was a lack of staff understanding of the pathway amongst nursing and medical colleagues. Staff did not know how to refer patients to the service.
71. In my experience, there were multiple barriers to ensuring that inpatient mental health treatment was appropriate and adequate. These included an over-reliance on the medical model, limited integration of psychological and relational approaches, inconsistent input from the wider MDT and allied health professionals, insufficient psychology provision, environmental constraints, and staffing pressures. Fragmentation between mental health, physical health, and substance misuse services further hindered the delivery of coordinated and holistic care. Collectively, these factors limited the ability to consistently provide therapeutic, recovery-focused inpatient treatment.
72. Medication
73. In my experience, medication for mental health inpatients was prescribed by the medical team and administered by the nursing team in accordance with Trust policy and relevant legal frameworks.
74. Patients' preferences regarding medication were considered during ward rounds wherever possible. With patient consent, the views of family members and carers were also considered. Community mental health professionals involved in a patient's care prior to admission were sometimes consulted, particularly during admission and discharge planning, and their views informed prescribing decisions where appropriate.
75. Capacity assessments were undertaken by the medical team when there were concerns about a patient's ability to consent to treatment. For patients detained under the Mental Health Act, where the three-month rule applied, emergency treatment under Section 62 of the Mental Health Act 1983 was used when clinically justified. Referrals for a Second Opinion Appointed Doctor (SOAD) were made where required. In complex cases, or where disputes arose regarding diagnosis or treatment, the medical team sought second opinions from other Consultant Psychiatrist colleagues.

76. For much of my practice, medication prescribing and administration were documented using paper medication charts. These paper-based systems relied on manual checks and carried inherent risks. Within the last year, the Trust implemented an Electronic Prescribing and Medicines Administration (ePMA) system, replacing paper charts for both prescribing and administration. The introduction of ePMA improved governance, auditability, and oversight of medication management practices.

77. In my experience, there was an over-reliance on PRN (pro re nata), as required medication, particularly medications such as Promethazine, Lorazepam, and Zopiclone. While medication was reviewed during ward rounds and other medical reviews, PRN medication was not consistently reassessed, and reviews were not always undertaken in a timely manner. This contributed to the continued use of PRN medication rather than planned reduction or discontinuation.

78. I am not aware of any restrictions placed on prescribers by the hospital regarding which medications could be prescribed beyond standard formulary guidance and national prescribing regulations.

79. Transfer

80. Decisions to transfer patients between wards were primarily based on clinical need, with consideration given to levels of acuity on wards at the time. Over time, there was an increased emphasis on admitting patients to wards within their locality. Prior to Basildon Mental Health Unit becoming a single-sex acute ward, Thorpe Ward was commissioned to accept patients from the North of the Trust. Transfers from acute wards to Psychiatric Intensive Care Units (PICU) were managed through a formal PICU referral process, completed by the referring team and screened by the PICU service. Transfers from Child and Adolescent Mental Health Services (CAMHS) to adult services were generally discussed through multidisciplinary discussions involving medical and nursing staff. Transfers between wards and to other hospitals followed similar processes.

81. Historically, bed management was coordinated through daily telephone bed calls attended by Ward Managers, who provided updates on acuity and operational pressures. This process later changed with the introduction of Microsoft Teams situation report calls. Over time Ward Managers were no longer required to attend these calls, instead inpatient services were represented by Service Managers. At times, there was a culture within the Trust of wards refusing admissions, including internal transfers, and in my experience, this was sometimes permitted and not consistently challenged or escalated.
82. In my experience, there were occasions where admissions, including internal transfers, were inappropriately refused. I consider that the development of this culture was multifactorial.
83. There were significant pressures within inpatient services, including high patient acuity, increased requirements for Therapeutic Engagement and Supportive Observations, and staffing constraints. These factors contributed to concerns among ward teams about their ability to safely manage additional patients, which at times led to refusals of admission on safety grounds.
84. In the context of heightened organisational scrutiny, including awareness of Coroners' Inquests and the Lampard Inquiry, staff may at times have adopted a more defensive approach to decision-making. This could result in prioritising perceived safety within individual ward environments over broader system-wide considerations of patient flow and access to care.
85. There was not a clearly defined or consistently applied escalation process to challenge or review decisions to refuse admissions. As a result, such decisions were not always subject to appropriate senior oversight or system-level coordination. In my experience, the response at a senior operational level, including from the Clinical Director of Flow and Capacity, could at times be to accommodate or "roll with" ward-level resistance, rather than consistently challenging or overriding decisions to refuse admissions. This further reinforced the culture whereby refusals were accepted.

86. There were also inconsistencies in how different parts of the system operated. For example, there was a disparity between the Assessment Unit – Grangewaters and treatment wards, with treatment wards able to refuse admissions, whereas the Assessment Unit – Grangewaters was not. This could result in patients being admitted off pathway to Assessment Unit – Grangewaters after being declined by treatment wards, further indicating a lack of cohesive and consistent processes.
87. Decisions regarding placement included consideration of family requests, open or historic safeguarding concerns, the existing patient mix on wards, and specific needs such as access to an accessible bedroom. When patients were transferred within the South of the Trust, information was available through the Mobius system. Where North patients were transferred to South wards, staff relied on the Health Information Exchange (HIE) to access clinical records. Not all information was available for staff to view on HIE. A copy of the medication chart was usually sent with the patient, and ward clerks could support transfers by downloading documentation. Multidisciplinary Team Clinical Handover forms were expected to be used, although I cannot recall when these were formally introduced.
88. Staff were expected to inform next of kin or family members when a transfer occurred, although this did not always happen. On some occasions, families became aware of transfers directly from the patient. Community professionals involved in the patient's care were generally informed via bed state systems rather than through direct communication.
89. In my experience, there were a number of barriers which impacted on staff consistently communicating transfer decisions to next of kin or family members. Operational pressures, including high patient acuity, staffing shortages, and competing clinical demands, meant that immediate clinical needs and risk management often took priority. As a result, communication with families, although expected, was not always prioritised or completed in a timely manner.
90. Responsibility for informing next of kin was not always clearly defined, which could lead to assumptions that another member of staff had completed this

task. In some cases, uncertainty regarding consent to share information, including consideration of patient preferences and confidentiality, led to delays or reluctance to communicate transfer decisions.

91. Trust guidance existed to support transfer decisions through the Discharge and Transfer Clinical Guidelines. I do not recall any dedicated training specifically focused on the transfer of patients. The use of two separate clinical record systems, Paris and Mobius, together with the fact that not all staff were authorised or trained to access both systems, created ongoing and significant barriers. As a result, continuity of care was sometimes compromised during transfers when staff could not access complete patient records.
92. Following a patient safety incident involving a transfer from CAMHS to adult services, transitional training was provided to one nominated member of staff and has not been reviewed in line with changes to staff establishments. In my view, this learning should have been more widely shared across teams. In my experience, additional barriers to safe and appropriate transfers included consultants refusing to accept patients, with these decisions not always being robustly challenged or escalated. Overall, I consider that transfer processes were not appropriate or adequate, largely due to fragmented access to information created using multiple clinical record systems.
93. At the time of Bethany Lilley's death, I was employed as Deputy Ward Manager on Grangewaters Ward and was allocated Site Officer duties on the long night shift during which she died. I completed the Datix Incident Report following her death and raised concerns at the time regarding the risks associated with the use of different recording systems for North and South patients. I recorded that nursing staff caring for patients across the Trust were required to use different systems and that not all staff had access to, or training in, Remedy.
94. Following Bethany Lilley's death, a Peter Bruff Unit (PBU) –Thorpe Ward Interface Meeting was established. During subsequent meetings, I raised concerns that the response was narrowly focused on the two wards involved and did not sufficiently address Trust-wide learning or risk, even though similar failures could occur during any patient transfer. Despite these concerns, the meetings continued with a limited focus.

95. I was not aware of the recommendations from the Root Cause Analysis Investigation Report relating to patient transfers and record-keeping systems until reviewing enclosure documents. The requirements for transfer emails to include patient identifiers, transfer details, and confirmation of receipt were and are not being followed in practice. Transferring clinicians were not consistently ensuring that information had been received. Where teams became aware of impending transfers, they sometimes had to request that risk assessments be updated. Transfer forms were not always completed prior to transfer, and patients occasionally arrived on wards without the receiving ward confirming that they were expecting them. Verbal handovers were not always documented in clinical notes, depending on ward acuity and competing priorities.
96. The Trust Ward Managers' Audits on Tendable did not include checks on whether inventories were completed on admission, which would have supported compliance with investigation recommendations. Patients nursed on Level 3 or 4 Therapeutic Engagement and Supportive Observations were not accompanied by ward staff during transfers, despite Level 3 Therapeutic Engagement and Supportive Observations requiring continuous observation within eyesight and Level 4 Therapeutic Engagement and Supportive Observations requiring continuous observation within arm's length due to the highest level of risk. Instead, the Trust relied on the contracted transport provider, SMT, to deliver the required level of supervision during transfer and to convey available clinical documentation. When patients arrived without sufficient background information or case notes, staff on receiving wards escalated these concerns and attempted to obtain the missing information urgently.
97. I am unsure whether all Consultants had access to, or training in, the clinical record system used outside their locality. I am aware that not all nurses had access to the Health Information Exchange, Paris, or Mobius, and that additional training was not consistently provided. Barriers to staff access and system training persisted. The Trust is working towards implementing a new integrated clinical record system. I am not aware that staff received further training on the Trust's Discharge and Transfer Guidelines following these

incidents. I believe the Trust needs to consider how learning from patient safety incidents is shared more effectively with staff.

98. At the time of Jason Standing's death, I was covering as Matron for the Hadleigh Unit while substantively employed as Matron for the Basildon Mental Health Assessment Unit, including the Health Based Place of Safety and Topaz Ward at The Crystal Centre in Chelmsford. I did not personally meet Jason Standing prior to his death due to annual leave and the bank holiday period. I was involved in assisting with the organisation of his transfer from the Christopher Unit to the Hadleigh Unit and in aspects of post-incident management. I attended a professionals' meeting on 17 December 2021, during which staff from the Christopher Unit provided a multidisciplinary overview. This included discussion of Jason Standing's obesity, weight and BMI, pressure sores, and referral to Tissue Viability services. Sleep apnoea was not discussed at that meeting.

99. Jason Standing's death demonstrated that issues relating to patient transfers persisted following Bethany Lilley's death. Admission assessment documentation recorded that when he was transferred, only the transfer approval letter, Form H4, and his belongings were available. No personal details, background information, risk assessments, or drug chart accompanied him. It was recorded that the Site Officer agreed to liaise with the Christopher Unit to obtain the missing information by email. In my view, these issues persisted because learning from previous incidents was not fully embedded across the Trust.

100. Safeguarding

101. Concerns relating to a patient's care and treatment could be raised through several mechanisms within the Trust. Safeguarding concerns could be raised directly by both registered and unregistered staff using the Trust's safeguarding reporting forms. Staff were also able to raise concerns with the Nurse in Charge, Ward Managers, Service Managers, Matrons, the Safeguarding Team, or the Freedom to Speak Up Guardians.

102. Patients themselves could raise concerns about their care and treatment directly with ward staff or via the Patient Advice and Liaison Service (PALS).

Where concerns were raised through PALS, these were communicated to the relevant clinical teams and often prompted consideration of whether a formal safeguarding concern also needed to be submitted.

103. Datix Incident Reporting provided a further mechanism for raising concerns about patient care and treatment. Reports submitted on Datix were reviewed by designated incident handlers, and individuals included on distribution lists were able to screen the information and initiate follow-up actions. This included prompting the submission of a safeguarding concern where this had not already been completed. In my experience, Datix provided an important additional route for identifying issues requiring escalation.

104. Overall, I found that these mechanisms were generally effective in enabling concerns about patient care and treatment to be raised. However, their effectiveness was often dependent on the quality and depth of the subsequent investigation, as well as the timeliness of the response to the concerns identified.

105. I felt able to raise and report concerns regarding the actions of clinicians or other staff involved in patient care. Where my concerns related to a registrant, I would discuss them with Human Resources and the relevant Professional Lead for Registrants. Where concerns related to a member of the medical staff, I would escalate these to the Deputy Medical Director. I was aware of the need to escalate concerns through appropriate professional and management structures. However, I had less assurance regarding the consistency of how concerns about medical practitioners were managed once escalated.

106. In my experience, while concerns were often acknowledged, there was not always a clear or timely response in terms of actions taken to address those concerns. For example, I raised concerns directly with the Clinical Director regarding the behaviour and practice of a ward Consultant Psychiatrist. Although these concerns were acknowledged, there was limited evidence of timely action or feedback regarding how they were being investigated or resolved.

107. Whilst I recognise the demands on senior medical leadership, this lack of visible follow-through led to uncertainty regarding how such concerns were managed more generally. There was also a perceived reluctance to take decisive action in response to concerns about the Consultant Psychiatrists behaviour. My understanding was that this may, in part, relate to challenges in recruiting and retaining Consultant Psychiatrists, particularly within certain inpatient settings. As a result, Consultant Psychiatrists were at times viewed as a scarce resource, which may have contributed to hesitancy in addressing concerns promptly or robustly.

108. I do not recall receiving specific training in relation to thresholds or formal referral routes to professional regulatory bodies such as the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), or the Health and Care Professions Council (HCPC). I was aware, however, that escalation through Human Resources and relevant professional leads would support decision-making regarding regulatory referrals where this was considered appropriate.

109. Clinical Records

110. When I first commenced my nursing degree, inpatient wards within the Trust relied on paper-based records, prior to the introduction of the Mobius electronic clinical system. I am not aware of what paper records were routinely available to clinicians at the point of admission, particularly in relation to community records. Over time, electronic systems were introduced, and the primary clinical system I have used as a clinician is Mobius, although I have also used Paris and the Health Information Exchange. These systems were used to record clinical assessments, nursing notes, medical reviews, risk assessments, and care plans during a patient's admission.

111. Patient information was shared between staff primarily during handover periods. Historically, this was facilitated using paper handover sheets, which were updated by the Nurse in Charge prior to handover and, at times, throughout the shift. More recently, electronic clinical dashboards were introduced to support handover processes. These dashboards drew information directly from clinical records, particularly the nursing continuation sheets. However, concerns were raised regarding the effectiveness of these

handovers due to IT issues, and information discussed verbally was not always accurately or consistently reflected in the clinical record.

112. Access to clinical records varied depending on the system on which the patient's information was held. Staff did not always have access to records for patients whose care was recorded on a different system, such as when patients transferred between areas of the Trust using Paris rather than Mobius. In my experience, access was restricted not only by system permissions but also by delays in authorisation. I do not recall receiving formal training in the use of either Mobius or Paris, and my ability to navigate these systems developed through experience rather than through structured training.

113. Concerns regarding the use of multiple clinical record systems and the barriers to accessing information were raised over time; however, these issues were not addressed in a timely manner. There appeared to be unnecessary obstacles to obtaining access for staff, even where such access was required to deliver safe patient care. Staff were required to submit additional access requests for Paris even where this was clinically necessary. This process involved multiple approvals and administrative steps, which could result in delays in access being granted. In the absence of immediate access, staff relied on information available on the Health Information Exchange (HIE), rather than directly reviewing the full clinical record, which at times, posed risks to safe and informed clinical decision-making.

114. In addition, there was insufficient access to appropriate IT hardware on wards. Ward environments often lacked adequate physical space to allow staff to use laptops or desktop computers effectively, and devices were frequently slow as multiple staff were logged into a single piece of equipment. This had a direct and detrimental impact on staff's ability to complete and review electronic records in a timely fashion.

115. Staffing pressures, including staffing numbers and workload demands, presented further barriers to ensuring that patient records were appropriately and accurately updated and reviewed. The Trust introduced Clinical Case Notes Guidance for nursing documentation, which set out twelve headings to be included in progress notes. Consequently, staff often copied and pasted

these headings and amended information without consistently ensuring accuracy, which reduced the clarity and usefulness of clinical records.

116. In response to record-keeping issues identified on the Assessment Unit, I introduced one-to-one engagement entries to better capture patient contact and interaction. More recently, I have worked with the Professional Nurse Educator to improve the quality of nursing documentation. I am not aware of what changes, if any, were implemented or embedded in practice on the Hadleigh Unit following the record-keeping failings identified in the Patient Safety Incident Investigation report relating to Jason Standing.

117. Overall, barriers to maintaining accurate, comprehensive, and contemporaneous patient records included staffing pressures, insufficient access to functioning IT hardware, slow computer systems, complex documentation requirements, and a lack of effective training in the use of electronic record systems. These factors combined to make clinical documentation particularly challenging within already pressurised inpatient environments.

118. Based on my experience, the processes and systems relating to patient records were not appropriate or adequate. The use of multiple clinical record systems, inconsistent staff access, limited hardware availability, and a lack of integration between systems adversely affected staff's ability to document, review, and interpret patient information accurately. These limitations impacted the quality-of-care planning, continuity of care, and the ability of staff to maintain a clear and shared understanding of a patient's presentation and needs.

119. Care Plans

120. In my experience, the intended purpose of a care plan was to provide a structured and collaborative document that identified a patient's needs, goals, and risks, and set out clear interventions to support their care, treatment, and recovery. Care plans were expected to be central to the delivery of holistic, person-centred care and to be developed with the patient and reviewed regularly in response to changes including but not limited to condition, risk, or

legal status. While this expectation remained consistent within Trust policy and guidance, the practical use of care plans did not reflect this intention.

121. In practice, care plans were often treated as an administrative requirement rather than a dynamic clinical tool used to actively guide care. Based on my direct experience, they were more commonly completed to meet documentation requirements than to meaningfully inform daily care. Initial care plans were usually completed shortly after admission alongside risk assessments and were predominantly developed by nursing staff using standard templates within the electronic clinical record. These initial plans were frequently brief, generic, and not tailored to the individual patient.

122. Patient involvement in care planning was inconsistent. Where patients were involved, their views were not always clearly reflected in the written care plan. In many cases, the content appeared generic, with evidence of repeated “copy and paste” wording across multiple care plans, particularly within intervention sections. Care plans were rarely used by staff as a reference point for delivering care and were not routinely discussed during handovers or ward rounds unless prompted by a specific incident. Updates were more likely to occur reactively, such as following incidents or Datix reporting, rather than proactively in response to changes in presentation or need.

123. Care plans were predominantly completed and reviewed by nursing staff. Medical staff were rarely involved in their preparation, and care planning was not routinely led or reviewed within the multidisciplinary team (MDT). Reviews were not undertaken systematically and were often not completed when changes occurred in observation levels, legal status, or clinical presentation. Where reviews did take place, they were usually undertaken by nursing staff alone, with limited MDT input and inconsistent patient involvement.

124. In my experience, next of kin, family members, and community professionals involved in the patient’s care were not routinely involved in care planning. Opportunities to incorporate collateral information were frequently missed. More recently, under the Therapeutic Acute Inpatient Operating Model for Adults and Older Adults, wards introduced Family and Carer Ambassador roles. At Basildon Mental Health Unit, this role includes updating carer views within the care plan. The content of care plans was not routinely shared with

families or community professionals, and patients did not always receive copies of their care plans. Many patients were unaware of the specific goals, risks, or interventions documented in their care plans.

125. Comorbid issues, including physical health problems, substance use, and neurocognitive difficulties, were documented inconsistently. When these issues were included, they were not always translated into clear and actionable interventions. Care planning tended to focus primarily on immediate mental health risks rather than addressing the patient's holistic needs. There were also no consistent additional considerations reflected within care plans for older adult patients. Age-related needs such as mobility, frailty, cognition, and complex physical health issues were not routinely addressed unless a Physiotherapy assessment had been completed and a separate care plan provided.
126. Formal training on the completion and effective use of care plans was not provided. There was significant variation in care planning practice across wards, with staff largely learning through experience rather than structured education. In my view, the lack of consistent training was not appropriate or adequate, given the importance of care plans in supporting safe, effective, and person-centred care.
127. Care plans were largely perceived as an administrative task required for record keeping and compliance, rather than as live documents central to delivering holistic, recovery-focused care. Several barriers contributed to this. Cultural factors played a significant role, with care planning often viewed primarily as a documentation exercise. Staffing pressures and time constraints limited opportunities for meaningful patient engagement. Multidisciplinary involvement was limited, particularly from medical staff. Limitations within the electronic record system also encouraged reliance on templated and generic care plans rather than personalised ones.
128. An additional barrier arose from the separation between the paper-based *My Care, My Recovery* (Exhibit 1) documentation and the electronic care planning system. Patients were often involved in completing *My Care, My Recovery* documents, which did capture elements of care planning. However,

because these documents were paper-based, their content was not consistently transcribed into the electronic care plan. This reliance on nursing staff to manually input patient-identified goals and preferences meant that patient contributions were frequently omitted from the formal care plan. Patients usually retained a copy of their *My Care, My Recovery* document, with another stored in the nursing office, but this information was not reliably integrated into the main clinical care plan record, rather scanned onto the clinical records.

129. At a site level, there has been recognition of the need to improve care planning practices at Basildon Mental Health Unit. Work has begun in collaboration with the Professional Nurse Educator to review care planning documentation and processes, with the aim of achieving greater consistency, increased patient involvement, and more meaningful use of care plans across the site.

130. Therapeutic Engagement and Supportive Observation

131. In my experience, decisions relating to risk and observation levels, including Therapeutic Engagement and Supportive Observations, were initiated by the nursing team at the point of admission, typically while awaiting clerking by the on-call doctor. As a minimum, patients were usually placed on Level 2 Therapeutic Engagement and Supportive Observations on admission, which involved staff visibly checking the patient a minimum of four times at irregular intervals within every one-hour period. Decisions about whether a higher level of observation was required were informed by the information available at the time, including referral documentation, handover information, staff knowledge of the patient's historical risks, and initial engagement with the patient on arrival.

132. Although nursing staff-initiated observation levels on admission, reductions in observation levels did not occur without medical involvement. In my experience, reductions were made as part of a multidisciplinary decision, and a patient would not be reduced without a doctor being involved. This approach remained consistent over time, with nursing-led initiation of

observation levels on admission and medical input required for any subsequent reduction.

133. Once a decision had been made regarding a patient's level of therapeutic engagement and supportive observation, it was expected that this level would be adhered to. Observation levels were revisited in response to changes in presentation, incidents, feedback from staff undertaking observations, or feedback from the patient, relatives, or carers.
134. Observation levels had a significant impact on patients, particularly in relation to privacy and dignity. Patient preferences were considered where possible, including issues relating to privacy and dignity, and decisions were made on an individual basis with least restrictive practice in mind. Any necessary adjustments were documented. Input from relatives or carers was considered when available, although this was not always a routine part of decision-making.
135. In my experience, deviations from required observation levels were not formally justified based on staffing availability. Where staffing pressures existed, staff were more likely to work beyond the expected two-hour periods on enhanced observations to maintain patient safety, rather than reduce observation levels due to staffing constraints.
136. There was a Therapeutic Engagement and Supportive Observations Policy in place, which outlined the different observation levels and provided examples of situations in which they might be used. However, in my experience, this policy did not directly drive individual decisions. Observation levels were determined primarily through clinical judgement, informed by staff feedback, patient engagement, and, where available, input from relatives or carers.
137. There was no in-person training specifically focused on decision-making in relation to therapeutic engagement and supportive observations. Staff relied on experience, peer discussion, and reference to policy documents. There were some alternative forms of training available, including e-learning modules and Engagement and Supportive Observations Core Competencies.

138. In my view, this level of training provision was not fully adequate as it did not provide the structured, skills-based learning or consistency required to support safe and effective decision-making across teams within the organisation.
139. I experienced several barriers to the delivery of appropriate and adequate Therapeutic Engagement and Supportive Observations. The ward induction process was lengthy and acted as a barrier to ensuring staff were consistently able to deliver observations to the required standard, particularly during periods of high reliance on temporary staff. Staff were required to complete Therapeutic Engagement and Supportive Observations Core Competencies before completing Therapeutic Engagement and Supportive Observations. However, completion of these competencies took time, and in practice staff sometimes undertook these duties before there was evidence that Core Competencies had been completed. This was particularly evident when there were high numbers of bank or agency staff on duty. Even where temporary staff had worked on other wards within the same building, competencies were still expected to be completed for each specific ward.
140. On the Hadleigh Unit specifically, the Ward Manager's sickness and other absence, alongside unfilled duties and high reliance on temporary workforce, including agency staff, limited oversight of staff practice. This affected assurance that duties, including Therapeutic Engagement and Supportive Observation Core Competencies and undertaking of these duties, were being completed appropriately. I raised concerns about safety on the ward to some members of the Executive Team prior to the death of Jason Standing in January 2022.
141. In response, Paul Scott, Chief Executive and Alex Green, Chief Operations Officer attended the site in October 2021. During the visit, I encouraged them to speak directly to members of the Hadleigh Unit team to understand the concerns being raised. While they attended the ward, there was no clear feedback provided to me at the time regarding any immediate actions or escalation of the issues I had raised

142. Following the visit, there were no immediate or observable changes to how Hadleigh Unit operated and I was not made aware of any specific measures implemented in response to the concerns.
143. I also believe that concerns relating to COVID-19 affected staff practice. The Hadleigh Unit had a high proportion of Black, Asian and minority ethnic (BAME) staff, and there were known concerns about the increased risk of COVID-19 for these groups. The unit had also experienced the death of a BAME colleague, which added to staff anxiety. In my view, this may have influenced staff willingness to undertake Level 3 Therapeutic Engagement and Supportive Observations as required.
144. On the night of Jason Standing's death, there was a high number of temporary staff on duty, including both bank and agency staff. It is possible that, as temporary staff are paid only for booked shifts, concerns about the impact of contracting COVID-19 on income and future work may have influenced adherence to Level 3 Therapeutic Engagement and Supportive Observations requirements.
145. In my experience, there was nothing about the physical environment of the Hadleigh Unit that presented a barrier to carrying out patient observations.
146. Discharge
147. In my experience, discharge planning began from the point of admission, with the ward team working throughout the inpatient stay towards discharge. During regular ward rounds, patients were reviewed by the Consultant Psychiatrist, and their progress against discharge planning goals was considered. Risk was assessed by the Consultant Psychiatrist as part of these reviews and formed a central element of discharge decision-making.
148. Discharge decisions were led by the Consultant Psychiatrist and informed by multidisciplinary team discussions. Relevant information was drawn from ward rounds, MDT discussions, clinical records, and feedback from patients, carers, and Care Coordinators where applicable. Factors considered included the patient's mental state, progress during admission, ongoing risk, successful completion of leave, and the availability of appropriate community support.

Patients' preferences were considered, and where patients consented, families and carers were involved in discharge planning, including being invited to provide feedback on the patient's progress and readiness for discharge.

149. Leave was an integral part of the discharge process and was used to assess readiness prior to discharge. This included ground leave, home leave, and overnight leave, which enabled the ward team to evaluate how the patient managed outside the ward environment before proceeding to discharge. In my experience, this approach was a useful and effective means of supporting safe discharge decisions, and I did not observe any significant changes to this process over time.
150. Where a patient had an allocated Care Coordinator, they were invited to be involved in discharge planning throughout admission. Where a patient did not have a Care Coordinator, a referral was made as part of the discharge process. Decisions were communicated through discussions with the patient on the ward and, where appropriate, through contact with families, carers, and community professionals. Discharge summaries were used to communicate outcomes and plans to General Practitioners (GP) and community mental health teams and were uploaded to the electronic record for access by relevant services.
151. Several factors outside the direct control of the ward team could delay discharge. These included accommodation issues, such as patients having no fixed abode or requiring cleaning or repairs to accommodation prior to return, as well as delays in arranging care packages. Wards were routinely informed of bed pressures, and requests were made to support the discharge of patients who were identified as clinically suitable and who could be supported by Crisis Resolution and Home Treatment Teams. In my experience, ward teams did not identify patients for discharge unless they were considered clinically ready and able to be discharged safely.
152. Discharge procedures were in place and followed. These included medical review, updating of relevant documentation, assessment of risk, and communication with community services. Decisions were made in line with

Trust guidance and statutory expectations regarding safe discharge and continuity of care.

153. Care plans were updated at the point of discharge; however, copies were not routinely provided to patients. Instead, patients were issued with a *My Care, My Discharge Plan* (Exhibit 2), which included information about crisis services and support following discharge. Discharge summaries were completed, shared with the patient and their GP, and uploaded to the electronic clinical record for access by community teams.
154. Patients were provided with a supply of their prescribed medication on discharge. The quantity supplied was determined by the Consultant Psychiatrist, based on their assessment of risk and in accordance with Trust guidelines. This decision was recorded on the Discharge Prescription Notification Form, and the rationale was often also documented in the discharge summary. Discharge medication was prepared by the Trust pharmacy. On occasion, FP10 prescriptions were issued on discharge if there were delays or limitations in Trust pharmacy supplying medication that could otherwise delay discharge; an FP10 is the standard prescription used to dispense medication in the community, allowing patients to obtain their medicines from a local pharmacy.
155. In my experience, barriers to discharge were primarily related to practical and external factors rather than clinical decision-making. These included accommodation difficulties and delays in arranging care packages. While bed pressures influenced the urgency of discharge planning, I believe that patients were only identified for discharge when they were considered clinically suitable and could be supported safely in the community.
156. Overall, in my experience, discharge processes were appropriate and adequate. Discharge planning began early, was medically led, supported using graded leave, and involved families, carers, and Care Coordinators where consent and availability allowed. Risk was formally assessed, medication provision was documented and risk-based, and effective communication with GPs and community teams was achieved through discharge summaries and electronic records. While external factors could delay discharge, patient safety remained the primary consideration.

157. Continuity of Care and Treatment in the Community

158. As an inpatient nurse, I cannot fully explain how continuity of care and treatment in the community operated following discharge. My understanding is limited to the processes that occurred immediately after discharge. Patients were discharged with a Next Day Clinical Courtesy Call from the ward. This was followed by further contact either from the Crisis Resolution and Home Treatment Team or Care Coordinator as a 48 hour follow up.

159. Engagement

160. During a patient's admission to an inpatient mental health ward, information was communicated to and obtained from patients through several routes. Patients attended ward rounds, during which they were asked about their views on their progress and were informed by professionals about observations made on the ward and progress towards discharge. In addition to ward rounds, patients had one-to-one engagement with nursing staff, which provided further opportunities for discussion and information sharing about their care and treatment.

161. Information was also communicated to and obtained from a patient's family members, carers, and other members of their support network. Where appropriate, families and carers were invited to attend ward rounds. Outside of ward rounds, nursing staff and the medical team would contact, and receive information from, families and carers as needed. However, communication with families, carers, and support networks was often affected by time pressures. Competing demands on staff time meant that communication was not always consistent or proactive.

162. Where it was considered necessary to share patient information with third parties, an assessment of the patient's capacity would be undertaken. If a patient did not consent to information sharing, this decision was kept under review throughout the admission. Even where consent was not given, information could still be received from family members or others within the patient's support network. This information was considered as part of ongoing risk assessment and care planning, particularly where risk levels increased.

Patients' wishes regarding information sharing should have been reviewed on an ongoing basis during admission. I cannot recall instances where a patient's wishes were formally overruled in relation to consent for information sharing.

163. When information was shared with families, carers, or support networks, there were limited mechanisms to ensure that it had been fully received and understood beyond standard verbal communication. Where individuals had identified communication needs or where English was not their first language, interpreters were used.

164. The extent to which communication was documented varied and was often influenced by staffing pressures. In my experience, communication with patients, families, or carers was not always consistently recorded in the clinical notes.

165. Involvement of patients, families, carers, and support networks in decisions relating to care and treatment varied depending on capacity, consent, and staff availability. Although NHS guidance emphasises shared decision-making and involvement, this was not always achieved consistently in practice.

166. Prior to the COVID-19 pandemic, families and carers were more routinely present on wards. Where families were able to attend ward rounds, this was a beneficial process, supporting the development of relationships between staff, patients, and families and enabling families to provide meaningful input. Barriers to family involvement included practical issues such as sickness absence of ward clerks or medical secretaries, which affected coordination and communication.

167. In relation to discharge planning and aftercare, ward teams worked with external providers such as community mental health teams and other support services. However, engagement with external services could be difficult at times due to high caseloads or because patients had been admitted outside their usual area of care.

168. Patients who experienced serious harm or near-miss incidents were supported through individual one-to-one engagement with staff. Psychological support was available, including individual psychology input and group work where

appropriate. Families, carers, and support networks were not always informed by ward teams when incidents of serious harm or near miss occurred, such as attempted suicide, absconsion, or allegations of abuse.

169. In my own experience relating to the death of Bethany Lilley, I requested that the On-Call Doctor, who was present during the incident, inform her mother, recognising that he would be best placed to respond to medical-related questions.

170. Families were informed and communicated with during internal and external investigations, usually through a designated Family Liaison Officer. However, in my experience, service demand meant that communication during investigations was not always as regular as it should have been. Families and carers were offered support through Trust-provided support mechanisms following serious incidents or deaths.

171. Overall, in my experience, engagement with patients, families, carers, and other members of their support network was insufficient. While there were established opportunities for engagement, including ward rounds and one-to-one contact, time pressures, staffing constraints, and service demand limited the consistency, depth, and quality of engagement in practice.

172. Safety

173. Safety on inpatient mental health wards was managed through a combination of environmental controls, clinical assessment, policies and procedures, and ongoing multidisciplinary oversight. Preventative measures included the completion and regular review of risk assessments and care plans, the use of Therapeutic Engagement and Supportive Observations, management of restricted and prohibited items, and regular ligature risk inspections in line with Trust policy. Safety alerts and multidisciplinary discussions also played an important role in identifying and mitigating risk.

174. Risk was continuously assessed throughout admission and management strategies adjusted through ward rounds and MDT discussions. Care plans and observation levels formed part of this ongoing risk management process. I did not observe a fundamental shift in the overall approach to safety during my

career; however, there was a significant improvement over time in the specific management of ligature risk. Earlier in my career, whilst ligature risk inspections were conducted in line with Trust policy, there was limited ward-level engagement and ligature risk inspection reports were not well embedded in ward practice, and their location was not known and were not easily accessible to staff. Following regulatory scrutiny from a Care Quality Commission inspection, the Trust introduced improved systems, such as ligature wallets, which increased staff awareness of environmental risks within the areas where they were working. In my experience, the current ligature audit processes are appropriate and adequate.

175. Crisis and emergency management systems included the use of personal alarms and enhanced levels, above Level 1, of Therapeutic Engagement and Supportive Observations, with Level 1 – General Observations, the minimum level of observations for all patients in inpatient areas, requiring staff awareness of patient whereabouts once every 60 minutes. In my experience, these systems were generally adhered to, and where this did not occur it was most related to gaps in staff training and education. Personal alarms were available to staff; however, there were occasions when insufficient devices were available, requiring additional alarms to be ordered and local mitigation put in place to manage the shortfall. This included staff who had been issued with personal alarms being asked to return these so that they could be used as pooled devices, which were then allocated to staff on duty on a shift-by-shift basis. In addition, wards would at times be supported by borrowing spare alarms from other areas or wards, to supplement the number of devices available locally.
176. There were also intermittent concerns regarding the accuracy of alarm pinpointing, which were escalated and resolved.
177. Forms of restrictive practice, including manual restraint, seclusion, and long-term segregation, were available at Basildon Mental Health Unit. Some of these practices required the patient to be detained under the Mental Health Act 1983. Restrictive practices were used in response to identify patient risk and in accordance with Trust policies. Their use was documented through Datix reports, medical and nursing entries, and MDT discussions, with details

recorded by medical secretaries. Where documentation was incomplete, this was generally attributable to staffing pressures or gaps in education.

178. For patients who lacked capacity, consideration of Deprivation of Liberty Safeguards occurred through MDT discussions, ward rounds, and safeguarding processes.
179. In my view, some hospital procedures and approaches to managing patients may have inadvertently caused harm, both physical and psychological. In particular, the use of physical restraint and intramuscular medication could be retraumatising for some patients, highlighting the importance of trauma-informed care approaches.
180. Patients did not always feel safe on inpatient mental health wards. Factors contributing to this included the use of mixed-sex wards, dormitory accommodation, staff speaking languages other than English in front of patients, and the overall ward culture in some areas. Families, carers, and support networks raised concerns relating to patient safety, including allegations regarding staff attitude, staff sleeping on duty, and physical assault. These concerns were addressed through safeguarding processes and, where appropriate, Human Resources procedures.
181. My own sense of safety at work was influenced by staffing levels, skill mix, and the robustness of patient management. Where staffing was insufficient or the skill mix inappropriate, staff safety was compromised. Incidents involving physical harm to staff were not always managed appropriately due to several factors relating to post-incident support, escalation, and organisational response. There was, at times, a lack of visible and consistent support from senior managers following incidents. Whilst incidents were recorded, staff did not always feel that their concerns were actively followed up or that sufficient action was taken to address the impact on their safety and wellbeing. This contributed to a perception that such incidents were not given the level of seriousness they warranted.

182. The lack of consistent presence and support of the Trust's Violence Abuse Prevention and Reduction (VAPR) team also meant that staff could feel unsupported and less confident in reporting incidents or pursuing outcomes.
183. In addition, Police response was often inconsistent, and the absence of a clear Single Point of Contact from the Police presented additional challenges. In some cases, incidents that constituted physical harm did not result in sustained Police engagement, which could impact staff confidence in pursuing further action. Linked to this, there were limited instances of prosecution following assaults on staff, which contributed to a perception that such behaviour was not consistently challenged or addressed through formal legal processes. This could have a demoralising effect on staff and reduce confidence in reporting incidents.
184. Staff safety concerns influenced inpatient care and decision-making, contributing to a more risk-averse culture and increased reliance on restrictive practices rather than therapeutic engagement.
185. Information and guidance on safety and raising concerns were available to patients, families, carers, and staff through mechanisms including Care Quality Commission processes, the Patient Advice and Liaison Service, community meetings, patient-led safety huddles, ward rounds, and the Patient Safety Incident Response Framework (PSIRF). The Trust also worked with partner agencies through multi-agency meetings, safeguarding boards, Multi-Agency Risk Assessment Conference (MARAC) processes, and liaison with Police.
186. I am aware of incidents involving serious harm short of death, including ligature attempts, cutting, and incidents of violence and aggression. Disclosures of serious harm and safety concerns were addressed through Datix Incident Reporting, safeguarding referrals, and PSIRF processes. In my experience, these concerns were generally escalated appropriately and in a timely way.
187. Overall, I believe the steps taken by the Trust to identify, assess, evaluate, and reduce safety risks to both patients and staff were appropriate. Structured governance arrangements and safety alerts contributed positively to risk

management, though their effectiveness was dependent on staffing levels and local leadership.

188. There were sexual safety concerns involving patient-to-patient, patient-to-staff, staff-to-patient, and staff-to-staff interactions. I personally witnessed incidents of inappropriate touching by patients towards staff. While I did not personally witness staff sexually harassing or abusing patients, I am aware of concerns raised regarding such behaviour. These reports were managed through safeguarding procedures, Human Resources processes, and referral to the police as appropriate.
189. Safeguarding procedures followed the Trust Safeguarding Policy for the protection of adults at risk. Where concerns arose, immediate action was taken to ensure safety, including risk assessment and, where required, removal or redeployment of staff from clinical duties. The individual involved would be spoken to in order to ascertain their views and assess capacity regarding next steps.
190. Concerns were escalated to line managers and advice sought from the safeguarding team via the Duty Line. Incidents were formally recorded on Datix and a Safeguarding Concern Form completed. The safeguarding team maintained oversight of all open cases and determined whether the threshold for a Section 42 enquiry with the local authority was met.
191. Cases involved multi-agency working where appropriate, including referral to the police in situations involving potential criminal offences. In parallel, internal Trust processes were initiated, including Human Resources investigations, suspension, and referral to professional bodies where required.
192. Safeguarding cases were subject to ongoing review, including safeguarding strategy meetings, to ensure risks were effectively managed.
193. In my view, responses were appropriate and safeguarding procedures were applied in a way that prioritised the immediate safety and protection of both patients and staff.

194. Following sexual safety incidents, it was my experience that the Trust worked collaboratively with safeguarding teams and the police to mitigate risk and support those affected. This multi-agency approach was appropriate and facilitated thorough investigation.
195. During my employment, both mixed-sex and single-sex wards operated as well as dormitory accommodation was in use. Some mixed-sex wards remain in operation. These wards generally carried a higher risk of sexual safety incidents. Although these risks were well recognised at an organisational level, in my view they were not always effectively managed in practice.
196. The physical ward environment on Assessment Unit – Grangewaters continued to present inherent risks. Patients shared communal areas, and there were limited options to fully separate individuals due to the ward design, including a lack of restricted access between designated male and female corridors.
197. Although this constraint was recognised, mitigating measures were not always consistently maintained in practice. For example, there had previously been dedicated staffing allocated to monitor sexual safety risks within corridor areas; however, I am aware of decisions for this function to be absorbed into the baseline staffing establishment.
198. In practice, this reduced the availability of staff specifically tasked with observation and supervision within these higher-risk shared spaces. When staff were required to respond to multiple competing demands across the ward, it was not always possible to maintain consistent oversight of corridor areas or intervene at an early stage where behaviours were beginning to escalate.
199. In my view, this limited the effectiveness of the measures in place to mitigate known environmental risks and contributed to a more reactive, rather than preventative, approach to managing sexual safety.
200. Specific measures were introduced to address physical and sexual safety risks in mixed-sex environments, including policies requiring separate sleeping

areas, toilets, and bathrooms, additional risk assessments where mixed-sex accommodation was unavoidable, and the provision of secured female-only lounges to support safety and dignity. Sexual Safety Charters were introduced on all wards. Associated risk assessments were recorded in governance systems such as General Workplace Risk Assessments.

201. Technology

202. During my time working on inpatient wards within the Trust, a range of technologies were used to support clinical care, observation, governance, and investigation processes. These included Electronic Patient Records, Oxevision, including the use of tablets, Body Worn Cameras, CCTV, Power BI, clinical dashboards and Tendable.
203. When I first began working in inpatient services around 2016, paper records were still in use. These were later replaced by the Electronic Patient Record system. Following my move to Basildon Mental Health Unit, but prior to the death of Jason Standing, additional technologies were introduced, including Body Worn Cameras and Oxevision. CCTV was installed on wards at Basildon following refurbishment works. Digital audit and governance tools, such as Power BI, Tendable and clinical dashboards, were introduced over time to support oversight and organisational assurance.
204. Mobile devices, primarily tablets, were used by staff to complete Therapeutic Engagement and Supportive Observations electronically via the Oxevision e-observation system. These devices were used throughout shifts, replacing paper-based observation documentation. Oxevision was also used to generate alerts, which staff were expected to respond to as part of maintaining patient safety. My understanding was that Oxevision utilised infrared, non-contact technology rather than functioning as traditional CCTV. The system was designed to support clinical care by monitoring physiological indicators such as pulse and breathing rate and by identifying potential risk factors, including ligature risks, prolonged periods spent in bathrooms, and time spent in blind spots within bedrooms. As I understood it, the overall purpose of Oxevision was to reduce risks of self-harm while supporting staff observation practices.

205. I understood that salient Oxevision data was retained for up to 24 hours and that staff could request access to this data from Oxevision within that period following an incident. Patients were not always aware of the use, functioning, or purpose of Oxevision. My understanding was that patients were implicitly opted into the system on admission. Where a patient raised objections or refused consent, the expectation was that Oxevision would initially remain active, an MDT meeting would be convened within 72 hours, and a decision would be made regarding withdrawal of the system and isolation of the bedroom. It was also expected that a Datix report would be completed in these circumstances.
206. Over time, the Standard Operating Procedure (SOP) was revised to require discussion with patients about Oxevision on admission and ongoing weekly discussions at MDT meetings. However, this practice was not consistently embedded, and more recent internal and external audits identified failures relating to consent and patient understanding. Although the SOP included a consent flowchart to guide staff when a patient refused Oxevision, consent discussions were not always fully undertaken or documented.
207. Barriers to compliance with the SOP, consent discussions and adequate documentation appeared to be relate primarily to staff understanding and the way in which the SOP and I believe this was a result of how the SOP and subsequent changes were communicated to frontline staff. There was a lack of clarity regarding the process for obtaining consent for Oxevision and the roles and responsibilities associated with this.
208. In addition, there were system related barriers. For example, there were no consistent prompts within nursing admission entries to ensure that discussions regarding Oxevision and patients' preferences were recorded. Similarly, there were no prompts within the Trust admission assessment or ward round forms used by medical staff, which limited opportunities to ensure discussions and assessment of capacity were undertaken and documented consistently.
209. Record keeping also presented challenges. Information relating to consent and patient discussions were not consistently recorded and there was no standardised Trust wide form to support staff in documenting Oxevision consent, which made both completion and subsequent auditing more difficult.

210. I took action locally to address some of these nursing barriers, including requesting support from the Professional Nurse Educator to develop prompts for nursing admission documentation and care planning improve recording of patients' views and preferences.
211. Compliance was monitored through a range of internal audits. Oxevision related questions were incorporated into existing audits, including the Person Centred Audit, Ward Managers Audit and Matrons Record Keeping Audit, which were undertaken monthly. Subsequently, more specific Oxevision audits were introduced, including the Oxevision Audit (Fortnightly), Matrons Oxevision Audit – Staff Training, Matrons Oxevision Consent Audit and Oxevision – Policy and Governance Audit, which were undertaken on a fortnightly basis. Through discussions with Deputy Directors of Quality and Safety, it was agreed that these could be completed by Matrons, Professional Nurse Educators and Clinical Site Managers, although the name of the audit did not change.
212. In relation to external audit, an external Assurance Review of Consent for Oxevision was completed, with a revised draft shared in December 2025. A further follow up audit was planned for February 2026.
213. There was recognised limitations in the reliability of audit findings. Variability in how audits were completed, alongside inconsistent documentation, led to concerns that audit scores were higher than expected in some areas and may not have fully reflected practice.
214. The external assurance review led to a renewed organisational focus on improving consent processes for Oxevision. As a result fortnightly Oxevision audit review meets were established to provide oversight, monitor progress and provide assurance to the Executive Team. It was expected that all areas would be represented, although this was not always consistently achieved.
215. Further actions included revision of the audit tools themselves. Following feedback from Matrons, audits were amended to include a set of questions requiring patient feedback on the use of Oxevision as part of their care. This represented a shift away from reliance solely on documentation review.

216. Body Worn Cameras were expected to be worn by staff during each shift and activated during incidents, but this did not always occur. Footage captured could be used to support internal Trust investigations as well as investigations undertaken by external agencies, including the Police. CCTV systems operated continuously within communal ward areas at Basildon Mental Health Unit, with live footage displayed on screens in nursing offices. CCTV footage was also used retrospectively for internal and external investigative purposes. The footage was available for staff to request for 28 days.
217. I raised several concerns regarding the implementation and use of Oxevision. At the point of implementation, I raised concerns about the lack of on-site technical support during a meeting and followed this up by email to [I/S] [I/S], Service Manager copying [I/S], Associate Director and [I/S] Personal Assistant to [I/S] subsequently contacted [I/S] from the Digital Projects Team regarding on-site support arrangements.
218. [I/S] responded to [I/S] and advised that Microsoft Teams training could be arranged. However, he advised that a more inclusive approach would be for all staff to complete the Oxevision and Oxevision Observations course on OxeAcademy. [I/S] said that completion would provide a certificate demonstrating staff had received training. [I/S] later emailed me that all staff should complete the training and attain the certificate.
219. Whilst this action supported staff training, it did not directly address the concern raised regarding the availability of on-site technical support when support was requested.
220. I also raised concerns about staff turning down alert volumes in nursing offices, which risked alerts being missed. This was addressed through discussion with staff and the placement of signage on nursing office screens emphasising that adjusting volume was a patient safety risk.
221. Further concerns related to privacy and dignity, particularly the potential for patients to be observed in states of undress and the absence of safeguards preventing staff from photographing screens. These were concerns I personally raised through discussion with senior staff and line manager. In

response, staff were reminded of their responsibilities in relation to the appropriate use of Oxevision.

222. I was also concerned that staff might rely on Oxevision rather than completing in-person observations, particularly at night, due to references within the SOP about reducing disturbance. Staff were repeatedly reminded that Therapeutic Engagement and Supportive Observations were required to be completed in person and should not be replaced by technological monitoring alone.
223. However, the nature of the system and ward environment meant that some risks, particularly around potential observation during private moments, could not be entirely eliminated.
224. Additional concerns were raised regarding the time required to complete electronic observations and the impact this had on meaningful engagement with patients. I raised issues with [I/S] from the Digital Projects Team about alert configuration, reporting formats, and Registered Nurse oversight. These included Oxevision alerting when observations were not being completed in line with policy, reports displaying multiple days instead of 24-hour periods, observations working backwards from midnight rather than mirroring paper-based processes, confusion arising from combined Level 1 and enhanced observations within reports, and the removal of a clear Registered Nurse sign-off that had existed on paper documentation.
225. [I/S] responded to my concerns, advising that my suggestions regarding Oxevision alerting when observations were not being completed in line with policy would require development enhancements outside of the project scope, but could be presented to the Project Board for consideration.
226. [I/S] confirmed that my suggestion regarding the reintroduction of a Registered Nurse sign-off had been presented to the Project Board Clinical Subgroup, comprised of [I/S], Director of Safety and a Patient Safety Specialist and [I/S] and [I/S], Deputy Directors of Quality and Safety. [I/S] advised that this could be progressed further through these individuals at the Project Board.
227. In response to my concern about combined Level 1 and enhanced observations within reports, [I/S] advised that the report was chronological

and did not include a filtering function. He stated that any enhancements to reporting functionality would need to be addressed at a clinical level and presented to the Project Board.

228. Following [I/S]'s responses, I emailed [I/S] and [I/S], who were members of the clinical group managing the Standard Operating Procedure for Oxevision, requesting that the suggestions I had made be considered. [I/S] responded, asking [I/S] and [I/S] to take these points forward if they were attending the next meeting. I did not receive any further updates. To my knowledge, these suggestions were not implemented.

229. A subsequent meeting took place at The Lodge, which I understood to be linked to Oxevision product development where others and I raised concerns about Oxevision.

230. The introduction of technology, particularly Oxevision and electronic observations, had a significant impact on ward practice. While alerts could be helpful, the time required to complete electronic recording often resulted in less comprehensive documentation. I am also aware of concerns regarding alert fatigue and of incidents within the Trust where patients experienced serious harm despite Oxevision being in place. In my view, the use of this technology negatively impacted inpatient mental health care. Some patients described increased paranoia because of the system, while others with histories of abuse reported feeling retraumatised. Concerns were also raised about privacy and dignity, particularly where patients were unaware when monitoring was active and could potentially be observed while undressed. Patients further reported that staff appeared less present due to time spent using tablets, reducing opportunities for therapeutic engagement.

231. One outcome of the introduction of Oxevision was a review of patient rights and consent processes. However, in my view, inpatient mental health care should remain focused primarily on people rather than technology. While technological systems may offer some safety benefits, they should not replace consistent staffing, therapeutic engagement, and in-person observation. Despite the presence of policies intended to protect patient privacy, I had ongoing concerns that dignity and privacy were not always adequately

maintained in practice, particularly in relation to patient awareness, consent, and observation via technological systems.

232. Staffing arrangements

233. Staffing arrangements on inpatient wards were managed through a formal rostering process, supported by a Trust rostering policy. Shifts were assigned by the Ward Manager, who provided first level approval, and were then reviewed and approved by the Matron. Duties on each shift were allocated by the member of staff completing the shift allocation, usually the Nurse in Charge.

234. Several factors influenced how duties and shifts were assigned, including the required skills mix, flexible working arrangements, and existing vacancies. Consideration was given to ensuring an appropriate balance of staff skills and experience; however, staffing pressures frequently affected the ability to achieve this consistently.

235. Grade mix and staff status were considered to some extent. Permanent staff were generally prioritised for day shifts, while agency staff were more commonly used to cover night shifts and weekends. This approach was adopted to ensure permanent staff availability for core daytime functions such as MDT meetings, ward rounds, and care planning activity.

236. Permanent, temporary, and agency Registered Nurses did not carry out the same roles and duties. Only regular, blocked booked temporary and agency Registered Nurses acted as Named Nurse for patients' alongside permanent staff. Temporary, and agency Registered Nurses unfamiliar to the ward were often limited to administering medication. Temporary and agency unqualified staff were also expected to undertake the same duties as permanent unqualified staff. Where staffing levels allowed, shift allocations were adjusted so that temporary or agency unqualified staff who were unfamiliar with the ward or lacked an established therapeutic relationship were not allocated to care for the most acutely unwell patients.

237. There was a noticeable difference in the level and quality of care when there was a higher reliance on temporary or agency staff, particularly when staff

were unfamiliar with the ward or patient group. This impact was reduced when bank or agency staff were block booked, as continuity allowed them to build therapeutic relationships and better understand ward routines. Late bookings of unfamiliar agency staff posed a risk to patient safety due to a lack of ward knowledge and reduced continuity.

238. Concerns raised by patients or staff about agency staff were managed through established Trust processes. This included completion of a Concern and Incident Form for temporary staff, Datix Incident Reporting, and escalation to the relevant agency for investigation. During investigation and where concerns were substantiated, staff could be precluded from working in the Trust. On occasion, I had specific concerns about agency staff performance, including incidents of staff sleeping while on duty.

239. Agency staff were more frequently assigned to night shifts and weekends. While this ensured permanent staff availability during weekdays, extensive use of unfamiliar agency staff during nights and weekends negatively affected the delivery of safe and therapeutic care. During these periods, Site Officers, who were Band 6 nurses, provided oversight of ward safety. Permanent staff would often cover unfilled shifts as additional bank shifts to mitigate risk.

240. Wards were frequently not sufficiently staffed, and it was common to work with low numbers, sometimes with only one registered nurse on shift. Staffing levels at that time were lower than current levels prior to the introduction of the Time to Care staffing model. At one point, caps were applied to the use of temporary and agency staff. I raised concerns about this by submitting Datix Incident Reports, as shifts were not being approved in a timely manner, resulting in wards being understaffed.

241. I am unsure how the agency caps were determined, as wards had established staffing establishments and staffing requirements fluctuated based on ward acuity, including the number of patients requiring enhanced Therapeutic Engagement and Supportive Observations. The caps were generally adhered to. Compliance with caps and staffing levels was monitored through daily telephone bed calls, during which wards reported expected versus actual staffing numbers on duty.

242. A different staffing model was applied overnight and out of hours. Wards typically operated with fewer staff at night, usually with one less Support Worker compared to day shifts. This was based on the belief that patient acuity reduced at night, although this was not always reflective of actual risk or need.
243. The numbers and types of staff assigned to shifts were not always sufficient or appropriate, particularly when agency requests were not approved. Consideration was given to the proportion of temporary or agency staff on shift, as this formed part of the staffing breakdown reported during daily bed calls. The balance of qualified and unqualified staff was also reported within these calls.
244. Individual patient vulnerabilities and needs were considered when allocating staff, particularly in relation to skills mix and risk. Adjustments were made where possible, including restricting bookings to male or female staff or reallocating staff across the ward to meet specific patient needs, including the requirement for single-sex care.
245. Nursing staff were able to apply for flexible working arrangements, and some staff held contracts that were day only or night only. I am not aware of Consultant Psychiatrists or ward doctors being required to work back-to-back night and day shifts, and I did not observe this impacting on the delivery of care.
246. Staff turnover on mental health inpatient wards was high among registered nursing staff. Many nurses joined as Preceptorship Nurses and subsequently left to pursue Band 6 opportunities elsewhere. Turnover among Support Workers was comparatively low. Consultant Psychiatrist vacancies did exist, with a mixture of substantive and Locum Consultants Psychiatrists across wards including Grangewaters, Thorpe Ward, Hadleigh Unit, and the Assessment Unit. I am aware of patients raising concerns about the Locum Consultant on Cherrydown Ward.
247. Absences and staffing shortfalls were not managed as robustly through Human Resources processes as they are currently. Vacancies were advertised as they arose. Low staffing was routinely reported through local

situation report bed calls and a Red-Amber-Green (RAG) rating applied, but Datix Incident Reports were not consistently completed due to time pressures on clinical teams. Low staffing levels impacted on patient care by limiting staff availability to meet patients' therapeutic needs beyond basic containment and risk management.

248. Training

249. Overall, I do not consider that the training I received during my time at the Trust was consistently appropriate or adequate. New systems and initiatives were at times introduced without a structured and comprehensive training rollout. One example was the implementation of Oxevision, which, in my view, was introduced without sufficient planned training. I believe this lack of structured preparation contributed to ongoing issues in how the system was understood and used in practice.
250. At the point of implementation, training for Oxevision was not coordinated. I do not personally recall any in-person Oxevision training being delivered. There was no centralised register of staff who had completed training prior to implementation, and staff were not required to complete training before using the system. In contrast, other system implantations such as the Electronic Prescribing and Medicines Administration (ePMA) system, there were no "floor walkers" available to provide real time support to staff during the rollout.
251. Staff are now required to complete mandatory online Oxevision training annually. However, this was not delivered as part of a structured and comprehensive training programme at the point of implementation.
252. I consider the training to have been inadequate because it lacked coordination, was not mandatory prior to system use, did not include face-to-face instruction and did not provide sufficient on the ground support during implementation or when needs arose. This approach differed significantly from other system rollouts, such as ePMA, where structured training, mandatory attendance and in person support were in place, which better supported staff understanding and safe use of the system.

253. When I first joined the Trust as a Staff Nurse, the training provided focused primarily on mandatory training requirements. I do not believe that this training adequately set out expectations of the role in practice. Much of the role specific learning occurred at ward level rather than through a consistent Trust wide approach, which resulted in variation in standards and practice across different wards and services.
254. I do not believe that training for newly appointed nurses, including preceptorship nurses, was consistently adequate. The Preceptorship Programme is delivered via Microsoft Teams (MST), with Preceptorship Nurses completing these sessions online in large cohorts. Whilst this ensured that training was recorded as completed, it did not necessarily reflect meaningful engagement or understanding. In my experience, some staff completed these modules as a compliance exercise, with limited opportunity to ask questions, develop clinical judgement, or relate the content to practice within the ward environment.
255. This approach contributed to variability in practice, as newly qualified nurses require interactive learning, supervision and opportunities to apply knowledge in clinical settings in order to develop competence and confidence.
256. In response to these concerns, I have requested that the Professional Nurse Educator develop a site-based Preceptorship programme. This was intended to strengthen training by introducing face-to-face sessions, enabling interactive learning, discussion of real clinical scenarios, and clarification of expectations around practice standards. The aim is to improve engagement, support newly appointed nurses more effectively, and reduce variability in practice.
257. As a new starter, I was supernumerary for a two-week period. Mandatory classroom-based training was protected and rostered, and online mandatory training was generally completed during working hours with the Nurse in Charge informed. While protected time was available in principle, competing clinical demands could still limit opportunities to complete training in practice.
258. When I commenced my Deputy Ward Manager role, I did not receive what I would consider to be adequate training. For example, I was not provided with Datix training as part of my role transition and only received this later while

working a bank shift at Basildon Mental Health Unit, when [I/S], the Matron at the time showed me how to complete incident reports. As a result, I operated in a senior role without full knowledge of key governance systems.

259. When I progressed to Ward Manager and Matron, the training I received was largely informal and delivered on the job. During this time, I completed a Postgraduate Certificate in Reducing Restrictive Practice, which was beneficial. However, this training was not part of a structured Trust-led development programme for senior staff. The Management Development Programme was not mandatory, and in my view, this should be considered for new starters in leadership roles. While I appreciate the purpose of the Resilience Intelligence Strength and Excellence (RISE) programme in ensuring equitable representation of Black, Asian and minority ethnic (BAME) staff in senior positions in the NHS, my experience at Basildon Mental Health Unit is that the majority of staff in senior positions were BAME staff and I believe consideration should be given to how this valuable training could be made more widely available so that all staff could benefit in equipping staff with the core skills to develop in their current roles and supporting staff to develop emotional intelligence.

260. Training updates and refresher sessions were determined by the Trust. Training was generally accessible in terms of timing and location, and I did not experience significant barriers in accessing scheduled training. I did not have to arrange or fund my own training during my employment with the Trust.

261. However, I believe there were areas where further training would have been beneficial, particularly structured training on core nursing standards such as risk assessment, care planning, and the Named Nurse role, as well as training linked to the implementation of new digital and clinical systems. While the Trust has demonstrated that it can deliver high quality and meaningful training programmes, such as Safewards, delivery of core nursing standards training was less consistent. The absence of structured, role-specific training in these areas contributed to variation in practice and reliance on local ward-based approaches rather than consistent Trust wide standards.

262. The Safewards model is an evidence based framework used mainly in mental health inpatient settings to reduce conflict and containment and improve the safety and therapeutic environment for both patients and staff.
263. Safewards has been delivered as part of a broader programme of quality improvement and ward-based practice development, rather than solely as a standalone mandatory training course. Staff have been supported to implement Safewards through a combination of training sessions, ward-based discussions, and practical implementation of the Safewards interventions, such as "Soft Words", which promotes the use of respectful communication to support positive engagement and avoid confrontation. This approach enables staff to apply learning directly within clinical practice and contributes to its effectiveness as a high-quality training programme.
264. **Support**
265. Based on my experience, the provision and delivery of emotional support and counselling for staff improved over time. This improvement largely aligned with the development and strengthening of psychology provision on inpatient wards.
266. More recently, the emotional support available to staff was appropriate and generally well received. Site based psychology teams at Basildon Mental Health Unit provide both group and individual support, which staff could access following incidents or during periods of increased work-related stress. In addition, the leadership team would refer staff to the Trust's *Here for You* service to provide further emotional and psychological support. This offer of support improved significantly over the past five years. I am unsure what specific emotional, or counselling support was available prior to the introduction of the *Here for You* service.
267. The availability of emotional support and counselling was appropriate because it enabled staff to access support following patient related incidents, including safety incidents, and following events that affected staff wellbeing. This support recognised the emotional demands of inpatient mental health work and provided staff with opportunities to process experiences that might otherwise have adversely affected their wellbeing or ability to work safely.

268. However, in my experience, the Trust did not consistently recognise or respond to the potentially traumatic nature of mental health inpatient work. At times, it appeared that both staff and the organisation had become desensitised to traumatic incidents, which reduced the emphasis placed on the emotional impact on staff and the importance of recovery.

269. Permanent staff were entitled to paid sick leave following involvement in patient assaults or other serious incidents. Bank staff were entitled to payment for pre-booked shifts following such incidents, although this required management authorisation.

270. I believe that staff were generally supported when raising concerns or complaints. While I am unable to provide specific examples, my experience was that staff who spoke up or raised concerns were treated supportively and that issues were addressed through established Trust processes.

271. Management and Leadership

272. In my experience, management and leadership support for staff was variable and frequently constrained by sustained operational pressures. Those in managerial and leadership roles were responsible for ensuring that policies and procedures relating to safe and therapeutic mental health care were understood and implemented. However, ongoing workload pressures, constant demands, and staffing challenges meant that policies and procedures were not always consistently understood or embedded in practice. Maintaining effective oversight at ward level was particularly difficult during prolonged periods of pressure.

273. Senior managers and leaders were not always visible on wards. Executive team visits did not occur regularly, and there was often a perceived disconnect between senior management and staff working in inpatient ward environments. This limited visibility sometimes contributed to staff feeling that senior leaders were removed from the day-to-day realities and challenges of inpatient care.

274. I felt able to approach my line manager and other managers within the Trust to raise concerns. However, I believe the extent to which those concerns could

be addressed was sometimes limited by competing operational priorities, workload pressures, and service capacity constraints.

275. Staff supervision was primarily provided through one-to-one meetings. In practice, these were not always formalised or delivered regularly, largely due to staffing shortages and high levels of clinical demand. As a result, staff did not consistently receive appropriate clinical supervision focused on reviewing patient care and clinical decision making. The primary barrier to effective supervision was the limited availability of protected time. Over time, there has been improvement in monitoring and oversight of meaningful staff supervision.
276. Although reporting lines were formally structured, there was, on some wards, a strong hierarchical culture. This occasionally resulted in Ward Managers being reluctant for staff to share concerns or information with others without approaching them first. In my view, this sometimes acted as a barrier to open communication and effective escalation and led to closed cultures.
277. Performance management processes were in place but were limited by the visibility and accessibility of Human Resources support. At the time, Human Resources Advisors were not as visible as they are currently, and consistent access was not always available to managers and staff.
278. Management and leadership sought to ensure that complaints and safety incidents were documented, reviewed, and investigated through formal complaints allocation processes, review of Datix Incident Reports, and patient safety processes. While these systems existed, their effectiveness was dependent on leadership capacity and the consistency with which they were applied.
279. In general, staff had sufficient understanding of how to report complaints and safety incidents, and access to reporting systems was not a significant barrier. However, time pressures and workload demand affected the consistency with which reporting was completed.
280. In my view, management and leadership were not always appropriate or adequate. When I was a Deputy Ward Manager, Grangewaters Ward functioned for an extended period without a Ward Manager, which adversely

affected leadership presence and oversight. When I was a Matron, the Hadleigh Unit experienced prolonged Ward Manager absence, coinciding with an increase in safety concerns. There was also a period during which as Matron, responsibilities were distributed across all wards at Basildon, which was not sufficient to meet the operational and safety needs of the services.

281. I observed clear differences between how management and leadership operated for patient facing staff working on inpatient wards and for those in strategic or senior leadership roles without regular patient contact. Leaders without routine ward presence were often less connected to the practical realities of inpatient care. This sometimes resulted in decisions or expectations that did not fully reflect ward level pressures, staffing challenges, or patient acuity. In my experience, this disconnect contributed to situations where policy expectations were not realistically achievable in practice, creating both operational difficulties and challenges to staff morale, something which is still occurring in practice.

282. Culture

283. In my experience, ward culture across the wards, units, and teams where I worked was variable and not consistently positive. There were periods during which wards operated with supportive, patient focused cultures; however, there were also times when ward cultures were negative. This variability was reflected in recurring patient complaints and feedback across wards. Importantly, the same ward could alternate between positive and negative cultures depending on factors such as staffing stability, leadership presence, team dynamics, and individual staff circumstances, including personal pressures affecting staff at the time.

284. Ward culture was not always conducive to the delivery of good quality inpatient care and treatment. Although many staff were committed to providing compassionate care, systemic pressures, including staffing shortages, high patient acuity, and inconsistent leadership often undermined this. As a result, care delivery at times became task focused and centred on containment and risk management rather than therapeutic engagement.

285. Learning and collaborative working were not consistently encouraged. Prior to staffing pressures being partially addressed through international nurse recruitment and changes to staffing establishments, ward teams were primarily focused on maintaining immediate patient safety. This left limited capacity for reflection, shared learning, or collaborative development of practice, reducing opportunities for innovation and service improvement.
286. Staff were generally aware of how to raise concerns, including the availability of anonymous reporting routes. However, awareness did not always translate into confidence that raising concerns would result in meaningful change. I believe that the ability to speak up comfortably varied depending on local leadership, team culture, and prior experiences of doing so. Poor behaviours towards colleagues and patients were evident at times and were not always aligned with the Trust's policies and values. Poor communication, strained working relationships, and inconsistent standards of interaction negatively affected staff morale and patient experience.
287. I am aware that concerns about bullying, harassment, and intimidation were raised by staff and managed with Human Resources involvement. At ward level, this typically involved the Ward Manager addressing concerns through informal processes supported by Human Resources in the first instance, including one-to-one discussions with the staff members involved to understand the concerns and attempt early resolution. Where concerns were more significant, or could not be resolved informally, they were escalated and managed in line with Trust policies, including formal processes supported by Human Resources.
288. At ward level, actions included reinforcing expected standards of professional behaviour, reminding staff of the Trust's values and encouraging staff to raise concerns through appropriate channels. In some cases, this was supported through supervision, team discussions or reflective practice.
289. I am not aware of how these issues were addressed beyond ward level management or higher managerial review. This lack of visibility contributed to uncertainty about accountability and organisational learning. In my experience, there were occasions where those in leadership and managerial roles did not

always demonstrate positive role modelling behaviours, which had the potential to impact on culture if not addressed.

290. Long standing practices significantly influenced the care and treatment delivered to patients. Restrictive practices were a notable feature across wards and had a detrimental effect on patient care. For example, on the Assessment Unit, informal patients did not routinely have leave in accordance with their legal rights and were often required to surrender items such as shoelaces on admission. These practices appeared to be driven by custom rather than by individualised risk assessment. Historically, higher levels of physical restraint and seclusion were common across wards, which contributed to patient re-traumatisation and damaged therapeutic relationships, while also increasing the risk of staff injury and burnout.
291. I am also aware of a Consultant Psychiatrist working on a female ward within the Trust who placed all patients diagnosed with Emotionally Unstable Personality Disorder on Level 3 Therapeutic Engagement and Supportive Observations. I believe this practice was harmful, as such diagnoses do not automatically indicate a need for constant observation. For some patients, this level of monitoring was intrusive, distressing, and counter therapeutic. Despite this, the practice continued, seemingly because it had become embedded as accepted practice.
292. Long held beliefs and assumptions among staff also shaped practice. I was aware of a belief held by some staff that a patient death could have a negative impact on their career. In my view, this has improved over time with the Trust's increased emphasis on Just Culture principles.
293. A Just Culture is an approach used within the NHS to ensure that staff are treated fairly, transparently and compassionately when things go wrong. It moves away from a "blame culture" focused on individuals and instead promotes learning from incidents by considering wider systemic factors and improving systems and processes to make it easier for staff to work safely. It also supports a culture where staff feel confident they will be treated fairly when something goes wrong, while maintaining appropriate accountability for behaviour.

294. I do not believe that stereotyping or stigma, including around addiction, directly affected patient care. Instead, disjointed systems, limited resources, and gaps in service provision had a greater impact on patient outcomes. I am not aware of patients' protected characteristics influencing how they were treated, nor of structural racism or discrimination being a feature of the wards or services where I worked.

295. Compassion fatigue was evident across multiple wards, reflected in Staff Satisfaction Survey findings. This affected staff wellbeing, emotional resilience, and the ability to consistently provide compassionate care. Measures to address compassion fatigue included psychology led group sessions, individual psychological support including referrals to the *Here for You* service, team debriefs, and one-to-one managerial support. Desensitisation to risk was also a concern, as repeated exposure to high-risk situations reduced sensitivity to potential harm and increased risks to patients and staff. Similar support measures were used to address this, though their effectiveness depended on consistency and staff engagement.

296. I am not aware of therapeutic nihilism being a significant factor within the teams I worked in. While staff were under significant pressure, I did not observe a widespread belief that treatment was ineffective or of no benefit to patient groups.

297. There were clear cultural differences between wards within Basildon Mental Health Unit, including Thorpe Ward, Hadleigh Unit, and Cherrydown Ward. These differences were largely influenced by the vision and approach of the Ward Manager and Consultant Psychiatrist, as well as staffing stability and leadership presence. Overall, ward culture had a direct impact on the care and treatment provided to patients. Staffing levels, staff attitudes, leadership quality, access to training, engagement with patients, and approaches to managing behaviour all shaped the therapeutic environment. Where culture was positive, care was more compassionate and patient-centred. Where culture was poor, care became more restrictive, risk focused, and less therapeutic.

298. At the time, the Trust did not operate an overarching inpatient care model, meaning ward culture was strongly shaped by local leadership and vision

rather than consistent Trust wide approach, as has more recently implemented through the Therapeutic Acute Inpatient Operating Model for Adults and Older Adults. Inconsistent oversight, governance, and performance management further contributed to these variations.

299. The implementation of the Therapeutic Acute Inpatient Operating Model for Adults and Older Adults has had a positive impact on ward culture by introducing a more consistent, structured, and person-centred approach to care across inpatient services. Prior to its implementation, ward culture was largely influenced by individual leadership styles and local practices, which contributed to variation in standards and patient experience.
300. The Operating Model has helped reduce this variation by setting out clear expectations for practice, including a focus on purposeful admission, therapeutic benefit, safe and effective discharge and transfer planning and trauma-informed care.
301. There has also been an increased emphasis on delivering therapeutic care, with a stronger focus on patient engagement, meaningful activity and recovery focused interventions. In practice, this has encouraged staff to spend more time engaging with patients in a therapeutic way, which can have a positive impact on patient experience and ward atmosphere.
302. In addition, the inclusion of trauma-informed care principles within the Operating Model has influenced ward culture. From my perspective, this has encouraged more compassionate, person-centred approaches and improved staff awareness of how patients' past experience may influence behaviour and presentation.
303. The Operating Model has strengthened MDT working and promoted shared responsibility for care delivery, supporting the development of more cohesive teams and consistent decision making.
304. Overall, the introduction of the Operating Model has supported a shift towards a more structured, therapeutic and consistent ward culture. The extent of this impact has depended on the level of engagement, leadership and consistency of implementation at ward level.

305. Quality of investigations

306. In my experience, the quality of investigations undertaken by the Trust was variable and largely dependent on the experience, skills, and capacity of the individual investigator. During the period within the scope of this inquiry, I do not consider that the Patient Safety Team was operating as effectively as it does currently, and it is my belief that oversight of investigations was not as robust as it should have been.
307. I was directly involved in several investigations. These included completing the Clinical Review into the death of Georgia Dehaney-Perkins, who died on 6th September 2022 following discharge from Cherrydown Ward. Prior to this I had undertaken a Root Cause Analysis investigation in 2018 following a serious incident involving a patient receiving community care, which resulted in serious harm and admission to the Royal London Hospital. Investigations were generally conducted in line with Trust guidance and recognised investigation methodologies. However, they were not always initiated promptly. In the case of Georgia Dehaney-Perkins, there was a delay in commencing the investigation due to internal pressures within EPUT, which meant that an investigator was not identified within an appropriate timeframe. I also contributed to delays due to my capacity to undertake the investigation due to other competing demands.
308. The Terms of Reference for the investigation into Georgia Dehaney-Perkins' death were determined by Hertfordshire Partnership University NHS Foundation Trust (HPFT), with EPUT participating as part of a joint investigation process. This was undertaken in accordance with HPFT's Incident and Serious Incidents Requiring Investigation Reporting Policy (2022), using Root Cause Analysis and Human Factors methodology. The intention of this approach was to establish factual findings and identify learning while minimising hindsight and outcome bias. I completed the investigation on behalf of EPUT as part of this joint process.
309. In my experience, the use of internal investigators affected the pace of investigations. Clinical pressures and the absence of protected time for investigative work significantly limited the capacity available to complete investigations promptly and often delayed progress. I am not aware of how

decisions were made in relation to when an external investigator was appointed.

310. Prior to undertaking my first investigation, I completed Trust delivered training on conducting investigations using Root Cause Analysis methodology. However, I am unclear how the Trust assured itself that investigators more broadly had the appropriate qualifications, training, or experience to carry out complex investigations consistently.
311. For the investigations that I completed, I did not receive formal feedback, and no concerns were raised with me regarding the omission of key individuals. However, there were investigations where I would reasonably have expected to be interviewed and was not. I would have expected to be spoken to as part of the investigations into the deaths of Bethany Lilley and Jason Standing, given my roles at the time, but this did not occur.
312. On 15th May 2024, I received an email entitled "E201738 – Co Authored PSII V0.1" from [I/S] Family Liaison Lead, which shared the first draft of the Patient Safety Incident Investigation (PSII) report into Jason Standing's death. I was advised that this had become a co-authored PSII rather than two separate investigation reports. Dr [I/S] Consultant Psychiatrist for the Christopher Unit and Deputy Medical Director for Mental Health Inpatients and Urgent Care replied to [I/S] email and raised concerns relating to factual accuracy. I also responded to the email and expressed that I had previously raised concerns regarding the original investigation, particularly the lack of comprehensive staff involvement. In my view, this resulted in an incomplete understanding of Jason Standing's care and treatment on Hadleigh Unit between 25th December 2021 and 5th January 2022. I believe that this lack of understanding adversely affected the findings and conclusions of the investigation and limited the opportunity for meaningful learning and the development of effective safety recommendations.
313. I raised that I was not interviewed by the original investigator at any point during the investigation into Jason Standing's death, despite being the Matron covering the Hadleigh Unit at the time and attending the ward on the morning of the incident after being notified at home of Jason Standing's death by the Site Officer on duty. I shared that I had secured and sent copies of relevant

records on more than one occasion, yet these documents were later referenced in the investigation report as not being available. Oxevision footage was not given appropriate consideration, despite my requesting it on the morning of the incident and observing the footage being viewed once it was received in 2022.

314. When the addendum to the report was produced, I questioned whether the Trust had considered a wider review of the investigation considering the concerns raised. I also queried whether interview records had been reviewed in full to determine whether a more comprehensive re-investigation was required. I expressed that it remained unclear to me as to why other key individuals were not consulted before further iterations of the report were produced.

315. In my view, the failure to involve the appropriate individuals had a significant detrimental impact on the investigation. It compromised the accuracy of the findings and limited the quality of learning and recommendations at the initial stage. I consider this to represent a material risk to meaningful patient safety improvement.

316. I believe that cultural and leadership factors within EPUT adversely affected the quality of investigations during this period. Having not been consulted during the investigations into the deaths of Bethany Lilley and Jason Standing, I perceived a lack of effective leadership within the Patient Safety Team. I personally felt that there was an attempt to downplay or avoid fully addressing aspects of what had occurred in respect of the death of Jason Standing. I felt that it was only following my engagement with the legal team that Oxevision footage was reviewed and that wider concerns relating to Jason Standing's death appeared to be taken seriously.

317. When undertaking investigations myself, I felt safe identifying learning and making critical findings based on the evidence available. I did not feel inhibited from highlighting areas for improvement and was supported in presenting learning identified through my reviews.

318. Quality of responses

319. In my experience, the quality of the Trust's responses to investigations was not always satisfactory. This was particularly evident in relation to the investigation into the death of Jason Standing, which I have referred to previously. Where investigations were incomplete or failed to involve key individuals, this significantly undermined both the quality of the organisational response and the Trust's ability to learn effectively.
320. Investigative findings did not consistently result in meaningful outcomes, recommendations, or actions for change. Where key staff were not interviewed or consulted, findings lacked sufficient depth and factual accuracy, which in turn limited the relevance and effectiveness of recommendations. As a result, opportunities to address underlying issues and improve practice were frequently missed.
321. During the period within the scope of this inquiry, the sharing, implementation, and monitoring of recommendations arising from investigations were not undertaken as robustly as they are currently. There was limited visibility regarding how actions were tracked, whether they were completed, or whether changes were sustained over time. This lack of robust monitoring reduced assurance that learning had been effectively embedded into practice across the organisation.
322. The dissemination of investigative findings was inconsistent. While senior leaders and some ward management teams were informed, it was not always clear that findings were shared with all relevant staff, particularly those directly involved in the care under review. Where findings were shared, this was not always done in a timely, transparent, or appropriately supportive manner.
323. My experience of the Trust's response to the investigation into Jason Standing's death is that it was not reasonable, open, or fully compliant with the overarching duty of candour. This lack of openness undermined the integrity of the investigative process and reduced the Trust's ability to acknowledge failings, learn lessons, and implement appropriate action.
324. The absence of a transparent and candid response also limited the ability to take appropriate follow up actions, including consideration of disciplinary processes where indicated. For example, concerns were identified regarding

the completion of Therapeutic Engagement and Supportive Observations, which were not being undertaken in line with Trust policy. However, the lack of a robust investigative response constrained how fully these issues were addressed.

325. Some appropriate external actions were taken following Jason Standing's death, including notifying the Police, who interviewed staff on duty at the time. However, in my view, internal organisational responses did not consistently reflect the seriousness of the concerns identified.
326. Regarding whistleblowing protections, I am not aware of any specific cases during my time at the Trust where staff formally acted as whistleblowers. I am aware that the Trust has policies in place designed to support and protect staff who raise concerns. As I do not have direct experience of these policies being tested in practice, I am unable to comment on their effectiveness or on whether staff faced repercussions after raising concerns.
327. I am also unable to comment on referrals relating to fitness to practise matters or potential criminal concerns beyond what I have already described, or on actions taken in response to disciplinary or criminal findings.
328. Following the death of Bethany Lilley, learning was shared within the Trust. During the inquest, I was informed that the Coroner, Sean Horstead, identified issues with record keeping, including failures in recording patients' movements and times of leaving and returning to the ward from the servery. In response, Servery Leave Forms were introduced to support accurate recording of patient leave at mealtimes. Wards were instructed to amend the template for local use and implement the process immediately. This was the primary change to practice arising from the Bethany Lilley inquest, although these are no longer in use.
329. Learning following the Jason Standing inquest was shared at a Basildon Leadership Meeting. However, I am not aware of any specific training being organised as a direct response to the findings of investigations or inquests following the deaths of either Bethany Lilley or Jason Standing. As a result, I am unable to comment on attendance or effectiveness, as no such training was provided to my knowledge. Beyond the introduction of Servery Leave

Forms, I am not aware of further substantive changes to practice, policy, or procedure arising from either inquest, or of planned changes still to be implemented.

330. In relation to the Patient Safety Incident Response Framework Decision Monitoring Tool, my understanding is that its purpose is to identify early learning following a patient safety incident and ensure immediate actions are initiated. The tool provides a structured means of reviewing care in the period leading up to an incident, identifying key questions, and determining whether a Patient Safety Incident Investigation is required. In current practice, I receive prompt requests from the Patient Safety Team to complete Decision Monitoring Tools following patient safety incidents. This did not occur at the time of Jason Standing's death.

331. It is my belief that this was not a delay in the traditional sense, as I was not asked to complete or review a Decision Monitoring Tool until after the co-authored investigation report was shared on 15th May 2024 and concerns were raised by both Dr [I/S] Consultant Psychiatrist of the Christopher Unit and Deputy Medical Director and myself. On 20th May 2024, [I/S] Director of Safety and a Patient Safety Specialist requested completion of the Decision Monitoring Tool, with a return deadline of 23rd May 2024. I was informed that an original Decision Monitoring Tool had been completed by the Patient Safety Incident Management Team in May 2022 and that its content had been transferred into the document for my review to ensure factual accuracy and completeness.

332. I was asked to review the accuracy of the information, ensure that the list of staff included all those who should have been interviewed, assess the key questions informing the Terms of Reference, and review the Just Culture section for accuracy. Oversight of this process was provided by [I/S] Deputy Director of Quality and Safety. I submitted the completed Decision Monitoring Tool on 23rd May 2024 in line with the request.

333. In my view, the original completion of the Decision Monitoring Tool without my involvement, and the lack of earlier sharing with care unit leadership, adversely affected the timely identification of learning and implementation of recommendations. This limited the Trust's ability to respond proactively

following a serious incident and reduced the effectiveness of subsequent patient safety improvements.

334. Recommendations

335. Based on my experience of working within mental health inpatient services, I would make a few recommendations aimed at improving patient safety, governance, and the overall quality of care provided to inpatients.

336. My primary recommendation is that Essex Partnership University NHS Foundation Trust should be divided into more than one Trust. In my view, the current size and scope of EPUT makes it difficult to achieve effective oversight, governance, and leadership consistently. A smaller organisational structure would support clearer accountability, greater visibility of senior leadership, stronger clinical oversight, and more meaningful engagement with both staff and patients. I believe this would enable earlier identification of risks, more responsive handling of concerns, and more consistent standards of care across inpatient services.

337. In addition, I recommend an enforced reduction in ward sizes, with a maximum of twelve patients per ward. Smaller wards would support safer and more sustainable staffing models, enable stronger therapeutic relationships, and facilitate improved observation, engagement, and individualised care planning. Reduced ward sizes would also improve clinical oversight, reduce environmental stressors, and contribute to the development of calmer and more recovery focused ward cultures.

338. I would also recommend that surplus bedrooms created through reduced ward sizes be recommissioned as therapeutic spaces. These spaces could be used for one-to-one work, psychological interventions, de-escalation, family meetings, and group therapeutic activities. Increasing the availability of dedicated therapeutic spaces within inpatient wards would support recovery-oriented care and reduce reliance on restrictive practices.

339. Finally, I would recommend a fundamental review of the role and functioning of Assessment Units, with a view to closing them or significantly redesigning their purpose. In my experience, Assessment Units have not been operating in line

with their agreed operational policies. Rather than functioning as short term assessment environments, they have increasingly accommodated detained patients, removing individuals from their intended care pathways. These units have also operated as mixed sex environments, which raises concerns regarding safety, dignity, and privacy. These deviations from policy have increased ward acuity, reduced therapeutic focus, and contributed to unsafe and inappropriate care environments.

340. Taken together, these recommendations are intended to improve safety, governance, staff wellbeing, and patient experience within mental health inpatient services in Essex, and to promote environments that are genuinely therapeutic rather than primarily focused on containment and risk management.

341. Statement of Truth

342. I believe the content of this statement to be true

343. 

344. 28/05/2026