

Monday, 5 October 2026

(10.00 am)

(Proceedings delayed)

(10.04 am)

Opening remarks by THE CHAIR

THE CHAIR: Good morning, and welcome to this October

hearing, to all those who are following these proceedings virtually, and to everyone joining us here in person at the Civic Centre in Chelmsford.

I've directed that this hearing is to focus on two key matters on which I have already heard some evidence, and from which there may arise active issues of safety for current patients. Those are emergency response and resuscitation, and observations and the use of technology.

Those two matters are not specific to Essex and therefore the evidence the Inquiry hears this week and next will be of relevance to service providers across the entire country. It should be of interest to everyone who is involved in mental health care and treatment nationally. It may carry implications for the care and treatment provided on all mental health units.

This hearing, which begins today, will run for two weeks at the Civic Centre in Chelmsford until Thursday, 15 October. A further virtual hearing will take place

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year's theme highlights the importance of the experience of those who have been affected by mental health deaths, being heard and bringing about real change. That principle is central to this Inquiry and the experiences shared by bereaved families continue to inform our investigations.

In my opening statement on 6 July this year I explained that family evidence would be the starting point for the case summaries produced by my team. These case summaries set out in summary form what the Inquiry understands happened in each of our illustrative cases, and identify the issues emerging and family concerns where those are known.

I continue to make clear that those case summaries do not in any way replace the written and oral statements provided to this Inquiry by bereaved families. As I have said, every family account is read carefully and reviewed in its full form by me and my team. It's those accounts, in their entirety, that form the record of this Inquiry.

I continue to find the case summary documents extremely valuable, as they help me and my Inquiry team to identify the key issues raised in each case in a proportionate and focused way. To date my team have diligently worked to share those illustrative case

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on Tuesday, 20 October.

To the bereaved families and to all those affected by the issues which I'm investigating, I wish to reassure you again that you remain at the very heart of this Inquiry's work. The evidence you have given is central to our understanding of the key themes and issues under investigation.

Though the focus of this hearing is not on reviewing any further family evidence, I remain grateful for the moving accounts from family members and for their considerable efforts in engaging with the Inquiry to date. I especially want to take a moment to thank those families who, on 17 September 2026, met with members of my team at the Inquiry's Q&A event.

This was an event hosted specifically for bereaved family core participants here in this building. I'm very grateful to them for their time and courage in sharing deeply personal and difficult experiences.

I remain open to hearing your concerns and would like to reassure you that we will update our frequently-asked questions page on our website in response to the issues raised at the Q&A event, after this October hearing has concluded.

I also wish to acknowledge that World Mental Health Day falls during this hearing, on 10 October. This

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summaries with families, NHS Trusts, and other organisations involved in those cases for comment. We've carefully considered all responses, and I'm very grateful to all involved.

We will shortly hear an opening statement from Counsel to the Inquiry, Rebecca Harris KC, who will speak in further detail about the evidence we will hear.

In July this year, the Inquiry's focus moved to investigating thematic issues in respect of inpatient care. I reflected on the urgent concerns raised by some core participants and their legal representatives about the use of technology on inpatient wards and current practices around emergency response and resuscitation. And I directed my team to investigate those issues without further delay.

As matters currently stand, and after reviewing the evidence received and heard thus far, I share some of those concerns about patient safety in mental health wards. As such, I've directed that we will hear further evidence, including focused and detailed evidence from experts in respect of those distinct themes during this October hearing.

Since the July hearing, I have received a great deal of evidence from core participants, and from a number of other individuals on these themes, as well as from

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experts instructed to provide focused evidence on various aspects of the themes.

It's extremely important that the Inquiry receives material promptly and that, should anyone wish to provide evidence to the Inquiry which the Inquiry has not requested, they communicate with my team in advance. Unfortunately, this has not occurred in respect of this hearing, with the Inquiry receiving material very late in the day. I wish to make it clear to all those engaged with the Inquiry that they should use every effort to meet deadlines set by the Inquiry and that any evidence that they may provide voluntarily is discussed with my team in advance.

This week, the Inquiry will examine emergency response and resuscitation in inpatient mental health settings. We'll hear evidence about the policies, procedures, training and equipment in place. The evidence will also look at how staff respond to emergency situations on mental health wards and about their ability to manage deteriorating patients.

Throughout, I will ensure that my team explores whether and to what extent there's been learning from past incidents, including some of the illustrative cases.

On the practice of observation and the use of

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I've also recently met with the newly-appointed Chair of the Tees, Esk and Wear Valleys Inquiry, which will be investigating issues relating to mental health inpatient care in that part of the country.

As an independent public inquiry, it's crucial that I ensure that we gather a wide range of views and perspectives. It is equally important that I listen to all those that can shed light on what went wrong as well as what went well, and from those who can tell us what happens currently, in inpatient care.

For the Inquiry to hear and consider that evidence properly, every witness must be able to speak fully and without in interruption. I therefore ask everyone attending this hearing, whether in person or remotely, to help maintain a calm and respectful environment by listening quietly to the evidence throughout. I must make clear there are to be no in interruptions of any kind. All mobile phones in the hearing room must be switched off and no recording or filming devices of any kind may be used.

I thank everyone in advance for their cooperation with this.

Given the highly sensitive nature of the evidence we're dealing with, anyone who wishes to leave the room is of course permitted to do so. However, I must ask

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technology on inpatient mental health wards, this Inquiry has already received extremely informative evidence, some of which outlines the practicalities of using these systems and the risks involved.

Next week, we will build further on our understanding of the use of technology, including the role of Oxevision and its use in mental health inpatient units.

I've invited legal representatives for core participants to attend a virtual hearing on 20 October to make submissions to me on these areas. I will consider those submissions as well as all the evidence we're to hear over the course of the next two weeks with great care, with objectivity, and complete independence, and with an open mind.

At the July hearing, I made reference to several other investigations relevant to mental health inpatient care. I remain mindful of the need to learn what we can from other inquiries.

I was encouraged to hear, during the Nottingham Inquiry's closing statement, that they share that same sentiment. I noted that the Thirlwall Inquiry report into events at the Countess of Chester Hospital made recommendations aimed at strengthening patient safety and accountability across the NHS.

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that should you wish to leave, that you do not seek to re-enter until there's a break in the proceedings.

For Core Participant families and their representatives, the proceedings are streamed to the family room so you are able to watch there should it be more comfortable for you to do so. It's very important that I am able to hear this evidence without distraction, and that witnesses are provided with the best opportunity to respond to questions without disturbance within the room.

Much of the evidence we will hear during this hearing will touch on sensitive and difficult matters. Although we'll not be hearing directly from bereaved families, I recognise that hearing some of the evidence in great detail may be distressing, particularly to those with personal experience of the issues under investigation. I ask everyone to remain mindful of this and to treat all those involved with consideration, courtesy and respect.

The Inquiry places the wellbeing of those engaging with it at the centre of its work. I wish to remind everybody that emotional support services are available throughout the hearing and anyone who would like support should speak to a member of the Inquiry team who will help them to access that support.

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1 I'll now hand over to Counsel to the Inquiry,
2 Rebecca Harris KC. Before doing so, I wish to thank all
3 those who will be giving evidence at this hearing, and
4 all those who have given evidence at previous hearings.
5 I am very grateful for their participation, their time
6 and their candour.

7 Ms Harris.

8 **Opening statement by MS HARRIS KC**

9 **MS HARRIS:** Thank you, Chair.

10 Chair, this is the Inquiry's eighth public hearing.
11 We return for this hearing to the Civic Centre in
12 Chelmsford where we began this Inquiry's hearings in
13 September 2024.

14 It was here that you opened this Inquiry by inviting
15 bereaved families to give deeply moving commemorative
16 accounts about those who had died and about the impact
17 of those losses on their families' lives. Since that
18 time, the Inquiry has made considerable progress.

19 Three of our hearings have been dedicated to
20 evidence from bereaved families. You have received and
21 heard evidence about the challenges in providing and
22 monitoring safe and therapeutic inpatient mental health
23 care from a wide range of organisations. In July this
24 year you heard from a number of members of staff at EPUT
25 about their individual experiences.

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1 Hestia support staff are wearing orange-coloured
2 lanyards and scarves. Alternatively, please do speak to
3 a member of the Inquiry team and we can put you in touch
4 with Hestia. All members of the Inquiry team are
5 wearing purple-coloured lanyards.

6 If you are watching this hearing online you can find
7 information about the emotional support available on the
8 Lampard Inquiry website at lampardinquiry.org.uk, and
9 under the "support" tab which is at the top right-hand
10 corner of the screen and you can also contact the
11 Inquiry team's mailbox on contact@lampardinquiry.org.uk
12 for the information.

13 We want all of those engaging with this Inquiry to
14 feel safe and supported.

15 Chair, there will be a number of the Counsel to the
16 Inquiry team involved in this hearing over the next
17 two weeks. You'll be assisted by this week by Teniola
18 Onabanjo, Paul Wakerley, and Katie Sage, and next week
19 you will also be assisted by Nicholas Griffin King's
20 Counsel and Claudia Hyde.

21 Counsel to the Inquiry have engaged with their
22 respective witnesses, working to ensure that each is
23 given the opportunity to provide their best evidence.
24 This Inquiry is independent from all other organisations
25 and any individuals with an interest, however, and we

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1 Work outside of hearings to investigate the systemic
2 issues emerging has continued without break. Throughout
3 this time, all those families who have been bereaved
4 have remained, and will continue to remain, at the very
5 heart of the Inquiry's work and at your direction, your
6 team continues to work closely with the families who
7 feel able to engage with the Inquiry.

8 Chair, within this hearing, we will be hearing some
9 evidence which is traumatic in nature and contains
10 descriptions around ligaturing, self-harm, and death.
11 As you have already been clear, Chair, the wellbeing of
12 those engaging with the Inquiry is extremely important,
13 and for that reason, may I take this opportunity again
14 to reiterate that emotional support is available to all
15 of those who are participating in the Inquiry.

16 Anyone present in the hearing room is welcome to
17 leave at any time, although, as you have just requested
18 Chair, we ask that they wait until a break in the
19 proceedings to come back in so as not to interrupt focus
20 on the difficult, sensitive, and sometimes highly
21 technical evidence that the Inquiry is hearing.

22 Throughout the hearing we will have here two support
23 staff from Hestia, an experienced provider of emotional
24 support. There is a private room where you can talk to
25 Hestia support staff if you require that support. The

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1 continue to exercise great care to ensure that we retain
2 that independence.

3 Your Counsel to the Inquiry team works closely with
4 The Inquiry Solicitor Team under the lead of Solicitor
5 to the Inquiry, Catherine Turtle.

6 You are also assisted by the Secretariat Team led by
7 Helen Gibson whose members provide crucial operational,
8 administrative and logistical support to enable the
9 Inquiry to carry out its work.

10 Chair, you are also assisted by the recognised legal
11 representatives and counsel teams of the core
12 participants, and a list of those representatives is
13 available on the Inquiry's website.

14 As you have outlined, Chair, earlier this year,
15 having considered carefully the evidence from bereaved
16 families that the Inquiry has received and heard over
17 the course of our hearings thus far, you determined that
18 at this hearing, the Inquiry would focus on issues that
19 had emerged with regards to specific themes, and as
20 I outlined at the start of the Inquiry's hearing in
21 July, and you have just reiterated, those themes are:
22 emergency response and the resuscitation of
23 deteriorating patients on mental health inpatient units;
24 and observations and the use of technology.

25 You directed your team to investigate these two

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1 areas further and without delay, because as you have
2 said, you are concerned that the issues arising may hold
3 implications for the safety of current patients. These
4 issues may also be of national impact, reaching beyond
5 the boundaries of Essex. Chair, you determined that
6 these investigations could not wait and that subject to
7 the evidence you receive, you may wish to consider
8 making interim recommendations.

9 At your direction, Chair, your team has sought to
10 obtain evidence in relation to both of these topics and
11 to carry out its investigations at pace, working
12 nonetheless to the exacting standards of rigour,
13 impartiality and fairness.

14 That, Chair, is the balance that must be struck by
15 this Inquiry in all of its work, with every member of
16 your dedicated team recognising at all times that there
17 are real, live and active issues in relation to the
18 safety of patients at the base of its investigations,
19 but in parallel, that its work must remain, in every
20 aspect, unfailingly meticulous.

21 Chair, as you have outlined you have invited core
22 participants to make oral and/or written submissions on
23 these topics at the close of this hearing. In order to
24 allow core participants and their legal representatives
25 time to consider the evidence that we will hear over the

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1 Service Development at Resuscitation Council UK, also
2 known as RCUK for short. RCUK is a non-statutory,
3 charitable incorporated organisation which describes
4 itself as "dedicated to saving lives by developing
5 guidelines, influencing policy, delivering courses, and
6 supporting innovative research concerning resuscitation
7 practice."

8 Mr Benson Clarke described RCUK's core remit as
9 writing the national guidelines for resuscitation for
10 the UK. And he explained the role that RCUK plays in
11 setting standards for the provision of emergency
12 response and resuscitation across all healthcare
13 settings in the United Kingdom, what the purpose of
14 those standards were, and why RCUK recommended a certain
15 level of training for certain roles.

16 RCUK's Quality Standards Mental Health Inpatient
17 Care document, which was first published in 2014 and
18 updated in 2020, is due to be reviewed as part of RCUK's
19 work plan for 2026, although as yet, there is no
20 confirmed timetable for its publication, but one of the
21 key criteria of RCUK's Mental Health Inpatient Care
22 Quality Standards, as explained by Mr Benson-Clarke, is
23 that training must be to a level appropriate for the
24 staff member's expected clinical responsibilities rather
25 than related to any particular job title they may have.

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1 next two weeks, the oral closing submissions for those
2 wishing to make them will be heard virtually on
3 20 October 2026 with any written submissions to be
4 received by the Inquiry by 30 October 2026.

5 The Inquiry looks forward to reviewing those
6 submissions and will consider them with great care, with
7 an open mind, and with reference to all of the evidence
8 it has obtained. Any findings or interim
9 recommendations you may make will be objective and will
10 be firmly grounded in that evidence.

11 I turn now, then, to the two topics that you
12 identified earlier this year for urgent investigation,
13 and I will start with the provision of emergency
14 response and resuscitation.

15 Chair, the evidence you heard in the July hearing
16 touched on some of the substantial and specific
17 challenges potentially faced by staff on mental health
18 units when responding to emergencies. There are
19 specific considerations connected to emergencies in
20 mental health settings. And we also learned that the
21 window of opportunity to improve outcomes for
22 deteriorating patients in mental health settings is
23 a very short one.

24 On 20 July 2026, the Inquiry heard oral evidence
25 from Adam Benson Clarke, the Director of Clinical and

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1 And in his evidence, Mr Benson Clarke described
2 cardiac arrest as the ultimate medical emergency, where
3 seconds count while he explained that a swift and
4 effective response was of fundamental value, he told us
5 that the most important interventions are those that
6 prevent cardiac arrest altogether and that, he says,
7 gives a greater chance of survival for managing
8 individuals as they deteriorate.

9 Mr Benson Clarke described to the Inquiry the
10 difference between primary and secondary cardiac arrest
11 with primary cardiac arrest usually due to the heart,
12 a primary organ. In contrast, secondary cardiac arrest
13 usually occurs in response to a preceding clinical event
14 or trigger such as low oxygen levels, hypoxia, airway
15 obstruction, overdose, severe physical deterioration or
16 ligature-related asphyxia.

17 Chair, the Inquiry learned in July that a larger
18 proportion of cardiac arrests in mental health settings
19 are secondary cardiac arrests which occur in response to
20 a trigger.

21 With a ligature event, for example, cardiac arrest
22 occurs at the end of a process that includes loss of
23 consciousness and breathing stopping. Those cardiac
24 arrests usually have non-shockable cardiac arrest heart
25 rhythms where the defibrillator will not work, time is

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short, and survival rates tend to be poor.

The key interventions for this group of patients are therefore related to the prevention of the cardiac arrest in the first place.

Mr Benson Clarke was asked about ligature-related asphyxia events. He emphasised that the first actions would be focused on preventing the individual from going into cardiac arrest. Actions would therefore be focused on calling for assistance, removing the ligature, looking to start chest compressions and doing basic-level life support whilst waiting for others to come and help.

Chair, you listened carefully to that evidence as well as to the evidence of the staff members who touched on this topic during the July hearing, and following that hearing, you directed your Inquiry team to obtain additional evidence, including expert evidence about (a) the special circumstances and the types of situation on mental health units that give rise to emergencies, and (b) the clinical position and clinical indications when such emergencies arise.

In addition to obtaining expert evidence, the Inquiry has worked to obtain evidence exploring the reality of the day-to-day workings of mental health units, and the challenges when emergencies arise, which

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who will provide evidence about NHS England's quality standards and imminent changes to mandatory training.

On behalf of the CQC, Stuart Dunn, who will provide further contextual evidence about how the regulator inspects and scrutinises emergency response and resuscitation provision.

And Professor Jasmeet Soar, a consultant at Southmead Hospital, Bristol NHS Foundation Trust, and a national and international expert in cardiac arrest treatments, guidelines and outcomes.

Chair, when you started hearing the evidence about emergency response and resuscitation in July, the Inquiry had already received information from a number of comparator Trusts as to their policies and procedures. The Inquiry made further requests of two of those comparator Trusts and we shall hear later today from witnesses from one of them, ELFT. And as I've said, that is Ruth Bradley, the Director of Nursing at ELFT, and Rebecca Lingard, the Borough Lead Nurse.

The evidence from ELFT will include: how relevant policies and procedures are implemented in practice, ELFT's training and provision, and staff experience of responding to and/or overseeing emergency response incidents.

And the purpose of the evidence from ELFT,

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include the ability of staff to recognise emergency situations, clinical response and emergency decision making, availability and accessibility of vital equipment, and the adequacy of interventions and resuscitation practices and procedures, past and present.

Chair, you were keen to understand how a member of staff who may be a first responder, whatever their title and position, is currently, or should be, trained to recognise patient deterioration and to use the skills required to prevent cardiac arrest in the distressing and inevitably traumatising circumstances in which cardiac arrest occurs. And over the coming week the Inquiry will therefore hear oral evidence from the following witnesses: firstly, two representatives from a comparator Trust from whom the Inquiry has requested evidence: East London NHS Foundation Trust, also known as ELFT, Ruth Bradley and Rebecca Lingard.

Secondly, three representatives from EPUT: Nicholas Archer, Head of Deteriorating Patient Pathways and the EPUT Resuscitation Training Officer, Dr Kallur Suresh, Consultant Psychiatrist and Chief Medical Officer at EPUT; and Ann Sheridan, Registered General and Mental Health Nurse and Executive Nurse at EPUT.

From NHS England, Thomas Simons and Dr Dawn Adamson,

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therefore, is twofold: firstly, to explore how other, similar Mental Health Trusts approach the provision of emergency response and resuscitation; and secondly, to understand from Rebecca Lingard, a practitioner who has worked for many years in mental health services, the practical realities of dealing with an emergency situation arising on the ward.

And I should say, Chair, that during the course of her evidence, Rebecca Lingard will describe in detail the process of the emergency response that should occur on finding an unresponsive person, setting out the various stages involved in that response and she will also provide evidence about the practical realities of response and resuscitation in an emergency on a mental health ward.

This necessarily involves content that can be described as traumatic, including references to self-harm and death that could cause deep distress to those following the evidence. This Inquiry cannot shy away from calling difficult and distressing evidence where it's necessary to do so. I therefore take this opportunity, again, to reiterate that emotional support is available for those participating in the Inquiry, both via our website and here in the hearing room through speaking to Hestia or any member of the Inquiry

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1 team.

2 Before I move on, Chair, it's right to acknowledge
3 that the Inquiry is aware that ELFT as a Trust, has
4 itself faced significant challenges, some of which have
5 been the subject of recent press reports. This Inquiry
6 is not tasked with the scrutiny of that Trust. It may,
7 however, be yet further indication that the issues
8 emerging in the course of this Inquiry extend far wider
9 than Essex and that any recommendations you may make in
10 due course are likely to have national impact.

11 I move now, then, to EPUT. Prior to the July
12 hearing, the Inquiry requested evidence in relation to
13 resuscitation practices and procedures from all of our
14 core participant Trusts and healthcare providers. Those
15 requests for evidence were to assist you in
16 understanding whether the current and most recent
17 procedures in place are and were appropriate to ensure
18 that those working on mental health inpatient units are
19 properly prepared and/or equipped to react in emergency
20 situations.

21 The Inquiry received responses from EPUT,
22 St Andrew's Healthcare, the Priory Group, Cygnet Health
23 Care, and North East London NHS Foundation Trust and we
24 will hear oral evidence from EPUT representatives during
25 the course of this week. Evidence provided by the other

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1 have taken place previously as well as the current
2 arrangements for medical emergency simulations, safety
3 alerts, memorandums and implementation of learning, how
4 competency is managed on the ward, the previous working
5 arrangements with Basildon and Thurrock University
6 Hospital, and emergency instant response and learning,
7 and recurring concerns.

8 Notably, Chair, within her second witness statement,
9 Louise Borton states that in September 2022, she raised
10 specific concerns with Nicholas Archer, the Head of
11 Deteriorating Patient Pathways at EPUT, about staff
12 having issues locating specific equipment during
13 time-critical situations.

14 We will be hearing from Mr Archer tomorrow morning
15 and he will be asked questions about that and for that
16 reason, and before Mr Archer's evidence is heard, a more
17 detailed summary of Louise Borton's second witness
18 statement will be read out in this hearing.

19 Turning, then, to Mr Archer's evidence as Head of
20 Deteriorating Patient Pathways and as Resuscitation
21 Training Officer, Mr Archer leads at EPUT on the
22 development and implementation of strategies to ensure
23 the safe and appropriate management of the deteriorating
24 patient, and he oversees EPUT's resuscitation training
25 provision.

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1 core participant providers will be summarised for you,
2 Chair, and made available on our website, and we will
3 also address briefly the material the Inquiry has
4 obtained from Non-Core Participant Trusts in different
5 parts of England, and from other relevant organisations
6 such as the Out of Hospital Cardiac Arrest Outcomes,
7 OHCAO, registry and the East of England Ambulance
8 Service.

9 Chair, the Inquiry has also received further
10 evidence on this topic from staff witnesses whose
11 statements were disclosed to core participants in
12 advance of this hearing, and will be published on the
13 Inquiry website afterwards. Those staff witness
14 statements include Judith Skargon, who sets out her
15 involvement in drafting EPUT's resuscitation procedure
16 between 2018 and 2023, and deals with the Trust's
17 failure to adhere to NICE Guideline NG10, and further
18 statements from Chloe Cawston and Louise Borton who you
19 will recall both gave evidence to you in July.

20 In her second statement to the Inquiry, Louise
21 Borton, who has been a matron at EPUT since
22 February 2021, addresses a number of matters relevant to
23 emergency response and resuscitation.

24 These include training and preparedness for medical
25 emergencies, emergency and resuscitation drills that

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1 His evidence, reflecting the key areas he oversees,
2 will address: EPUT policy and practice, including
3 changes he has implemented; staff training, required
4 standards of training for staff on the ward, and changes
5 to training over the past few years; oversight
6 monitoring and audit in the areas where he is
7 responsible for that oversight, monitoring and audit;
8 simulations and drills, and whether or not those are
9 taking place as required; learning, including how the
10 Trust identifies areas for improvement, in what ways and
11 to what extent the Trust learns from previous incidents
12 as well as from good practice, and how such learning is
13 implemented.

14 On Wednesday, we will hear from Dr Suresh,
15 Consultant Psychiatrist and Chief Medical Officer at
16 EPUT, and Ann Sheridan, Registered General and Mental
17 Health Nurse and Executive Nurse at EPUT, and in broad
18 terms, their evidence will address: the Trust's review
19 processes for CPR policy; oversight of emergency
20 response and resuscitation provision at board level;
21 steps taken to address a recognised need for improvement
22 in the early identification of deteriorating patients
23 and appropriate escalation; emergency equipment and
24 drugs, including EPUT's particular requirements for
25 life-saving medications; staff training, including

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1 training budgets, orientation for locum, bank and agency
2 staff, simulations, CPR drills, and scenario training
3 and availability of immediate life support trained
4 staff.

5 Dr Suresh and Ms Sheridan will also be asked about
6 the responses they have provided in a joint witness
7 statement with regards to the Trust's learning or
8 ability to learn from previous incidents. The Inquiry
9 will ask the approach they have taken in addressing
10 those concerns. The Inquiry will scrutinise evidence
11 relating to the Trust's ability to identify, formulate
12 and disseminate important and relevant learning and to
13 implement appropriate changes.

14 Tomorrow afternoon the Inquiry intends to hear
15 evidence from Dr Dawn Adamson, NHS England's National
16 Speciality Advisor for Heart Disease who is the topic
17 lead for the resuscitation part of the statutory and
18 mandatory training reform within NHS England, and Thomas
19 Simons, the Chief Human Resource and Organisational
20 Development Officer for Workforce, Training and
21 Education at NHS England.

22 Mr Simon's evidence provides an explanation of the
23 current core skills training framework, the CSTF, which
24 is the principal national framework for statutory and
25 mandatory training across providers of NHS services in

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1 received material relevant to this hearing very late in
2 the day. This includes material from NHS England.
3 Chair, you have expressed your dissatisfaction at this
4 late disclosure, which, in your view, was wholly
5 avoidable. It has inconvenienced you and the Inquiry
6 team. It has further placed unnecessary pressure upon
7 the core participants, many of whom are bereaved
8 families. Having to review sensitive material at such
9 short notice and having to provide instructions to legal
10 representatives on the same, can cause significant
11 distress.

12 Chair, you have directed that NHS England be
13 required to provide you with an explanation as to this
14 late disclosure and assurances moving forwards that this
15 will not occur again.

16 On Wednesday afternoon, Stuart Dunn will give
17 evidence to the Inquiry on behalf of the Care Quality
18 Commission, the CQC. Mr Dunn is the Interim Director of
19 Mental Health for the CQC. The CQC have provided the
20 Inquiry with a number of monitoring and inspecting
21 mental health services brief guides, which are described
22 as a learning resource for CQC inspectors and inspection
23 teams. These provide information, references, links to
24 professional guidance, legal requirements or recognised
25 best practice guidance about particular topics.

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1 England as it relates to resuscitation.

2 In April 2024, NHS England announced its intention
3 to reform the existing approach to statutory and
4 mandatory training through the development of a new
5 professional StatMand framework. This has been
6 developed jointly by NHS England, the DHSC, the CQC, the
7 HSIB, NHS Resolution, and a range of expert and staff
8 stakeholders. NHS England has endorsed the framework
9 which is now undergoing final approval from ministers
10 prior to publication.

11 NHS England has provided to the Inquiry the draft
12 version of the framework, which imposes a number of
13 competencies, including role-specific competencies which
14 we'll hear about in more detail. NHS England has told
15 the Inquiry that the new framework recognises that staff
16 working within mental health services may be required to
17 respond to emergencies that are less commonly
18 encountered in other healthcare settings, and has
19 included competencies relating to resuscitation
20 following self-harm. The Inquiry will be looking to
21 examine the proposals and to understand the reasons for
22 the development of the new framework. We will explore
23 what the changes are and the likely impact of those
24 changes.

25 Chair, you have already noted that the Inquiry has

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1 Included amongst these brief guides is the Brief Guide:
2 Immediate Life Support Training for Services That May
3 Use Restrictive Interventions, which is not specific to
4 mental health settings but refers to National Institute
5 for Health and Care Excellence, NICE, guidance, and that
6 NICE guidance recommends that any setting where
7 restrictive interventions, rapid tranquilisation,
8 restraint or seclusion are used, should have immediate
9 access to staff trained in immediate life support, or
10 ILS, and to appropriate ILS medication and equipment.

11 The Inquiry intends to consider the status and
12 practice of the CQC brief guides, how they're received,
13 viewed, and treated by the healthcare profession,
14 including in mental health settings. The Inquiry also
15 intends to look at the content of the relevant brief
16 guides, their adequacy and appropriateness and whether
17 or not they reflect the relevant national standards.

18 To this end, Stuart Dunn will also address some of
19 the evidence we heard from Mr Benson Clarke of RCUK in
20 July. Mr Dunn will confirm the CQC's view as to RCUK's
21 potential input into their work and Mr Dunn suggests
22 that such input could include incorporating checklists
23 and/or other protocols developed by RCUK into the
24 existing brief guides. The Inquiry may wish to explore
25 the feasibility of input from RCUK to assist the CQC in

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its inspection work and potentially to monitor implementation.

Chair, at the end of this week, on Thursday, 8 October, the Inquiry will hear from Professor Jasmeet Soar. Professor Soar is a Fellow of the Royal College of Anaesthetists, the College of Intensive Care Medicine and the Royal College of Physicians. He has been a consultant at Southmead Hospital, Bristol NHS Foundation Trust since 1999, and he works full time providing anaesthesia and caring for critically ill or injured adults. He is a national and international expert in cardiac arrest treatments, guidelines and outcomes.

Professor Soar has been instructed as an independent expert to provide the Inquiry with his opinion, amongst other matters, on the Quality Standards for Resuscitation, the special circumstances leading to cardiac arrest that might arise in mental health inpatient settings, and the clinical considerations and indications in relation to the prevention and treatment of cardiac arrest.

Chair, the Inquiry has also instructed Professor Soar to provide his expert opinion on some of the guidelines, policies and procedures issued by the relevant authorities as well as the relevant policies,

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stops beating secondary to causes which have led to a process of physiological changes in the body.

Professor Soar is emphatic in his opinion. In circumstances where a trigger event may give rise to secondary cardiac arrest, the best method for preventing loss of life, is prevention of that secondary cardiac arrest, either by preventing the trigger event in the first place, or by intervening as quickly as possible once the event has taken place to prevent the secondary cardiac arrest.

In evidence, Professor Soar will explain the physical condition in which a deteriorating patient may be found, and will explain the ABCDE approach to emergency response in the varying circumstances.

Professor Soar will address some of the complexities in identifying deterioration and cardiac arrest which he explains can be difficult for healthcare staff let alone laypeople.

Professor Soar will explain to the Inquiry the interventions that can be undertaken in mental health inpatient settings for a deteriorating patient.

The Inquiry has already heard some evidence, as I said, from Mr Benson Clarke about what are known as special circumstances, and as I outlined a few moments ago, the Inquiry asked Professor Soar to provide an

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procedures and training provision relating to emergency response and resuscitation in place at EPUT.

Chair, it's important to highlight now, although I will do so again on the morning of his evidence later this week, that Professor Soar's evidence, particularly his evidence in relation to special circumstances giving rise to cardiac arrest and the associated clinical indications, will necessarily include detailed descriptions of the physiological processes that take place following self-injury and other trigger events, the different mechanisms by which these processes can be brought about, and the ways in which they can lead to cardiac arrest and ultimately to loss of life. And for some, this evidence may simply be too graphic and too challenging to hear.

So may I say, again, for those engaging with the Inquiry, who are following online, or who are present in the room, please be assured that emotional support is available. The Inquiry's emotional support counsellors stand ready to assist those who need support.

Turning, firstly, to cardiac arrest the Inquiry will hear expert evidence from Professor Soar about the differences between primary cardiac arrest when the heart stops beating first due to a primary heart problem, and secondary cardiac arrest, when the heart

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expert clinical opinion about the particular circumstances that may cause deaths in mental health inpatient settings.

These special circumstances reflect trigger scenarios such as asphyxiation by ligature or airway obstruction, overdose or other serious self-harm, those that may be more likely to occur in mental health inpatient settings and which lead to secondary cardiac arrest.

Professor Soar's evidence will also include information about the critical time frames between injury and cardiac arrest, and in every case, this is a matter of minutes.

Professor Soar will also address the RCUK's Quality Standards for Mental Health Settings, as well as changes to training requirements.

And one key feature of the RCUK Mental Health Quality Standards, as identified by Professor Soar, is that staff should be trained and updated regularly to the level of proficiency and skill appropriate to their expected role. As we heard from Mr Benson Clarke, the standards do not differentiate between registered and non-registered clinical staff. This is important because there is an observable increase in the use of non-registered staff in clinical roles in all healthcare

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settings. Professor Soar cites a King's Fund report published in 2024 that for adult mental health services in 2012-13, the skill mix of adult acute wards comprised 60% registered nursing staff, and 40% support staff, i.e. non-registered staff, but by 2022-2023, this staffing mix had reversed.

The level of training specified in the Quality Standards, therefore, is focused on what an individual is expected to do as part of their clinical role, rather than their specific clinical role.

In Professor Soar's opinion, there is no reason why a non-registered member of clinical staff should not undertake immediate life support training, for example. The fact that ILS training is suitable for non-registered staff is, he explains, important in mental health settings because the first responders to an emergency are often non-registered staff. Professor Soar confirms that ILS training is already being completed by people in non-clinical roles outside of healthcare, including police officers and members of the armed forces, who have no clinical registration, and, unlike a healthcare assistant, have no day-to-day exposure to patients.

The Inquiry also invited Professor Soar to provide expert opinion on consistency across RCUK guidelines,

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Quality Standards, CQC guidance, NICE guidelines, and other relevant standards. National standards include those set by NHS England. Resuscitation training currently falls under mandatory training for all NHS staff within NHS England's core skills training framework, the CSTF, but as I've already outlined, the Inquiry understands that the CSTF is due to be replaced by a national programme with a new competency-based framework and the Inquiry will hear further detail from NHS England about those changes.

Professor Soar has reviewed the proposed resuscitation element of the new framework, and observes that the basic level for most staff, including in mental health settings, is probably lower than at present. He considers there will still be gaps to be filled. For example, it's not clear how the new framework will address guidance on the need for ILS-trained staff for settings using tranquilisation or restraint.

Finally, Professor Soar was asked to provide his expert opinion on the relevant EPUT policies and procedures and to evaluate the extent to which those policies and procedures are compliant with RCUK guidelines and quality standards, NICE guidance, and any other relevant national standards.

Professor Soar will point out, however, that for all

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healthcare organisations, including EPUT, it's the translation and the implementation of policy and procedure documents into the delivery of safe and effective patient care that matters. System-focused and engineered intervention, such as removing ligature points, are the most effective interventions. Least effective are interventions that require staff to be more vigilant, to work harder, or to rely on staff memory, because human factors are the most prone to failure.

EPUT's CPR policy appears to be generic for all Trust settings, which means that some issues that are specific to mental health inpatient settings are not always addressed explicitly within the policy. And Professor Soar -- sorry, we will explore a number of the observations Professor Soar makes about the content of EPUT's documentation, including the CPR policy, the mandatory training policy and the basic life support lesson plans when he gives evidence on Thursday.

But as I've already outlined, Professor Soar is emphatic in his central opinion, and that is this: where a trigger event may give rise to secondary cardiac arrest, the best possible chance of saving a patient's life is to prevent that secondary cardiac arrest and that may be by appropriately trained and equipped staff

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reacting and intervening quickly when the patient is discovered in medical emergency, or better still, by those appropriately trained and equipped staff, making sure that no trigger event takes place in the first place.

So it's for this reason, amongst others, that this Inquiry has looked so carefully at how observations are carried out in mental health inpatient settings. And so, with that, Chair, I turn to the Inquiry's investigation into observations and the use of technology within mental health inpatient settings. With the exception of one witness, from whom we will hear this morning, straight after this opening in fact, we will hear evidence on this topic on observations and the use of technology in the second week of this hearing.

The Inquiry has previously explored the role of observations in the care and management of mental health inpatients and has examined failings of providers in Essex. The Inquiry has also considered the role of vision-based patient-monitoring systems in the care of patients in mental health inpatient settings.

As you will recall, Chair, in October 2025, the Inquiry heard evidence from Zephany Trent the Executive Director of Strategy Transformation and Digital at EPUT,

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from Laura Cozens, Head of Patient Safety and Quality at Oxehealth Ltd, and from Hat Porter a representative of the national campaign group, Stop Oxevision. That evidence provided important information as to the use of Oxevision system at EPUT, and to the nature of the system more generally.

The Stop Oxevision evidence provided you with context about the lived experience of some of the patients who have been subject to the use of vision-based patient monitoring systems as well as setting out their concerns about the use of such systems.

And having heard evidence in October 2025, you identified several areas you wanted to explore further in relation to Oxevision, and those areas included, although they were not limited to, the purpose and use of Oxevision in mental health inpatient settings, the potential benefits and harms associated with the system, including any unforeseen or unintended consequences of its use, the strength of the evidence based in support of the use of the system, the adequacy and operability of EPUT's governance, training, and standard operating procedures relating both to observations generally and Oxevision in particular, and the processes and decision making that informed EPUT's pilot, evaluation, and

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moment.

Chair, you also heard evidence in July from several members of staff who described their experiences of observation practices generally at EPUT, as well as their interactions and engagement with the Oxevision system.

And you heard from other Mental Health Trusts as to their approach of the use of Oxevision. We heard evidence in July from Mr Freire-Patino, Deputy Director for the Directorate of Mental Health Services at Leicestershire Partnership NHS Trust and Elspeth Devanney, Director of Nursing quality at Tees, Esk and Wear Valleys NHS Foundation Trust. Those witnesses described their respective organisations' differing experiences with, and approach to, the Oxevision system. In addition, further witness statements were obtained from four other Trusts revealing a range of approaches to, and views about, the Oxevision system.

Lastly, in July you heard evidence from Professor Christl Donnelly and Dr Maria Christodoulou, the Inquiry's expert health statisticians. They gave evidence as to the strengths and weaknesses of the academic literature structure and research based appraising the use of the Oxevision system. In summary, they identified weaknesses in the evidence base which

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ultimately, EPUT's wide deployment of Oxevision.

In July of this year the Inquiry heard evidence relating to observation practices more generally, from Jill Archibald, a Consultant Mental Health Nurse and Responsible Clinician in Cumbria. Her evidence considered observation practices in the round, which included the role of vision-based monitoring systems.

Ms Archibald's evidence not only helped inform the Inquiry's investigations into the use of observations prior to EPUT's adoption of the Oxevision system, but it also assisted you understanding the expected practices at other providers which have not deployed the Oxevision system. And that understanding is of critical importance to any assessment of the purpose and utility of technologies such as Oxevision and its purported role in the delivery of mental health care.

Key themes emerging from Ms Archibald's evidence included the different purposes which observations may have and the critical importance of therapeutic engagement. Ms Archibald also considered the evidence provided by families of those who have died whilst under the care of EPUT. Following the hearing in July, the Inquiry instructed a further expert who has undertaken the same exercise. That is Dr Francesca Denman, Consultant Psychiatrist, about whom I'll say more in a

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mean that, in their joint view, the conclusions which can be drawn from the evidence base are limited and should be treated with caution.

Chair, over the course of this hearing, you will hear evidence from seven further witnesses in relation to observations and the use of technology, and as I've already said, for the most part, this evidence will be heard in the second week of this hearing.

Firstly, however, in order to accommodate his availability, you will hear later this morning from Mr Gareth Harry, NHS England's National Delivery Director for Mental Health Learning Disability and Autism.

He will provide evidence as to NHS England's approach to new technologies being considered for use in healthcare settings and NHS England's understanding of the Oxevision system.

Next Monday, 12 October, the Inquiry will hear evidence from Dr Francesca Denman, an expert Consultant Psychiatrist. Dr Denman will provide opinion from her perspective on observation practices generally in mental health inpatient settings, as well as her views as to the role and capabilities of the Oxevision system.

Dr Denman describes what are, in her view, some of the system's limitations. Her evidence builds upon that

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1 which the Inquiry heard in July from Ms Archibald, and
2 will inform the Inquiry as to the expected practices and
3 standards for undertaking observations in mental health
4 inpatient settings, as well as identifying where and how
5 there have been departures from those standards.

6 Furthermore, the Inquiry will draw on Dr Denman's
7 considerable experience of clinical leadership within
8 NHS Mental Health Trusts. Between 2012 and 2021, she
9 was the Medical Director of Cambridge and Peterborough
10 NHS Foundation Trust. She will assist the Inquiry in
11 understanding and appraising EPUT's approach to the
12 trial and deployment of the Oxevision system on the
13 inpatient wards and the relevant considerations for an
14 NHS Trust when evaluating and assessing whether new
15 technologies meet an organisation's requirements.

16 Dr Denman is well placed to speak to the broader
17 government aspects of how the system was deployed and
18 used at EPUT, and whether and to what extent the Trust
19 responded appropriately to emerging concerns.

20 The Inquiry will hear evidence again from Laura
21 Cozens of LIO, the organisation formerly known as
22 Oxehealth. Ms Cozens has now provided the Inquiry with
23 a total of four witness statements, the most recent
24 being an unsolicited witness statement received by the
25 Inquiry on 24 September 2026. That statement was

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1 Dr Suresh, EPUT's Chief Medical Officer, and together
2 they will give evidence addressing a number of matters
3 arising from the evidence heard last July. These
4 include: EPUT's evaluation of the Oxevision system prior
5 to its widespread deployment; EPUT's approach to consent
6 over Oxevision's period of use; the Trust's system for
7 training and audit; emerging concerns as to Oxevision's
8 use; and how EPUT considers that Oxevision assists in
9 the management of patients' physical health needs.

10 On Thursday, 15 October, the Inquiry will hear
11 evidence from Robert Reid, Deputy Director for
12 Innovative Devices at the Medicines and Healthcare
13 products Regulatory Agency, the MHRA. He will speak to
14 MHRA's oversight of new technologies and its assessment
15 of the Oxevision system.

16 Taking that evidence alongside other witness
17 statements obtained from the Department of Health and
18 Social Care, the National Institute for Health and Care
19 Excellence, the CQC and the British Standards
20 Institution, the Inquiry aims to understand the
21 supervisory landscape and the principles which support
22 and regulate the deployment of new technologies in
23 mental health care settings. It will be a matter for
24 you, Chair, as to whether that landscape provides
25 sufficient monitoring or whether the evidence of how the

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1 accompanied by a letter from the Oxehealth board to you,
2 Chair, which we were told was also circulated by LIO to
3 core participants via their legal representatives. This
4 is another example of late disclosure of material to the
5 Inquiry, the difficulties with which I have already
6 outlined.

7 Ms Cozens' fourth statement considers the
8 capabilities and role of Oxevision as LIO sees them.
9 The Inquiry intends to address the matters covered in
10 Ms Cozens' four statements during this hearing, as well
11 as wider issues which arise from LIO's earlier evidence,
12 both written and oral. In doing so, it will consider
13 all of the evidence provided from all core participants
14 with an open mind.

15 Following Ms Cozens' evidence on 13 October 2026,
16 the Inquiry will hear from Derrick Trimble, the
17 Oxevision project manager at EPUT. His evidence sets
18 out how EPUT viewed the Oxevision platform and the
19 organisation's experiences of the system during the
20 rollout and since. His evidence will supplement the
21 evidence which we will hear from senior EPUT witnesses.
22 Those witnesses will be Zephan Trent and, once again,
23 Dr Kallur Suresh.

24 As I've previously outlined, Mr Trent gave evidence
25 to the Inquiry in October 2025. He will be joined by

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1 system has operated in relation to Oxevision suggests
2 that improvements in that system of oversight,
3 assessment and regulation are required.

4 Chair, our hearing in Chelmsford will then conclude
5 on Thursday, 15 October. But as we have both outlined,
6 you have invited core participants to make oral
7 submissions to you on the topics of emergency response
8 and resuscitation and on observations and the use of
9 technology at a virtual hearing on Tuesday, 20 October.

10 As you have already recognised, Chair, whilst this
11 Inquiry is founded in Essex, these topics, like so many
12 of the other issues which you are investigating, appear
13 to extend well beyond this county and have a wider
14 reach.

15 Finally, Chair, the Inquiry is grateful to all core
16 participants and external organisations for their input
17 and engagement into these important issues so far.

18 Chair, that brings me, then, to the end of the
19 opening statement and I think we will have a short break
20 of 15 minutes, please, before coming back to hear from
21 Mr Gareth Harry from NHS England.

22 **THE CHAIR:** Thank you.

23 **MS HARRIS:** Thank you.

24 **THE CHAIR:** Fifteen minutes.

25 **(11.11 am)**

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1 (A short break)

2 (11.29 am)

3 **THE CHAIR:** Ms Onabanjo. Good morning.

4 **MS ONABANJO:** Good morning, Chair.

5 Good morning, Mr Harry, could you please read the

6 words of the affirmation.

7 **DAVID GARETH HARRY (affirmed)**

8 **Questioned by MS ONABANJO**

9 **MS ONABANJO:** Thank you.

10 You have already stated it as part of your

11 affirmation but could you please state your full name

12 for the record.

13 **A.** David Gareth Harry.

14 **Q.** Thank you. And Mr Harry, you have provided two witness

15 statements to the Inquiry. The first statement -- do

16 you have a copy in front of you there?

17 **A.** I do.

18 **Q.** The first statement in front of you is dated 20 May 2025

19 but in fact that should be dated 20 May 2026; is that

20 right?

21 **A.** That's correct.

22 **Q.** And but for that date, the contents are the same as the

23 version you supplied to the Inquiry, dated 20 May 2026?

24 **A.** That's correct.

25 **Q.** And then you've provided a second statement to the

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1 **A.** Yes.

2 **Q.** And just to say that the version of your statement, of

3 your first statement, dated 20 May 2026, will be

4 published and disclosed to core participants following

5 the hearing?

6 **A.** Yes.

7 **Q.** At paragraph 3 of your first, witness statement, that is

8 NHSE023333, you explain that you are currently the

9 National Delivery Director for Mental Health, Learning

10 Disability and Autism in NHS England, and you've been in

11 that role since June 2022 --

12 **A.** Yes.

13 **Q.** -- is that correct? Can you explain your background and

14 previous experience within the NHS.

15 **A.** I've worked for the NHS since 2000, I'm a graduate of

16 the NHS Management Training Scheme which I completed in

17 2004. Since then I've undertaken a range of roles in

18 primary care, community services and mental health

19 services. In the last four years I've worked for

20 NHS England in my current role but prior to that I

21 worked for Derbyshire Healthcare, a mental health and

22 children's services provider in Derbyshire as an

23 executive board member and four years previous to that,

24 I was an executive board member of the local Clinical

25 Commissioning Group which was the lead mental health

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1 Inquiry dated 27 August 2026; is that right?

2 **A.** Yes.

3 **Q.** Have you had an opportunity to read those statements

4 recently?

5 **A.** I have.

6 **Q.** Do you have any corrections you wish to make to the

7 statements?

8 **A.** Yes, I would, Chair. I would like to make a correction

9 to paragraphs 36 to 44 in the first statement. We

10 became aware through the disclosures that were made by

11 the MHRA on 17 September that there were previous

12 communications between NHS England's Patient Safety Team

13 and the MHRA dating back to February 2021. So I would

14 like to correct my statement as it relates to that

15 period of time as to when NHS England were first aware

16 of patient safety issues with Oxevision.

17 **Q.** Thank you. I will deal with those substantively in your

18 evidence, and save for that correction in relation to

19 NHS England's awareness of issues with Oxevision, can

20 you confirm that the contents of both statements are

21 accurate and true to the best of your knowledge and

22 belief?

23 **A.** Yes.

24 **Q.** And are you content for those statements to stand as

25 your evidence to the Inquiry?

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1 commissioner for Derbyshire.

2 **Q.** Thank you. And what does your current role entail?

3 **A.** I'm responsible for the delivery of a series of service

4 improvements nationally, and service improvements --

5 service delivery improvements and service improvements

6 across the country as set out by NHS Plans, but I'm also

7 accountable to the NHS England board, and indirectly and

8 sometimes directly to ministers for the delivery of

9 specific performance and targets for delivery.

10 **Q.** Thank you. I will now ask you about your description of

11 NHS England's role in the oversight of digital health

12 technology. And if I can take you to paragraph 9 of

13 your first witness statement on page 3, please.

14 First, you say that:

15 "Following the merger of NHS Digital and NHS England

16 on 1 February 2023, NHS England is responsible for

17 designing and operating national data infrastructure and

18 digital systems."

19 If we stop there, could you explain what you mean by

20 that?

21 **A.** Yes, that would, for example, the national databases

22 into which providers submit regular information, as it

23 would relate to providers' performance but also their

24 activity, that we would collect as a national

25 organisation in order to look at performance, delivery,

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1 to inform commissioning decisions. So the
2 responsibility for designing and operating those
3 national databases and the infrastructure to enable that
4 to happen is essentially what that paragraph is
5 referring to.

6 **Q.** Thank you. You then go on to say that:

7 "The overall responsibility for the use of digital
8 health technology products sits with care providers and
9 commissioners at a local level. However, NHS England
10 has produced a variety of supporting framework standards
11 and policies that guide the assurance of digital health
12 technology products so that they are safe for use within
13 the NHS."

14 At paragraph 12, further down that page, you say
15 that:

16 "NHS England is accountable at a national level for
17 patient safety risks posed by technologies it directly
18 commissions for deployment across NHS England."

19 Then in the following paragraph you say:

20 "Providers who commission new technologies, as is
21 the case with vision-based monitoring systems ... are
22 responsible for their procurement, evaluation and
23 deployment."

24 So you say:

25 "... the responsibility for patient safety rests

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1 and risks of individual providers. Therefore, whilst
2 systemic risk may be raised through these processes,
3 general oversight and day-to-day concerns will typically
4 be dealt with at a local level between providers,
5 commissioners, and CQC."

6 The Chair would like to better understand the
7 precise remit of the NHS, NHS England's responsibility.
8 You accept, don't you, that NHS England is obliged by
9 statute to monitor NHS Trusts in carrying out their
10 functions and to provide such advice, guidance and other
11 support as it considers appropriate; is that right?

12 **A.** That's correct.

13 **Q.** And so in terms of digital health technology, that
14 oversight obligation surely extends beyond technology
15 which NHS England directly commissions itself?

16 **A.** I think there are a range of different powers and
17 responsibilities that have just been outlined in the
18 relevant paragraphs that you've just taken us through.
19 The first is where NHS England directly commissions
20 software or digital technologies itself, in which case
21 it is responsible for undertaking the processes that are
22 outlined in my evidence. It also provides advice and
23 guidance to providers and commissioners in a local
24 system where they are procuring or purchasing and
25 choosing to use digital technology. Thirdly, in the

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1 with individual NHS Trusts ..."

2 If I can then take you to your second statement,
3 that's NHSE0281124, at page 3, paragraph 7, you follow
4 on the point that you've already made in your first
5 statement. You say:

6 "Each Trust will have their own policies and/or
7 procedures in relation to their own procurement and
8 purchasing arrangements, and governance arrangements.
9 The oversight and assurance process for the procurement
10 of digital technologies begins with individual Trusts.
11 Each Trust is responsible and accountable, through its
12 Board and leadership, for the provision of services and
13 for any technology procured to support those services."

14 If I can then take you to paragraph 9 of that
15 statement on the following page, so the second
16 paragraph, you say that, as explained in your first
17 statement:

18 "... NHS England coordinates closely with a range of
19 national bodies to support the identification,
20 monitoring and mitigation of emerging risks associated
21 with new technologies."

22 At paragraph 11, on the following page, you say
23 that:

24 "... NHS England draws on information from NHS
25 Trusts, ICBs and the CQC to understand the performance

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1 final paragraph, which is the wider NHS responsibility
2 in terms of the accountability of providers and systems
3 for the overall delivery of their functions.

4 But as it says in paragraph 11, those issues that
5 tend to get raised at that level for NHS England's
6 intervention, tend to be more systemic than purely
7 a single issue with digital product. It would tend to
8 be, in that framework, which I think -- NHS England
9 calls it the National Oversight Framework, it would tend
10 to be significant, systemic issues with a particular
11 provider, such as a significant deficit, financially, or
12 significant issues with the quality of the services as
13 found by the CQC.

14 **THE CHAIR:** Can I just come back on that. A systemic issue.
15 In the case of the technology, this patient monitoring
16 technology, when does that become a systemic issue? I'm
17 thinking about issues relating to a technology that is
18 widely employed across a significant, possibly even half
19 of mental health Trusts. Does that make it a systemic
20 issue, if there is a particular problem with that
21 technology?

22 **A.** If -- apologies. If there was -- if there were issues
23 in a particular provider, that in addition to their use
24 of digital technology, there were wider patient safety
25 issues or wider quality issues, then via inspections and

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1 the ratings by the CQC, then that might indicate a wider
2 systemic issue with the quality of the services being
3 provided by that organisation, which could lead then to
4 intervention at a provider level by NHS England.

5 **THE CHAIR:** Right.

6 **MS ONABANJO:** Just following on from what the Chair asked,
7 where there are concerns about, for example, the safety
8 of technology and that technology is being used across
9 multiple NHS Trusts or suppliers or providers, such that
10 one can say that there is a system-wide issue, is that
11 something for which NHS England is responsible?

12 **A.** That would depend on how it was reported to NHS England.

13 So, as NHS England has that responsibility for
14 collecting patient safety information, into the patient
15 safety single reporting mechanism, where there was,
16 as -- in the words here, systemic the patient safety
17 challenges, then NHS England could respond within its
18 patient safety responsibilities to those, if there were
19 systemic patient safety reports, and a number of reports
20 across a number of providers, but that is different from
21 the scenario that you just set out to me.

22 **THE CHAIR:** Why is that different?

23 **A.** Because under paragraph 11, what I am referring to is
24 the wider powers of NHS England to assure itself of the
25 breadth of services provided by an individual provider,

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1 From paragraph 19 of your first statement at page 5,
2 so that's the NHSE023333, at page 5, paragraph 19, you
3 explain part of how NHS England discharges this
4 oversight function, and how part of what it does is that
5 it issues standards, and so you say NHS England has
6 issued two digital clinical safety assurance standards
7 to ensure that new technologies are sure to safe -- are
8 safe and to ensure both manufacturers and providers
9 conform to a national standard.

10 And then at paragraph 20, you explain that, in the
11 final sentence, that the standards are mandatory under
12 the Health and Social Care Act 2012, and that they also
13 apply to independent sector providers of NHS funded
14 services.

15 When you say they are mandatory, do you mean they
16 are binding obligations on manufacturers and providers?

17 **A.** Yes.

18 **Q.** Thank you. At paragraph 25 on page 7, you explain that
19 the NHS also publishes guidance and in this respect you
20 refer to the Digital Technology Assessment Criteria,
21 DTAC, What Good Looks Like, and the Digital Maturity
22 Assessment framework. In your second statement, and
23 I wouldn't take you to it, you explain the status of
24 these documents and so in relation to the DTAC, you say
25 that the DTAC establishes a mandatory national baseline

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1 and the quality of the services as regulated by the CQC.
2 The ability to respond in those circumstances within the
3 Oversight Framework that NHS England has for individual
4 providers and systems is different from the patient
5 safety response that might occur from the reporting of
6 patient safety incidents.

7 **THE CHAIR:** But you will accept that if there were patient
8 safety issues, that could be a systemic issue which the
9 NHS would of its own volition and of its own -- on its
10 own, respond to, perhaps even on a national scale by,
11 for instance, issuing directions or taking some sort of
12 other action?

13 **A.** Yes, and where there are patient safety issues that get
14 reported to NHS England, there is the ability of NHS
15 England to directly communicate to all Trusts through
16 the national patient safety alerts.

17 **THE CHAIR:** I think we've got there.

18 **MS ONABANJO:** Thank you.

19 But it is -- your evidence is that NHSE doesn't have
20 a proactive -- responsibility to proactively monitor the
21 implementation of digital health technologies?

22 **A.** No, because that is the responsibility of individual
23 providers and the people who have purchased and
24 implemented the digital technology.

25 **Q.** Thank you.

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1 for the procurement of digital health products intended
2 for deployment within NHS settings but that compliance
3 with the DTAC is not a statutory requirement, and by
4 that, do I understand you mean that it is not a binding
5 obligation on providers, manufacturers?

6 **A.** Not directly but it is something that would be expected
7 for a provider to go through when it was commissioning
8 digital processes and has been required as part of
9 procurement regulations as well.

10 **Q.** And so, in circumstances where, for example, there is
11 a failure to comply with DTAC, what powers does
12 NHS England have to ensure -- to enforce compliance?

13 **A.** I'm not aware of any. That would be the responsibility
14 and the judgement that was made by an individual
15 provider or commissioner of the digital technology.

16 **Q.** Thank you.

17 In relation to the What Good Looks Like framework
18 you say in your second statement that it's not
19 a statutory requirement and that it is not mandated, it
20 reflects best practice, and NHS England will expect
21 providers of NHS funded care to have regard to it.

22 So again, no binding obligations?

23 **A.** No.

24 **Q.** And then the same is true of the Digital Maturity
25 standard?

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1 A. That's correct.

2 Q. And the digital principles, which I will return to in

3 detail later, but you explain in relation to that, that

4 also they are not legally binding.

5 A. They're not.

6 Q. Could you explain how the -- how NHS England determines

7 whether to issue standards that are binding and have

8 legal force, or principles or guidance which are not

9 binding on those to whom those documents apply?

10 A. I think the difference is where we've set out mandatory

11 guidance around those, the two documents that are

12 prefaced DCB, that has been really clear with both the

13 providers of the digital technology and the people who

14 commission it, that these are the minimum standards.

15 These are the standards which we expect people to adhere

16 to. Where we publish advice or guidance, they are tools

17 in order to be able to assist providers and

18 commissioners in their responsibilities.

19 Q. I understand that. What factors -- can you assist with

20 the factors that NHS England takes into account in

21 determining the form in which the documents, the

22 guidance, the standards, that it publishes should take?

23 How does it determine whether these should be mandatory

24 minimum standards where the -- those to whom it applies

25 are obliged to comply with it, or whether it ought to be

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1 The programme focuses on innovations that addresses

2 challenges in the NHS and are already sufficiently

3 developed to be scaled. The NIA operates through an

4 annual competitive application process."

5 Then you say, in the last sentence, that:

6 "Since launching [that's on page 9] in 2015 the NIA

7 has supported a significant number of innovations to

8 scale, including Oxevision."

9 Then at paragraph 29 you refer to this document, the

10 Health Technology Pathway Navigation Tool which you say

11 is published to support innovators. And what that

12 document describes is an innovation infrastructure in

13 which NHS bodies work with innovators.

14 Given this collaborative ecosystem, how does NHS

15 England ensure that the Trusts and NHS England itself

16 remain sufficiently independent to assess whether

17 technologies should continue to be commissioned or used

18 notwithstanding that through the NIA, relationship has

19 been established with the innovators?

20 A. Sorry, can you repeat the question, please?

21 Q. How does NHS England ensure that itself and Trusts

22 remain sufficiently independent when they are assessing

23 whether to commission digital health technology given

24 that the innovation ecosystem which NIA is a part of

25 results in collaborative working between innovators and

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1 guidance or a statement of best practice, principles,

2 that they are expected to adhere to? What informs that

3 decision as to what NHS England decides to do?

4 A. Based on these examples, I think the difference is where

5 NHS England has a power that it has to be able to

6 discharge and those powers or responsibilities that sit

7 elsewhere, rightly, with the individual providers or

8 commissioners but for which we would want to provide

9 advice and guidance to them in conducting their

10 responsibilities.

11 Q. Thank you. I'll now ask you questions about the NHS

12 Innovation Accelerator and Oxevision. The Inquiry has

13 heard a lot of evidence about Oxevision which is a type

14 of digital health technology and importantly for the

15 purposes of the evidence today, it is a technology that

16 uses infrared sensitive cameras to relay information and

17 so it falls within vision-based monitoring systems.

18 At paragraph 27 of your first witness statement at

19 page 8, that is the statement ending 23333, you describe

20 at the bottom of page 8, please -- thank you -- you

21 explain what the NHS Innovation Accelerator, is you say

22 it is:

23 "... a national programme established by NHS England

24 to support the rapid adoption and scaling of high-impact

25 evidence-based innovations across the NHS in England.

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1 NHS bodies?

2 A. Ultimately I think you would be expecting a provider to

3 be able to make a separate judgement about each

4 individual product that it was looking to procure and

5 looking to buy and that that would necessarily under the

6 procurement regulations and competition law need to show

7 it was completely separate from whatever was happening

8 in terms of how the NIA wanted to particularly promote

9 or advocate for particular products.

10 The final decision made by an individual provider

11 would need to be made in line with procurement and

12 competition rules.

13 Q. And so NHS England doesn't, for example, sort of publish

14 any guidance or have in place any mechanisms to address

15 any potential conflicts that might arise as a result of

16 the fact that certain digital health technology is

17 essentially promoted or is supported by NHSE's

18 innovation accelerator?

19 A. Ultimately the decision being made by the provider is

20 independent of NHS England. It's a separate procurement

21 decision conducted under procurement law, and

22 challengeable if it was not in line with procurement or

23 competition regulations.

24 Q. Is there -- do you recognise that there is at least

25 a risk that in making decisions, because the particular

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1 technology has been supported by the Innovation
2 Accelerator, there might be a risk of preferring that
3 technology? Is that a risk that NHS England recognises?
4 **A.** I think it's a risk that's mitigated by it being the
5 provider responsibility and the need to follow fair,
6 transparent, and accountable procurement and commercial
7 and working within competition law.
8 **Q.** Thank you. At paragraph 28 of your statement, page 8,
9 you refer to the economic impact case study on
10 Oxevision. The Inquiry has heard evidence from its
11 expert statisticians, and they've opined that that case
12 study should be assigned low evidential weight as
13 economic modelling evidence and low weight as proof of
14 actual cost effectiveness. Is NHSE aware of that
15 critique of the study?
16 **A.** Yes, and agree, I think it's a really weak piece of
17 work.
18 **Q.** And has NHSE reflected on whether it was appropriate for
19 Oxevision to have been supported to scale, given the
20 flaws identified in the research supporting it?
21 **A.** I think if you take the Oxehealth study out of it and
22 the process that Oxevision obviously went through in
23 terms of trying to build a cost effectiveness evidence
24 base for its product, as it was rolling out to
25 individual providers, then there were other studies that

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1 adequacy of the evidence to support the deployment of
2 such technology?
3 **A.** I would expect every provider of mental health services
4 to have, primarily, their values and behaviours driven
5 by human rights-based approach to mental health care,
6 and that that would override any other commercial
7 interests or cost-benefit analysis and that that would
8 be at the forefront of their minds.
9 **THE CHAIR:** But are you aware of circumstances where that
10 has not been the case?
11 **A.** I'm -- I couldn't comment on -- because I'm not part of
12 those board discussions at a provider level and to what
13 extent those sorts of discussions played out at the time
14 of decisions.
15 **MS ONABANJO:** Thank you. I'll now turn to ask you questions
16 about NHS England's awareness of concerns about
17 Oxevision and you've indicated at the outset of your
18 evidence this morning that NHS England became -- first
19 became aware, contrary to what is implied in your
20 statement, in around February 2021, as a result of
21 a patient safety incident that was raised. And if I may
22 take you to the paragraph 23 of your witness statement
23 on page -- of your first witness statement, page 6,
24 before getting into the detail of the document I think
25 it's useful to situate what the National Patient Safety

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1 were being developed at that time and perhaps we'll come
2 to it in terms of later products where there has been
3 a systematic review of that evidence base which
4 similarly points out to weaknesses within some of those
5 cases.
6 **Q.** Thank you. The Inquiry will be hearing evidence later,
7 next week, from its expert, Dr Denman, on observations
8 and engagement and the use of vision-based patient
9 monitoring system, but in her reports to the Inquiry,
10 she opines that consent is the first line of defence in
11 safeguarding autonomy and dignity, and it pays to spend
12 time ensuring patients give valid consent to treatment
13 and intervention.
14 Does the NHS England recognise that there is --
15 there might be a risk that enthusiasm for innovation
16 outpaces scrutiny of consent and ethics and other
17 evidence which is said to justify the deployment of new
18 technology?
19 **A.** Can you repeat the bit of the question about
20 NHS England, please?
21 **Q.** Does NHS England recognise that there is a risk that
22 enthusiasm for innovation in digital health technology
23 might risk proper scrutiny of emerging technology or the
24 uses of emerging technology, including in relation to
25 how patient consent is obtained and the weight -- the

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1 Team is and what you say is that:
2 "The National Patient Safety Team acts as the NHS's
3 central mechanism for collecting, interpreting and
4 responding to information about patient safety events,
5 primarily through the learning from Patient Safety
6 Events Service, and this enables the systematic
7 collection of safety intelligence across the NHS ..."
8 If I may have up on the screen, please, NHSE028913.
9 This is described as an NRLS analysis summary, and
10 my understanding is that the NRLS is the National
11 Reporting and Learning System; is that right?
12 **A.** Yes.
13 **Q.** If we can go to the end of that document, page 15,
14 you'll see that the document was reviewed and prepared
15 by the Deputy Director of Patient Safety and was
16 completed on 25 May 2021.
17 **A.** (The witness nodded).
18 **Q.** If we go back to the first page, this describes
19 a trigger incident involving Oxevision and in the second
20 paragraph it explains that in the trigger incident there
21 are different perspectives on whether the staff member
22 viewing the monitor rather than going into the room once
23 the patient was observed to be missing had sped up or
24 delayed the response. It was clear the device had not
25 alerted staff to patients who had been near to a door

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1 and was unconscious, hypoxic and not breathing, but it
2 was unclear whether the device would have been expected
3 to do so.

4 In the next box it says that this trigger incident
5 was discussed at the VRM on 18 February 2021. Could you
6 assist us with what VRM is?

7 A. Yes, it stands for the Virtual Response Meeting and it's
8 named such as -- it's a rather confusing title because
9 it was set up during Covid. It used to meet in person
10 so it was called the Virtual Response Meeting. That is
11 where senior clinicians within the National Patient
12 Safety Team review particular patient safety events that
13 have come up through the national system for discussion
14 about whether it requires further investigation or
15 further action, and that is -- what the decision was
16 made at the VRM concerned here was that the incident,
17 particularly the narrative content, was enough of
18 a trigger to require further investigation.

19 Q. It is stated in your statement that you weren't aware of
20 this discussion that were happening at the VRM and the
21 subsequent engagement with the MHRA and Oxehealth in
22 2021 at the time you prepared your statement. Why was
23 that?

24 A. When we'd done the initial trawl of relevant documents,
25 it didn't appear. This was found following us looking

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1 relating to Oxevision. And of those -- and the reports
2 came from 11 different Mental Health Trusts. Are you
3 aware of the number of those reports that were related
4 to EPUT?

5 A. No, I'm not.

6 Q. Thank you. If we can turn to page 8 of the document.
7 These -- this sets out some of the issues that were
8 identified by the Deputy Director for Patient Safety.
9 If we look at the second paragraph, for example, it says
10 that the CCTV 15 Seconds of Life video function was
11 being used to conduct all patient checks and planned
12 intermittent frequent checks for patients in their
13 bedroom in 57 instances.

14 If we go on to page 9, the penultimate paragraph,
15 starting "Two reports":

16 "Two reports suggested staff believed the device
17 would alert them automatically to change in breathing
18 rate."

19 If we go on to page 10. At the final paragraph in
20 the "Themes" box, stated that:

21 "Website patient quotes" -- so this is the website
22 of Oxehealth -- "suggest that the patients may believe
23 that the device automatically and immediately alerts
24 staff to any self-harm attempt."

25 And then if we go on to page 13, in the summary box

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1 at the disclosures of the MHRA on the -- I think the --
2 late September, we were able to see from that disclosure
3 that there had been some communication from the National
4 Patient Safety Team to the MHRA so we then conducted
5 further information trawls within the National Patient
6 Safety Team, which then discovered -- we then discovered
7 these additional -- this additional information and the
8 correction that we've made.

9 Q. Thank you.

10 A. It was in the archive of a retired colleague, so it
11 wasn't -- it was difficult to get.

12 Q. Thank you. If I may take you to page 6 of that
13 document, please. So the patient safety question that
14 was being considered in this analysis was:

15 "Incidental or direct mentions of Oxehealth within
16 the NRLS, give indications of the purposes for which it
17 has been used. If staff using the device clearly
18 understood what it can and cannot do, and whether there
19 were any indications of it affecting staff or patient
20 behaviour in ways that positively or adversely affect
21 patient safety." [As read]

22 And if we can then go to page 7, please.

23 So the Deputy Director for Patient Safety carried
24 out a search of this system, and stated that the search,
25 at the bottom of the page, generated 136 incidents

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1 at the bottom of the page, this summarises some of the
2 issues that were identified by the Deputy Director of
3 Patient Safety. One was that there appears to be some
4 mismatch between the medical device authorisation and
5 instructions for use for the system, and the website
6 material suggesting how it can be used to prevent falls,
7 prevent self-harm, and monitor Covid-19 patients.

8 In the third paragraph, the final paragraph on that
9 page, there are indications that only pulse and
10 respiratory rate is being taken in circumstances when
11 full physiological observations should have been taken.
12 And on to the next page, the third paragraph, starting:

13 "There are some indications that staff may expect
14 the device to perform functions it cannot actually
15 perform (for example automatically alerting them to
16 significant changes in respiratory rate). There would
17 be a significant risk to patient safety even if a small
18 minority of staff misunderstood this functionality."

19 In the next paragraph it noted that:

20 "There are some indications that patients may expect
21 it to automatically and immediately alert staff if they
22 have self-harmed, which may lead to risks that they may
23 then attempt self-harm believing staff intervention will
24 save them from the severe consequences."

25 So a number of potentially significant patient

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1 safety issues were identified in that -- in that
2 document.
3 In terms of the planned action on page 14, the final
4 bullet point there, says that:
5 "Our measurement unit has a role more generally in
6 assessing whether safety innovations are suitable for
7 adoption and spread."
8 Do you know what the measurement unit is, and do you
9 know whether any assessment or research was undertaken?
10 A. I don't know what the measurement unit refers to. I'm
11 sorry. I don't know whether it's a unit of measurement
12 or whether it's a team. Apologies.
13 Q. It appears to be a team within NHSE. So you cannot
14 assist the Inquiry as to whether -- what the measurement
15 unit is and whether this work that the Director of
16 Patient Safety indicated that needed to be done was
17 undertaken?
18 A. My understanding was that the work that was undertaken
19 was that wider -- the incident that resulted in the
20 initial interest from the National Patient Safety Team
21 was a severe incident and a significant incident. The
22 action that they took in preparation for the VRM was to
23 undertake that wider assessment across all of the
24 patient safety incidents that mentioned Oxevision,
25 Oxehealth, or vision-based systems.

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1 requiring to. There have since been two rounds of MHRA
2 posing questions to Oxehealth and asking us whether we
3 have questions to add. MHRA have been steady but
4 persistent on the regulatory angle, Oxehealth initially
5 defensive response to MHRA but becoming more responsive
6 now that MHRA are making it clear that they are on
7 unsteady ground ..."

8 In relation to the changes as to how the product was
9 marketed, she says that:

10 "... weak changes have been made so far," and they
11 need to make more so that there's movement in the right
12 direction.

13 As we've seen from the NRLS analysis document, one
14 of the concerns indicated in that document was the
15 concerns both patient and staff might get a false
16 reassurance that Oxevision would alert staff were
17 a patient to self-harm, and it appears from the comments
18 of the Deputy Director in this email that she wasn't
19 satisfied with the responses of Oxevision in that
20 regard. She describes the changes that they made so far
21 as weak, for example. Do you know whether any further
22 steps were taken to ensure that those risks that were
23 identified were addressed?

24 A. My understanding from the email and the relevant
25 disclosures that were made, is that it did result in

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1 So it may be referring to that.
2 Q. Given the significant concerns identified by the Deputy
3 Director of Patient Safety in that document, did NHS
4 England consider, at that stage, whether it needed to
5 issue warnings, for example in relation to staff
6 understanding and patient understanding of the system?
7 A. It was felt at this VRM that the current understanding
8 of the issues was not sufficient to require a national
9 patient safety alert, and that there were other actions
10 that should be taken ahead of any alert, which were the
11 actions that the National Patient Safety Team took.
12 Q. The action that National Patient Safety Team took
13 included discussions with MHRA and discussions with
14 Oxevision itself and if I may call up NHSE028973,
15 please.

16 So this is an internal email sent by the Deputy
17 Director of Patient Safety relating to the actions that
18 had been taken since that analysis in May 2021. And if
19 we go down to the paragraph starting "Sarah and me met
20 Oxehealth," and so she says:

21 "Sarah and me met Oxehealth once ... on 27 October
22 2021 -- MHRA pursued the regulatory angle whilst I tried
23 to appeal to their better nature and asked them to
24 reduce the risk of staff/patients misunderstanding what
25 the device will do, even if they were not legally

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1 changes being made through conversations and through
2 communications between MHRA and Oxevision that changes
3 were made both to the instructions to use and to their
4 website.

5 Q. And so it's your evidence that those changes that were
6 made satisfied NHS England?

7 A. I think they satisfied the MHRA, which were the relevant
8 regulator of the device.

9 Q. In the following -- in the next paragraph on that page
10 the Deputy Director also indicated that there was alarm,
11 she says, in the sixth sentence:

12 "... team was alarmed that medical device regulation
13 is not as robust as medication regulation."

14 Do you know whether NHS England took any action in
15 relation to that, for example raising the robustness of
16 regulation with the Department of Health and Social
17 Care, whether it be officials or ministers?

18 A. So this is the start of the national mental health
19 programme becoming aware of it as an issue, both from
20 the national patient safety angle, but also from the
21 stories that were starting to emerge in the media, and
22 Tim Kendall who was the National Clinical Director for
23 Mental Health at the time, and a colleague, has
24 obviously indicated here in a meeting that he is
25 surprised that the medical devices regulation is not as

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1 clear as he would expect in terms of the other
 2 implications, I think, from reading this, around consent
 3 that obviously would be an issue for him as a senior
 4 clinician.
 5 Q. And do you know whether any action was taken in relation
 6 to that?
 7 A. This is the start of the mental health programme within
 8 NHS England starting to take action and starting to
 9 respond to what we're hearing around vision-based
 10 monitoring systems, yes.
 11 Q. But there was no specific action that was taken in
 12 relation to the robustness of the regulation as was
 13 identified in that email?
 14 A. Yes, but that would not have been within the gift of NHS
 15 England to decide that the MHRA regulations weren't
 16 strong enough. This is a personal opinion being shared
 17 in an email, third party.
 18 Q. Thank you.
 19 If I may call up NHSE024225, this is an email being
 20 sent by, if we scroll down to page 3, please, this is an
 21 email shared internally within NHS England in relation
 22 to concerns that had been shared with somebody within
 23 NHS England, and if we scroll down to page, at the end
 24 of page 3, point 1, some of the concerns that were
 25 raised.

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1 be many patients for whom it is traumatising and
 2 psychologically harmful and I am certainly aware of a
 3 number of Trusts not giving the patients a choice to
 4 refuse to be filmed."
 5 Do you know whether any specific actions were taken
 6 in 2022 in relation to those risks identified in that
 7 email, specifically about the fact that use of
 8 vision-based monitoring systems reduces therapeutic
 9 engagement and also the privacy -- the privacy risk and
 10 the exacerbation of the mental health of patients?
 11 A. You'll see from the different fonts in this email that
 12 this is a cut and paste of comments that a colleague has
 13 received --
 14 Q. Yes.
 15 A. -- from people that we've engaged with around Oxehealth,
 16 Oxevision, and other vision-based monitoring systems
 17 that have been collected in a single point. But I think
 18 it's fair to say that at this point, this is a point
 19 where, as a mental health programme, we are starting to
 20 think about this in its implications for consent and
 21 consenting practices, the implication for -- on
 22 observations and the potential unintended consequences
 23 of the technology, but also in terms of wider privacy
 24 and human rights issues outside of purely the consent.
 25 So I think it is a useful point that shows, from this

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1 "The whole point of observations is that they are
 2 therapeutic (they are mostly not), but they are meant to
 3 be about building a therapeutic relationship with
 4 service users and having a more robust opportunity to
 5 assess safety and risk -- the best hope we have of
 6 knowing if someone is at risk of harm is talking to them
 7 and our best hope for keeping them safe is having
 8 a therapeutic conversation with the person. I cannot
 9 understand how this technology enables/supports this and
 10 would say it actively detracts from it."
 11 Then the second point is made, it says:
 12 "I think tech such as this, along with other
 13 approaches to make the ward environment 'safe',
 14 completely miss the point that the only way to make
 15 patients stay safe is to build a therapeutic
 16 relationship, help the person feel psychologically safe
 17 and to have a care plan which supports the person to
 18 increase their safety -- I worry that approaches like
 19 this lead to staff missing the point. They are about
 20 managing risk as staff see it, not focusing on patients
 21 feeling safe."
 22 Then the third point:
 23 "The use of CCTV is absolutely an infringement of
 24 people's human rights to privacy, but as you say, there
 25 may be some patients for whom it is helpful. There will

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1 point onwards, these are the lenses that we are, as
 2 a mental health team, starting to look at the
 3 technology, and then start to feed in to the range of
 4 actions that we took over the forthcoming three years.
 5 Q. Thank you.
 6 The Director of -- Deputy Director of Patient Safety
 7 appears to have left the NHS. You mentioned that she
 8 retired.
 9 A. Yes, they -- I think it's a gentleman but they retired.
 10 Q. That he retired, in March 2022, it appears from the
 11 correspondence recently disclosed by NHS England that he
 12 retired at the end of March 2022, and as a result, the
 13 communications, for example, with the MHRA were
 14 transferred to a different team within NHS England?
 15 A. My understanding is that it transferred elsewhere within
 16 the National Patient Safety Team to someone else who was
 17 working within that same team when that person retired.
 18 Q. It certainly appears from the disclosed correspondence
 19 that the interaction, the level of interaction with the
 20 MHRA and the level of focus on Oxevision issues appeared
 21 to tail off in 2022; is that correct? And if so, why
 22 was that?
 23 A. The National Patient Safety Team made a decision that
 24 the MHRA were the relevant regulators to be able to deal
 25 with the issues with the device and the communications

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1 around the device, but also alerted us as a mental
2 health programme around the wider policy implications
3 and the delivery of services that they had found through
4 their work, which was why, in October '21, the mental
5 health programme starts to look at the wider policy
6 issues around the vision-based monitoring systems.

7 **Q.** If we could then turn to the work of NHS England leading
8 to the development of the digital principles in
9 February 2025. At paragraph 53 of your first witness
10 statement, so that's NHSE023333, page 13, you state
11 that:

12 "In autumn 2022, NHS England developed the 'Good
13 Practice Principles in implementing vision-based patient
14 monitoring technology in mental health inpatient
15 settings' but that this was not published as NHS England
16 recognised that there was a need for further exploration
17 of service users and clinicians' views on [vision-based
18 monitoring systems]."

19 At around that time, in September 2022, the National
20 Mental Health and Learning Disability Nurse Director
21 Forum set up a working group also to consider
22 vision-based monitoring system and they subsequently
23 published their guidance, at paragraph 38 of your
24 statement, page 9, you say in the last sentence that:

25 "NHS England did not support that guidance."

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1 NHS taking responsibility at this stage for those issues
2 which you have sort of said to me earlier is a matter
3 for individual Trusts. How do you square that with what
4 you told me earlier?

5 **A.** I think there's a difference between taking
6 responsibility and being responsible for something.
7 There's a difference between that and seeing something
8 that might not be right, and asking those providers to
9 review their practices, which is what the letter does.
10 It's not -- in writing that letter, it didn't mean that
11 NHS England was suddenly legally or otherwise
12 responsible for the poor practice; that remained that of
13 the NHS providers.

14 **THE CHAIR:** But it does assume that you have the right to
15 identify how they take responsibility?

16 **A.** I think all the way through we've been wanting to
17 provide advice and guidance to providers that would help
18 them to provide higher-quality services to patients and
19 also potentially avoid them making a wrong decision that
20 might have legal implications for those providers.

21 **THE CHAIR:** Okay, and say they ignored that advice
22 completely, then what happens?

23 **A.** That would be the individual responsibility of each
24 board who was making that decision to ignore the advice
25 and guidance which we're offering.

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1 Why not?

2 **A.** The issue of consent, it was our view that, through that
3 guidance still assuming that implied consent was okay,
4 we firmly felt that that should not have been the case
5 and that individual consent should be seen -- should be
6 sought on every occasion that it was used and if someone
7 was not able to consent through their capacity, that the
8 relevant parts of the Mental Capacity Act should be
9 used. And we've been very clear on that throughout.

10 **Q.** Yes, and in fact in some of the recent disclosure from
11 NHS England, it appears that the NHS England took that
12 stance as far back as July 2023. Was that position
13 communicated to Trusts and providers at the time?

14 **A.** Yes, it was communicated in September '23 by a letter
15 from Tim Kendall to -- who was National Clinical
16 Director for Mental Health -- to Chief Medical Officers
17 and Chief Nursing Officers in every provider and also to
18 the Senior Responsible Officers within the ICBs and the
19 NHS England regions.

20 **THE CHAIR:** I'm sorry to go back to a point we've slightly
21 laboured already, but this is not a classic patient
22 safety response as you described it earlier; this is
23 proactive intervention in what I think you've described
24 as something that has wider policy implications and
25 implications for delivery of service. So here is the

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1 **THE CHAIR:** And what's the power of the NHS if they carry on
2 with that, and it has other implications for performance
3 or for patient safety? Do you not then feel that's your
4 responsibility to go in and performance manage that?

5 **A.** If it became a wider systemic issue around the wider
6 approach to patient safety or the quality of the
7 services or the delivery of their functions, then it
8 would be picked up through NHS England's Oversight
9 Framework of all providers and systems.

10 **THE CHAIR:** Okay.

11 **MS ONABANJO:** You've mentioned the September 2023 letter
12 that NHS England sent out to Trusts, and I'm going to
13 come to that. Prior to that letter, NHS England
14 commissioned Public Digital to carry out some work and
15 then it also commissioned the National Institute of
16 Health and Care Research to conduct a review and then we
17 come to September 2023, and there is the letter from NHS
18 England, and if I take you to paragraph 61 of your first
19 statement on page 15, you say that the letter was, in
20 the final paragraph:

21 "The letter was in response to the concerns raised
22 in the open letter sent by the NSUN and Stop Oxevision
23 in July 2023, and concerns from provider colleagues who
24 recognised a variation in the application of
25 vision-based monitoring systems in practice who were

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1 asking for a national steer."

2 Given that NHS England was aware, as I've just taken
3 you through, from early 2021 of concerns in relation to
4 the use of Oxevision, I've taken you through to the
5 concerns that were passed on to NHS England in 2022, why
6 did it take NHS England until September 2023 to issue
7 this letter to NHS Trusts?

8 **A.** I'll take you back to the previous document that wasn't
9 published, so we've responded in 2022 with those -- that
10 first guidance document which we didn't publish because
11 we didn't feel that in pulling that work together, that
12 we had involved experts by experience and people with
13 lived experience as much as we should, and we also
14 wanted to make sure that there were further review of
15 the evidence base before we made any communication out
16 to the system.

17 That's why we commissioned Public Digital to do that
18 additional work with people with lived experience and
19 that's why we also commissioned that wider research
20 review as conducted by the National Institute. So after
21 we'd received both of those reports and through the
22 raising of issues from survivors' networks and from the
23 start of Stop Oxevision, and other patient voices that
24 we were hearing, that's what led to the September
25 letter.

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1 NHSE024203 -- in the second paragraph, the second
2 sentence starting "However", it says:

3 "However, it is our view that any VBMS which
4 operates as a form of surveillance should never be
5 implemented in a blanket way and that any decisions to
6 use VBPMs in patient bedrooms should be made in
7 a person-centred way with the patients themselves where
8 they have capacity to make a decision or through a best
9 interests process compliant with the Mental Health
10 Capacity Act where they lack capacity to consent to the
11 monitoring system."

12 And it is your evidence that NHS England expected
13 Trusts to take corrective action following the receipt
14 of this letter.

15 **A.** The letter asks --

16 **Q.** Yes.

17 **A.** -- Trusts to review their practices. And yes, I think
18 it's pretty clear from the letter about what
19 NHS England's position is in terms of individual
20 consent.

21 **Q.** Did NHS ascertain whether Trusts reviewed their
22 practices following receipt of the September 2023
23 letter?

24 **A.** I'm not aware that we did.

25 **Q.** Why not?

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1 **Q.** But the findings of the Institute weren't published
2 until November 2024. At the time when NHS England
3 decided not to publish the draft guidance in autumn of
4 2022, is it not the case that it could have issued
5 something equivalent to the open letter setting out its
6 position? Why was it that it required essentially the
7 actions of Stop Oxevision and other patient bodies in
8 order for it to respond formally?

9 **A.** I don't think it did. I think we were in the process of
10 responding across those wide range of sources, but yes,
11 undoubtedly, patient voice coming forward, either from
12 Stop Oxevision or from elsewhere, of course we were
13 listening.

14 **Q.** You describe the September 2023 letter as a formal
15 communication. What is the status of formal
16 communication? How do you expect Trusts to take on
17 board what you have said in a normal communication?

18 **A.** NHS England, when it writes formally to the system, it
19 goes through a particular process for agreeing those
20 communications and sign-off, and it is published, as
21 well. We would expect NHS organisations, having
22 received a letter from the National Clinical Director
23 for Mental Health, to have quite significant due regard
24 to it.

25 **Q.** In the letter -- and if we may pull it up, it's

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1 **A.** I don't know the answer to that.

2 **Q.** The Inquiry has heard evidence, for example in relation
3 to EPUT and the implied consent model that it operated
4 at the time, which clearly wasn't consistent with
5 what -- the expectations that NHS England set out in the
6 letter. If NHS England sets out an expectation and then
7 doesn't follow through by overseeing what NHS Trusts do
8 in response to what it's requiring of them, its
9 oversight is ineffective, would you not agree?

10 **A.** I think this is misunderstanding the roles and powers of
11 NHS England. We have had -- in this letter, we have
12 submitted a request that they review their systems and
13 their processes and their use of VBMS, but also, as part
14 of this letter, there is advice and guidance to those
15 providers. As I outlined earlier on in my evidence,
16 that is different from NHS England having responsibility
17 and then discharging it via providers. Ultimately it is
18 for provider boards to make their own decisions around
19 how they use digital technology as they are also
20 responsible for patient safety and for the provision of
21 high-quality services.

22 **Q.** So what you're saying is that if NHS England issues
23 a formal communication stating that it expects
24 certain -- it expects that certain action to be taken in
25 relation to vision-based monitoring systems, individual

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1 Trusts can decide not to comply with what NHS England
2 says, and with impunity? There is no consequence from
3 NHS England, no enforcement or other action taken
4 against the individual Trusts?

5 **A.** Impunity is taking it too far. Where a letter like this
6 were to land with providers, to a Chief Medical Officer
7 and a Chief Nursing Officer, we would expect them to
8 undertake the review even if there wasn't a formal
9 checking mechanism, we would still expect them to
10 respond. And as we go through the process of the coming
11 years as NHS England develops its digital principles but
12 also other products, then ultimately, a failure to work
13 in line with best practice would be something that you
14 would be expecting other regulators such as the CQC and
15 their inspections to pick up. But the core element of
16 this is around consent. And the other legal
17 requirements that we are reminding providers around --
18 so whether NHS England is requiring of it or not or
19 checking of it or not there are some legal expectations
20 that are there for all providers.

21 **THE CHAIR:** But if you're suggesting that, in a way, it's
22 neither here nor there, this letter, because there are
23 legal responsibilities being identified in it, why does
24 NHS England bother to send a letter like that at all?
25 I mean, it must have expectations that it will be

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1 Trust systems, of which the severe -- incidents that
2 resulted in severe harm, I think is the technical term,
3 then get drawn into the National Patient Safety Database
4 which was that learning from, I can't remember the exact
5 acronym for it, but that national system. So it would
6 be primarily those severe and significant incidents that
7 the National Patient Safety Team would review in the
8 first instance. They would then go into that VRM
9 process, as I outlined earlier, and a decision would be
10 made to look at the wider incidents that might not have
11 been such severe harm but in order to look at a wider
12 picture to see if there were further patterns.

13 **Q.** Thank you. I'm now going to ask you questions about the
14 digital principles and the timeline of the publication
15 of the principles. You've already addressed in the
16 course of your evidence this morning the concerns that
17 were raised in 2021, 2022, we have the September 2023
18 letter, and then the digital principles were published
19 in 2025.

20 **A.** Yes.

21 **Q.** Did NHS England give consideration to whether, in the
22 interim period, before the publication of the digital
23 principles, whether some interim principles, interim
24 guidance, interim documents, ought to have been
25 published?

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1 adhered to, and it must also assume that it has a right
2 to expect adherence. Is that not implicit in this
3 activity, in writing these letters?

4 **A.** I think it's implicit, but that is different from the
5 questions I've had around powers or responsibilities.
6 I think, if you are a Chief Medical Officer within
7 a provider Trust and you get a letter like this from the
8 National Clinical Director for Mental Health, it would
9 be something that you would expect someone to have
10 significant due regard for.

11 **THE CHAIR:** Thank you.

12 **MS ONABANJO:** Chair, it's a convenient time to take a break.

13 **THE CHAIR:** Thank you.

14 **MS ONABANJO:** Fifteen minutes.

15 **THE CHAIR:** Fifteen minutes.

16 **(12.36 pm)**

(A short break)

18 **(12.51 pm)**

19 **MS ONABANJO:** Mr Harry, could you explain how NHS England
20 determines what amounts to a patient safety risk?

21 **A.** Do you mean a significant risk or do you mean any risk?

22 **Q.** Firstly, any risk, and then what type of patient safety
23 risk would NHS England investigate or take action in
24 relation to?

25 **A.** So the patient safety incidents get recorded on local

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1 **A.** I think the short answer is no. But the development of
2 the digital principles, we wanted to do it properly and
3 we wanted to make sure that providers were effectively
4 engaged, that providers of the digital systems were
5 properly engaged but also, and as importantly, that any
6 principles that we put out were co-produced with people
7 with lived experience of inpatient care, and so that
8 took time, in order to be able to put together what
9 I think is a really good piece of work.

10 **Q.** In your statement you reference the fact that Stop
11 Oxevision in particular raised concerns about the
12 digital principles, and some of the concerns they raised
13 were that the digital principles merely reiterate
14 pre-existing legal frameworks, that have not been
15 followed by many NHS Trusts, and that NHS England chose
16 to develop principles that are weaker than guidelines
17 which are also weaker than regulations and that the
18 document lacks any accountability or recognition of the
19 grave harms which are associated with vision-based
20 monitoring systems.

21 Did the -- what consideration did NHS England give
22 to these criticisms?

23 **A.** Of course we've listened, and of course we take into
24 account those views, but an organisation that is called
25 Stop Oxevision probably wasn't going to be satisfied

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1 with anything that didn't stop Oxevision and we have to
2 just respect that, as well. But I think the voice of
3 both that conference but also the work we've been doing
4 before and after in engaging a wide range of views from
5 people with lived experience has informed that -- those
6 digital principles.

7 **Q.** Taking the criticism in relation to the fact that the
8 principles are less strong than guidance, which are less
9 strong than standards which have binding effect, you
10 have said in the course of your evidence this morning
11 that, in a sense, NHS England does not -- doesn't
12 oversee compliance with non-binding standards and
13 doesn't take enforcement action. What, then, is the
14 purpose of the principles? What happens if -- if a
15 Trust fails to comply with every single principle, what
16 would the consequence be?

17 **A.** The principles are essentially advice and guidance for
18 each of those individual providers in discharging their
19 responsibilities, their legal responsibilities and other
20 responsibilities. Providers who are following that
21 guidance are less likely to find themselves being
22 challenged on a legal basis, whether that is by
23 individual patients or by other bodies, for their
24 failure to comply with either the legal requirements
25 that they've got or other requirements. And I think the

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1 **A.** We've discovered that there are ten Mental Health Trusts
2 currently who are not operating their consent mechanisms
3 in line with the digital principles.

4 **Q.** And what is -- what action does NHS England intend to
5 take in relation to those ten NHS Trusts?

6 **A.** We've shared that information with the CQC who are the
7 relevant regulator, both nationally and with each
8 regional inspection team.

9 **Q.** So in line with what -- in line with the evidence that
10 you've given this morning, NHS England itself will not
11 take any regulatory or enforcement or other action
12 against those providers?

13 **A.** Not directly, because it was advice and guidance, but
14 we've rightly, when we've discovered incidents where the
15 consent wasn't in line with what we think the principles
16 outline, we've rightly shared that information with the
17 relevant regulator.

18 **THE CHAIR:** Sorry, just remind me, when did you take that
19 action to inform CQC?

20 **A.** We informed them via email, I'd have to check on the
21 exact date, but we wrote to them on 2 October. But that
22 was after we'd had previous communication with them via
23 email and conversations.

24 **MS ONABANJO:** If I can add this, Chair, it was 2 October,
25 Friday. Last Friday.

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1 other thing to remember is that the, in terms of the
2 principles, they are there. I think it is fair to say
3 that they point out people's responsibilities to the
4 legislation, but it would have looked a strange document
5 if those weren't referred to at all.

6 **Q.** In relation to the monitoring of compliance, you state
7 in your second witness statement that a compliance audit
8 has been considered but it was agreed that further fact
9 finding should first be undertaken. What is the
10 difference between a compliance audit and fact finding
11 of the nature which you refer to in your witness
12 statement?

13 **A.** I think we're talking about two different time periods.
14 So there was definitely a decision not to conduct an
15 audit of behaviours against those principles. Later,
16 when Stop Oxevision have helpfully provided us with the
17 information about their work on non-compliance with the
18 principles, when they have shared that with us, we have
19 then followed that up at a later date this summer with
20 the fact-finding exercise conducted by NHS England
21 regional teams, conducted with each Mental Health Trust,
22 to test whether the findings of Stop Oxevision were the
23 reality. And that's the exercise that we've been
24 carrying out in recent weeks.

25 **Q.** And what has been the outcome of that exercise?

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1 **A.** Yes.

2 **THE CHAIR:** Last Friday?

3 **A.** Yes.

4 **MS ONABANJO:** In terms of the -- you set out some monitoring
5 mechanisms in your witness statement and that includes
6 the National Patient Safety Team. And we've already
7 looked at the role of the National Patient Safety Team.
8 In what circumstances are Trusts and other providers
9 required to send information to the team?

10 **A.** The Patient Safety Team?

11 **Q.** Yes, in what circumstances do Trusts feed information
12 into that learning reporting system that is then
13 accessible by the Patient Safety Team?

14 **A.** Sorry, I was interrupting. It's the other way around.
15 So the national database takes information from local
16 providers into a national repository and it will be
17 those severe, the severe harm incidents that it will
18 take at that point, but there is the ability to then
19 look and investigate further other incidents that
20 haven't resulted in severe harm, if that virtual
21 response meeting decides that it's something that
22 requires further investigation.

23 **Q.** Thank you. And so the process essentially requires --
24 relies on Trusts and providers adequately reporting
25 incidents that occur in their area?

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1 A. Yes, it relies on well-established clinical governance
2 and corporate governance mechanisms that every Trust,
3 should have in place.

4 Q. And is NHS England aware of a risk of gaps in reporting
5 that will then in turn affect the picture that NHS
6 England can get from the information that it extracts
7 from that national system?

8 A. Each individual Trust will have a policy and a procedure
9 around how it reports incidents, severe or otherwise,
10 and how it enters it into its local systems. Compliance
11 against those mechanisms and policies will be something
12 that will be part of any CQC visit or investigation.

13 Q. Could I ask you about information sharing between NHS
14 England and the Patient Safety Team in particular, and
15 MHRA. How does that work?

16 A. The MHRA have got full access to the -- under controlled
17 data processing agreements -- have full access to the
18 National Patient Safety Database.

19 Q. Thank you. You also refer to the Digital Safety Review
20 Group --

21 A. Yes.

22 Q. -- that was set up in January 2026. Was that set up in
23 response to the issues that the Inquiry was -- this
24 Inquiry is considering?

25 A. No, not directly. I think the virtual response meeting

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1 unrecognised, so that went -- from that clinical review
2 went into the VRM.

3 Q. In terms of the digital -- the Digital Safety Review
4 Group that was created in January 2026 and so that
5 wasn't in existence at the time of the 2021 incident
6 that was considered at the VRM, how do matters get
7 brought before that -- this new group that has been
8 established?

9 A. The same process that would result in previously things
10 being considered by the VRM, if they're related to
11 digital technologies, then now they will be trained by
12 that Digital Safety Reference Group.

13 Q. And given the concerns that have already been raised in
14 relation to Oxevision, why has that -- the use of
15 Oxevision, not come before the group?

16 A. At the moment that group has not been considering
17 retrospective incidents that have -- that arose, but
18 there is nothing intrinsically to stop it doing that.

19 Q. Finally, you say in your statement that NHS England has
20 been following the evidence relating to Oxevision that
21 has been shared with the Inquiry. How and via what
22 mechanism does NHS England intend to harness the work of
23 the Inquiry to inform its approach to video-based
24 monitoring systems?

25 A. I think what we're learning is much wider than the

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1 decided that it needed to have a more specialist group
2 as a -- working alongside it in order to pick up wider
3 patient safety issues, not just from this vision-based
4 monitoring systems issues, but across the wider
5 implementation of digital and -- digital technologies
6 across the whole of the NHS. So its remit is much wider
7 than purely mental health.

8 Q. What is the criteria for referral to the group, the
9 review group?

10 A. The review group would rely -- so the National Patient
11 Safety Team is a group of clinicians that are reviewing
12 every single one of those incidents that come up where
13 there is severe harm. Where that reviewer, as with the
14 original case here in 2021, sees within the narrative or
15 within an incident something that is either new or
16 emerging, they will take that incident to the VRM for a
17 wider discussion and then the VRM will decide whether
18 something is -- requires further investigation or not.
19 Has that answered your question? I'm not sure ...

20 Q. Not quite. I just want to understand how incidents
21 essentially move up to be considered by the review
22 group. What is the -- yeah, what is the criteria? Or
23 is there a criteria, what is the -- (overspeaking) --

24 A. I think there are a range of criteria, but the one for
25 this one was something that was new and previously

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1 vision-based monitoring systems. So I think, as a team,
2 we have been really struck by the expert evidence
3 submitted by the expert nurse Jill Archibald and
4 Dr Denham (*sic*), much more widely around the use of
5 observations, full stop. So we're listening carefully
6 and we're considering what future actions we want to
7 take, things that perhaps could go further than our
8 culture of care work that we've been doing to look at
9 how we can not just learn lessons from the
10 implementation of Oxevision by individual Trusts but the
11 wider approach to relational work on the wards and that
12 importance of that as a culture of care.

13 MS ONABANJO: Thank you.

14 Chair, those are my questions.

15 THE CHAIR: I have no further questions.

16 MS ONABANJO: We will now take ten minutes for Rule 10s.

17 THE CHAIR: Thank you. We will be back in ten minutes.

18 (1.07 pm)

19 (A short break)

20 (1.18 pm)

21 THE CHAIR: Ms Onabanjo.

22 MS ONABANJO: Mr Harry, earlier in the course of your

23 evidence you talked about the NHS Innovation

24 Accelerator, and about the potential risks of

25 independently assessing devices that have been supported

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1 by the NIA. You told us that the rules around
2 procurement provide a safeguard in relation to that. To
3 what extent is there also a role for NHSE alongside the
4 procurement rules that you mentioned in ensuring the
5 independence of decision making when commissioning new
6 technology?

7 **A.** Can you ask that again? I'm sorry.

8 **Q.** When discussing the risks that commissioning decisions
9 may not -- there is a risk of a lack of independence in
10 relation to new technology that was supported by the
11 NIA, you said that that risk, the safeguards against
12 that risk are the laws and the rules in relation to
13 procurement, and so my question is, does the NHSE have
14 a role alongside that in ensuring that that independence
15 is maintained in relation to commissioning decisions?

16 **A.** NHS bodies are under direction that they need to be
17 working within procurement regulations and competition
18 law, partly as a public body that they need to be
19 working within those requirements, legal requirements,
20 but also via, I understand, the NHS standard contract
21 also requires particular actions on when it comes to
22 commissioning and procurement of services, as well. So
23 there are a number of responsibilities that an NHS
24 provider has to make sure that when they are making
25 procurement provisions they're doing so in a transparent

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1 between he understands the regulations are pertaining to
2 clinical services and professional regulations, and
3 those pertaining to the devices regulated by the MHRA.
4 So he's expressing surprise at that difference there.
5 But I think that's slightly different from the comments
6 that are made from the Deputy Director of Patient
7 Safety.

8 **Q.** Thank you. Finally, what powers and responsibilities
9 does NHS England have in relation to patient safety?

10 **A.** Well, it can issue national patient safety alerts. So
11 in those circumstances, and there is a threshold for
12 issuing those alerts, it can require certain treatments
13 or certain products or certain ways in which the health
14 and care is delivered to stop or change in response to
15 patient safety incidents.

16 **MS ONABANJO:** Thank you.

17 Chair, we'll now break for 45 -- we'll now break for
18 50 minutes and return at 2.15 pm.

19 **THE CHAIR:** 2.15. But you are now released. Can I thank
20 you very much indeed for coming to give evidence.

21 **THE WITNESS:** Thank you.

22 **THE CHAIR:** I'm very grateful, thank you.

23 (1.24 pm)

(The Short Adjournment)

24 (2.15 pm)

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1 and fair way.

2 **Q.** Thank you. Are you aware of whether there are any
3 planned changes to the scope of NHSE's regulatory and/or
4 supervisory functions in respect of patient safety and
5 the digital technology we've been discussing today as a
6 result of the proposed changes to NHSE and its
7 incorporation within the Department of Health and Social
8 Care?

9 **A.** I'm not aware of any changes. No, I'm not.

10 **Q.** In the course of your evidence I took you to
11 a 17 March 2022 email which was sent by the Deputy
12 Director of Patient Safety, where he indicated that he
13 had appealed to Oxehealth's better nature to reduce
14 identified risk even if they were not legally required
15 to, and he referred to "Alarm that medical device
16 regulation is not as robust as medical regulation". In
17 to answer that, you said that NHS England did not do
18 more because it was not in your gift. Does this mean
19 that you consider that there is a gap in the regulatory
20 framework?

21 **A.** I think there are two different statements within that
22 email there. One is from the Deputy Director of Patient
23 Safety and the other one is him quoting Tim Kendall.

24 **Q.** Yes.

25 **A.** So Tim has made the comments there around the difference

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(Proceedings delayed)

2 (2.17 pm)

3 **THE CHAIR:** Mr Wakerley.

4 **MR WAKERLEY:** Thank you, Chair. This afternoon, we are
5 returning to the topic of emergency response and
6 resuscitation and we are ready to hear from our
7 witnesses this afternoon. We intend to call both
8 witnesses at the same time, Ruth Bradley and Rebecca
9 Lingard. And they will give evidence about the policies
10 and the practice of resuscitation emergencies within the
11 East London NHS Foundation Trust, or ELFT. And to
12 remind parties that the purpose of this evidence is to
13 explore and illustrate how this subject is dealt with
14 within a comparator Trust.

15 And I think we are ready for both witnesses to be
16 sworn, please.

17 **RUTH BRADLEY (sworn)**

18 **REBECCA LINGARD (sworn)**

19 **Questioned by MR WAKERLEY**

20 **MR WAKERLEY:** Again, then, just perhaps to start by
21 confirming -- Ms Bradley, you're sitting furthest away
22 from the Chair to her right, and Ms Lingard, you are
23 slightly nearer to the Chair to Ms Bradley's left.

24 Ms Bradley first, please. You provided a witness
25 statement to the Inquiry, didn't you --

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1 **MS BRADLEY:** I did.
 2 **Q.** -- dated 19 June this year. Do you have a copy of that
 3 in front of you?
 4 **MS BRADLEY:** I do.
 5 **Q.** You've signed the final page, which bears a statement as
 6 to the truth of that statement; is that right?
 7 **MS BRADLEY:** It is.
 8 **Q.** You've had an opportunity to read it again before coming
 9 in to the hearing room this afternoon?
 10 **MS BRADLEY:** Yes.
 11 **Q.** Is there anything that immediately you wish to amend as
 12 to its content?
 13 **MS BRADLEY:** There was a reference to a Nurse Consultant on
 14 one of the pages and actually, it should read "Physical
 15 Health Lead Nurse", not "Nurse Consultant".
 16 **Q.** All right. Well, I think we will trespass upon that
 17 a little later on but it's your paragraph 54, perhaps if
 18 that could be put up on screen, please, page 21 of your
 19 only statement of 19 June, at paragraph 54. You refer
 20 there to "additional specialist support is available
 21 through the Physical Health Nurse Consultant" --
 22 **A. (The witness nodded).**
 23 **Q.** -- and I think you just clarified -- could you say that
 24 again, please?
 25 **MS BRADLEY:** Physical Health Nurse.

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1 that for us as I ask you questions as we go along. But
 2 can you confirm that the content of your statement of
 3 3 September is true and accurate to the best of your
 4 knowledge and belief?
 5 **MS LINGARD:** That's correct.
 6 **Q.** Ms Bradley, just a little bit about you, then, first,
 7 please. You are the current Director of Nursing for
 8 ELFT and you've been in that position since February of
 9 2018; is that right?
 10 **MS BRADLEY:** Yes.
 11 **Q.** Prior to that you were Director of Care at St Joseph's
 12 Hospice in Hackney, and I think before then you are
 13 a Registered Nurse?
 14 **MS BRADLEY:** I am.
 15 **Q.** And you have any practical experience of resuscitation
 16 incidents or emergencies on wards prior to your
 17 leadership roles?
 18 **MS BRADLEY:** Yes, I do. I was a ward sister for almost
 19 10 years at Bart's Health, during which time
 20 I experienced resuscitation attempts and identified
 21 deteriorating patients but the actual number of
 22 occasions in reality were very few. But as a ward
 23 sister and leader, clinically, I had to keep abreast of
 24 resuscitation technique and training.
 25 **Q.** Thank you, but given your role now, you can help the

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1 **Q.** So a Physical Health Nurse, they're not a consultant?
 2 **MS BRADLEY:** That's right.
 3 **Q.** I see, okay, thank you. But other than that, you're
 4 content that the contents of your statement are true and
 5 accurate to the best of your knowledge and belief?
 6 **MS BRADLEY:** I do, yes.
 7 **Q.** Ms Lingard, I've got the same question for you. You
 8 gave us a statement, didn't you, but yours is dated
 9 3 September?
 10 **MS LINGARD:** That's correct.
 11 **Q.** And again, you have signed it on the last page as to its
 12 truth; is that right?
 13 **MS LINGARD:** That's correct.
 14 **Q.** Have you seen it again before coming in today?
 15 **MS LINGARD:** Multiple times, yes.
 16 **Q.** Multiple times, thank you.
 17 Did you have anything that immediately you wished to
 18 amend as to its content?
 19 **MS LINGARD:** There was just some clarification around the
 20 numbers of resus or medical emergencies that I have been
 21 physically involved with and I didn't want my statement
 22 to make it look as if that had been a large amount so
 23 I wanted to be a bit clearer on how many resus events
 24 I'd been involved with.
 25 **Q.** Thank you, and I'll give you the opportunity to clarify

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1 Inquiry with the Trust's overarching Resuscitation
 2 Policy, can't you? And can you perhaps begin by giving
 3 us some idea of the size of the Trust and the areas in
 4 which it operates, please?
 5 **MS BRADLEY:** Yes. So we are a large Trust across East
 6 London and Luton and Bedfordshire. We've multiple
 7 sites, so, you know, the geography is large. We have
 8 over 9,000 staff and have increased in size in the
 9 eight years that I've been employed with ELFT.
 10 **Q.** I think, again, sorry to interrupt you, but we'll look
 11 at some of the question of numbers of staff as we move
 12 through your evidence, but thank you for that.
 13 Moving then, please, to you, Ms Lingard. Again, if
 14 I summarise it, if I've got this right, please let me
 15 know.
 16 You've been involved in the caring profession for
 17 almost 35 years. Currently, you are the Borough Lead
 18 Nurse for ELFT.
 19 **MS LINGARD:** Correct.
 20 **Q.** You began as a care assistant, then qualified as
 21 a Registered Mental Health Nurse in 2003. You've been
 22 involved in training, you've been involved in research,
 23 and you have been a contributing author to published
 24 works --
 25 **MS LINGARD:** Correct.

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1 Q. -- that you identify in your statement.
 2 MS LINGARD: Correct.
 3 Q. You tell us your experience within ELFT includes matron,
 4 2017 to '18 for a women's Psychiatric Intensive Care
 5 Unit, and a women's acute inpatient unit; 2018, lead for
 6 nurse development programmes at ELFT?
 7 MS LINGARD: (The witness nodded).
 8 Q. 2019, you were seconded to a different Trust as
 9 Associate Director and then, since February of 2020 and
 10 to date, you are the Borough Lead Nurse for City and
 11 Hackney Centre for Mental Health and that was formerly
 12 known as the Homerton Mental Health Services unit.
 13 You tell us this: you're responsible for all
 14 inpatient mental health settings there --
 15 MS LINGARD: (The witness nodded).
 16 Q. -- which include four acute adult wards, one Early
 17 Intervention Service, one male Psychiatric Intensive
 18 Care Unit, one regional mother and baby unit, and two
 19 health-based place of safety suites and hospital site
 20 services; is that right?
 21 MS LINGARD: That's correct.
 22 Q. I think this is right: that you can help us with the
 23 processes that the training and procedures, as in
 24 practice at the City and Hackney inpatient setting, but
 25 also across parts of your career; is that right?

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1 Q. Of resuscitation, please.
 2 MS LINGARD: I've been physically involved in two episodes
 3 of resuscitation, one of which I detail in my statement,
 4 and I had a second experience in an elderly care
 5 service, but being a leader and in a leadership role,
 6 I have been aware and have been involved in cardiac
 7 events and resus incidents that I'm aware of by being
 8 the Borough Lead Nurse and supporting staff and service
 9 users.
 10 Q. Thank you.
 11 THE CHAIR: Can you give a number for those? Could you put
 12 number on it?
 13 MS LINGARD: It would be difficult. It would be very
 14 difficult.
 15 THE CHAIR: More or less than 20, 30?
 16 MS LINGARD: I would say probably more than -- for resus
 17 specific?
 18 THE CHAIR: Yes.
 19 MS LINGARD: I would say no more than 20. Probably no more
 20 than ten.
 21 MR WAKERLEY: And so we're clear, that's a career spanning
 22 over 35 years?
 23 MS LINGARD: Correct.
 24 Q. But one that specifically you've referred to in your
 25 statement took place not at City and Hackney; it took

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1 MS LINGARD: Correct.
 2 Q. And so the first topic I want to ask you about, please,
 3 is to you, Ms Lingard, which is your direct experience
 4 of emergency response which has involved resuscitation
 5 events; all right?
 6 MS LINGARD: Mm-hm.
 7 Q. You tell us in your statement, and for those following,
 8 that's paragraph 42 of your statement, that you've had
 9 multiple occasions across your career when you've been
 10 involved in such incidents, but I think you wanted to
 11 clarify, when you first started to give evidence this
 12 afternoon, as to what that means, "multiple occasions".
 13 Can you give us some idea, please?
 14 MS LINGARD: Yes. So through the course of my career I have
 15 been involved in multiple medical emergencies,
 16 deteriorating patients with service users under my care.
 17 I've had direct experience of participating in resus and
 18 that was the distinction I wanted to make and clarity of
 19 my statement.
 20 Q. Thank you. Insofar as direct involvement in
 21 resuscitation emergencies, across your career, can we
 22 get an idea of the scale of that, that you've
 23 experienced? Is it many hundreds of occasions or far
 24 less than that?
 25 MS LINGARD: Sorry, of resus or medical emergencies?

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1 place in Tower Hamlets on a ward called the Rosebank
 2 ward which was a female Psychiatric Intensive Care Unit;
 3 is that right?
 4 MS LINGARD: That's correct.
 5 Q. You make the point in your witness statement that that
 6 ward was not covered by an acute hospital emergency
 7 resuscitation team?
 8 MS LINGARD: Mm-hm.
 9 Q. Unlike the City and Hackney, the Homerton, which is
 10 covered being an acute hospital emergency resus team; is
 11 that right?
 12 MS LINGARD: That's correct.
 13 Q. I want to ask you about that incident, and you weren't
 14 able to pinpoint for us exactly when it happened, but
 15 you make the point that it is some time ago but it's
 16 still recent enough in your mind that the events are
 17 memorable?
 18 MS LINGARD: Correct.
 19 Q. For the avoidance of doubt, I'm focusing on staff rather
 20 than the patient themselves. But this began as
 21 a choking incident, as I understand it?
 22 MS LINGARD: Yeah.
 23 Q. Can you tell us, where were you when you became aware of
 24 the fact of an incident?
 25 MS LINGARD: I was in my office which is situated on

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1 Rosebank ward, adjacent to the dining room, and I have
 2 a window in my office, a large window so that I can see
 3 out and people can see in, so I was very close to the
 4 dining room where the incident was taking place.
 5 **Q.** You tell us in your statement that you were alerted to
 6 it because you heard staff shouting for help --
 7 **MS LINGARD:** Correct.
 8 **Q.** -- and pulling alarms?
 9 **MS LINGARD:** Yes.
 10 **Q.** Now, first question: do you mean multiple members of
 11 staff shouting and multiple members of staff pulling
 12 alarms or was it a single; can you help us with that?
 13 **MS LINGARD:** It was lunchtime, and on a psychiatric
 14 intensive care unit, the focus is maintaining a safe
 15 meal service, bringing all the service users together.
 16 So normally most of the staff would be in that day area
 17 supervising meals. So my recollection is that multiple
 18 staff were calling for help and the alarms were pulled.
 19 **Q.** So we understand that, another member of staff would
 20 pull an alarm even though they were aware that an alarm
 21 was already sounding?
 22 **MS LINGARD:** Possibly -- that might happen. People might
 23 just automatically pull the alarm when they can already
 24 hear it sounding but I do recollect that there were
 25 appropriate shouts for help and the alarms were pulled.

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1 **MS LINGARD:** Yes, all staff have an alarm. We have two
 2 different alarm systems in City and Hackney. We can
 3 have pinpoint alarms, the same ones from Rose Bank that
 4 can be signed out from Security, particularly if we have
 5 visitors or perhaps temporary staff or bank staff that
 6 come, and then for regular staff, substantive staff that
 7 are on a particular ward, they have an alarm that's
 8 attached to their identification badge, but it works on
 9 the same system, just a different vehicle for delivery.
 10 **Q.** And the same question: that is all staff regardless of
 11 the role that they fulfil, regardless of whether they're
 12 a registered practitioner --
 13 **MS LINGARD:** Correct.
 14 **Q.** -- or a healthcare worker or assistant, or otherwise?
 15 **MS LINGARD:** Correct.
 16 **Q.** Ms Bradley, can I just ask you then, please, on that,
 17 the Trust Resuscitation Policy current, that you've
 18 helpfully provided refers to pinpoint alarm system, and
 19 I think that's what Ms Lingard has just told us about --
 20 **MS BRADLEY:** Yes.
 21 **Q.** -- and also two-way radios for summoning immediate
 22 assistance. Is that another facility? Is that
 23 different or in some way separate to the alarms we've
 24 already heard about?
 25 **MS BRADLEY:** That's an additional facility.

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1 **Q.** Did all staff have an alarms?
 2 **MS LINGARD:** All staff have access to an alarm, yes.
 3 **Q.** When you say "have access to an alarm", do all staff
 4 have an alarm with them at all times?
 5 **MS LINGARD:** Yes, they sign it out, or at that point on
 6 Rosebank ward, the procedure was to sign out an alarm
 7 and a set of keys for the duration of that shift.
 8 **Q.** Is that all staff regardless of the role that the member
 9 of staff was performing?
 10 **MS LINGARD:** Correct.
 11 **Q.** And again, to help us, are there different types of
 12 alarm?
 13 **MS LINGARD:** On Rosebank ward they were called PIT alarms,
 14 so they are part of the integral alarm system, the
 15 fabric of the unit. So we always -- also used to have
 16 rape alarm so, you know, what some women in society
 17 sometimes use, but it was always the operational
 18 standard was to wear a PIT alarm.
 19 **THE CHAIR:** Where were you wearing it?
 20 **MS LINGARD:** It goes on a loop and it sits on a belt, so
 21 part of the requirements of working a shift on Rosebank
 22 ward was to wear a belt so you could have the alarm.
 23 **MR WAKERLEY:** So that's the incident then. What about now
 24 on City and Hackney? Is it the same? Do all staff have
 25 an alarm?

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1 **Q.** Again, who would be provided with a two-way radio?
 2 **MS BRADLEY:** My understanding is it's the Duty Senior Nurse
 3 that would be coordinating the radios.
 4 **Q.** Right. So not every member of staff would have that,
 5 but every member of staff would have the pinpoint alarm?
 6 **MS BRADLEY:** They would, yes.
 7 **Q.** Back to the incident then, please, Ms Lingard. You
 8 heard the alarm or shout, or both, and you responded?
 9 **MS LINGARD:** (The witness nodded).
 10 **Q.** Did anybody else respond, please?
 11 **MS LINGARD:** The ward manager responded as well, multiple
 12 colleagues who were working on that shift were already
 13 at the site of the incident, the alarms were pulled, the
 14 Duty Nurse attended with the Rapid Response Team.
 15 **Q.** All right, just pause there. That's the Duty Senior
 16 Nurse, is it?
 17 **MS LINGARD:** Yes.
 18 **Q.** What about a doctor, did a doctor attend?
 19 **MS LINGARD:** There was a doctor there immediately, or very
 20 close to the alarm being pulled.
 21 **Q.** Just help the Inquiry, please. How was the doctor
 22 summonsed? Did they just respond to the alarm too, or
 23 were they separately called, do you know?
 24 **MS LINGARD:** I can't recall specifically, but I can very
 25 clearly see that they were, in my mind, as I'm recalling

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1 the events, they were on scene very quickly.
 2 **Q.** You've mentioned the Duty Senior Nurse, you've also
 3 mentioned the Rapid Response Team which I'm going to
 4 come back to a little later on, that role. But what
 5 I want you to help with, on this particular incident,
 6 how, when a different number of people are arriving, how
 7 are people deciding upon who did what? How are roles
 8 determined?

9 **MS LINGARD:** So I rushed out of my nursing office, and
 10 I guess in my role, took over the leadership of
 11 responding, and I can remember myself and the Ward
 12 Manager went in to do the immediate interventions that
 13 were necessary for a choking incident. I remember the
 14 doctor on the ward and I remember the doctor came to
 15 assist and it was the doctor at that point that
 16 requested that we lay the patient on the floor. At the
 17 same time, our medical emergency equipment was being
 18 collected.

19 **Q.** Just pausing there for a moment then, please. Can you
 20 tell us at this point, did you sense any element of
 21 panic amongst staff members?

22 **MS LINGARD:** Yeah, I think they are such rare events in the
 23 field of mental health care, and it's not something that
 24 we deal with every day. And the service users that we
 25 are looking after are individuals that we work with,

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1 users very quickly away and pre-occupy and distract them
 2 and offer, you know, support and care and reassurance.
 3 **Q.** Is that members of the team that were dealing with the
 4 emergency response that are then having to, in effect,
 5 take on another role in almost controlling the wider
 6 environment rather than concentrating on the person who
 7 is going through the emergency?

8 **MS LINGARD:** It's complex in that sometimes service users
 9 respond differently to different staff members and
 10 I think when we have these emergencies, we swap out
 11 roles to maintain as much safety as possible, either in
 12 managing the service users secondary to the resus event.
 13 So we would quite often rotate but the general team on
 14 the ward would know the patients the best and would
 15 therefore be in the best position to support them.

16 **Q.** Now, you tell us that in this incident, what began as
 17 a choking incident deteriorated?

18 **MS LINGARD:** Yes.

19 **Q.** And you tell us that emergency equipment was brought.
 20 How quickly was that equipment brought to the scene?
 21 Can you help us with that?

22 **MS LINGARD:** Seconds. It arrived in seconds. It was in the
 23 treatment room which is very close to the dining room.

24 **Q.** And you tell us in paragraph 43 that the equipment that
 25 was used, I can remind you, Ms Lingard, was an automatic

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1 unfortunately over lengthy periods of time, and we
 2 develop lovely relationships with them. And that adds
 3 to the intensity and the stress of having to respond to
 4 that.

5 **Q.** And you told us this took place, this particular
 6 emergency takes place in the lunch area?

7 **MS LINGARD:** Yeah.

8 **Q.** Presumably there were other service users in that area?

9 **MS LINGARD:** And that's another complicating factor to
 10 responding to either a medical emergency or a resus
 11 event: that you have the primary incident that you're
 12 managing and then you have a cohort of service users
 13 that are witnessing this, and their mental health
 14 presentations may provide a challenge in terms of how we
 15 support them, thinking about how distressful that is.
 16 On the intensive care unit we might have people who are
 17 distressed and display that through violence and
 18 aggression so that's another layer of behaviour.

19 **Q.** Now, on this particular incident that you're recalling
 20 was there that sort of reaction, do you recall, at the
 21 time: that there was either distress or behaviours from
 22 other service users who were reacting to what they were
 23 seeing taking place?

24 **MS LINGARD:** I remember the distress, and I remember that
 25 some of my colleagues were trying to move the service

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1 external defibrillator and a bag valve mask with
 2 high-flow oxygen.

3 **MS LINGARD:** Correct.

4 **Q.** You've already answered I think the first question: were
 5 there any issues finding those items?

6 **MS LINGARD:** No.

7 **Q.** You've told us where they were kept. Did everyone know
 8 where they were?

9 **MS LINGARD:** Yes.

10 **Q.** And in your experience, direct experience, have there
 11 ever been issues with the finding of emergency equipment
 12 when they're needed?

13 **MS LINGARD:** Not in my direct experience, no.

14 **Q.** Likewise, have there been issues with, in your
 15 experience, with staff not knowing how to use the
 16 equipment when it arrives?

17 **MS LINGARD:** Not in my experience that I can recall, no.

18 **Q.** What, at the time, was your level of life support
 19 training, please?

20 **MS LINGARD:** ILS training.

21 **Q.** So immediate life --

22 **MS LINGARD:** Life support.

23 **Q.** We know from your statement that ultimately an ambulance
 24 arrives but prior to the ambulance arriving, was there
 25 anyone present with advanced life support skills in this

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1 particular incident?

2 **MS LINGARD:** I can't, I can't remember.

3 **Q.** You told us there was a doctor?

4 **MS LINGARD:** There was a doctor, yeah.

5 **Q.** Would they have had advanced life support skills, do you

6 know?

7 **MS LINGARD:** I would have thought so, yeah.

8 **Q.** When you describe the incident in your statement you say

9 that the defibrillator did not advise a shockable

10 rhythm --

11 **MS LINGARD:** Correct.

12 **Q.** -- and that somebody called an ambulance and just in

13 that process, do you remember how it was that -- or when

14 it was, that the decision was made to call for an

15 ambulance? Was that immediate or --

16 **MS LINGARD:** It would have been immediately. It would have

17 been immediately.

18 **Q.** Again, who was it? Did someone instruct that an

19 ambulance be called or someone make that call? Or did

20 it just happen?

21 **MS LINGARD:** It didn't just happen. It would have been an

22 instruction. I can't recall if it was me. I can't

23 recall specifically who called the ambulance but an

24 ambulance was called. I'd be very surprised if, as

25 a manager or matron of that ward, I didn't check on

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1 **Q.** You tell us that in this particular incident, the

2 ambulance took over 20 minutes to arrive on scene?

3 **MS LINGARD:** Correct.

4 **Q.** As in to patient's side; is that right?

5 **MS LINGARD:** Correct.

6 **Q.** Were there issues with the ambulance staff getting

7 access to where you were?

8 **MS LINGARD:** That was never raised to me as an issue, no.

9 **Q.** So did you know why it took so seemingly long for the

10 ambulance to arrived?

11 **MS LINGARD:** Operational pressure, I believe.

12 **Q.** Upon whom?

13 **MS LINGARD:** Upon the Ambulance Service.

14 **Q.** And in terms of the question I asked a moment ago about

15 whether there were issues with the ambulance staff

16 getting access to where you were, have you on any other

17 occasion experienced that sort of issue with staff,

18 ambulance staff, responding, not getting access to the

19 patient's side?

20 **MS LINGARD:** Not from my recollection, no.

21 **Q.** And you did tell us that one of the team went to meet

22 the ambulance. And again, how was that decided? Who

23 takes that role and who gives that instruction?

24 **MS LINGARD:** The Duty Senior Nurse would do that, and it

25 would be a member of staff that's familiar with the

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1 knowing that there was a very significant incident

2 happening, that an ambulance hadn't been called for.

3 **Q.** Within this particular ward, we're talking about this

4 ward, we know there wasn't an acute resuscitation team

5 liaison with the ward. How were or whoever called for

6 the ambulance, they must have simply used the standard

7 route. Do you know the route they would have used to

8 summons the ambulance? A 999 call, for example?

9 **MS LINGARD:** It would have been with an extra 9, to get an

10 outside --

11 **Q.** An outside line.

12 **MS LINGARD:** -- line and that person would have been

13 instructed to go to the main part of reception in order

14 to accompany the ambulance crew directly to the scene.

15 **Q.** Now, just in terms of the fact that it would have been

16 a 999s number, how would staff at that time have known

17 that?

18 **MS LINGARD:** It's part of the training, and there are

19 posters on the wall and it's just known as part of the

20 induction that you need to press 9 to get an external

21 line because of the internal phone system.

22 **Q.** I think you've just told us there are posters up too?

23 **MS LINGARD:** Yes.

24 **Q.** And again, multiple?

25 **MS LINGARD:** Yes.

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1 unit, and the intensive care unit is a swipe access ward

2 anyway so you would need to be able to accompany the

3 ambulance crew into the unit.

4 **Q.** In this particular incident, we know from your statement

5 at paragraph 43 that ultimately, the patient recovered

6 from this incident. It was a successful outcome.

7 And you go on to say that after you went to meet

8 with the patient, asked them if they wanted to talk

9 about what happened, and then discussed that with them.

10 **MS LINGARD:** The patient approached me, actually. So I went

11 to the Royal London on a couple of occasions to visit

12 and to check in with the treating team there, and then

13 when the patient returned to Rosebank I was sat in my

14 office with my door open, which was my normal practice,

15 and she walked in and sat down, and she said something

16 like "Becky, something serious has happened to me,

17 hasn't it?" And I said, "Yes, it has."

18 And she sat there and I could see that she was deep

19 in thought, and I asked her: "Did you want to know some

20 more details?" I didn't want to make the assumption

21 that she would want to relive a traumatic experience.

22 I didn't want to retraumatise her. And she said that

23 she did want to know what happened so out of respect and

24 using my skills as a Mental Health Nurse, I took her

25 through it very briefly to explain what had happened and

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1 sat with her.

2 **Q.** Just on that topic, please. You told us you visited the

3 patient in the acute hospital?

4 **MS LINGARD:** Correct.

5 **Q.** Again, was that something you're trained to do as part

6 of -- or is that something you simply took on board

7 yourself?

8 **MS LINGARD:** Um, as a nurse responsible for that service and

9 the care, I felt it was my duty to go down and to visit

10 with her, and to offer guidance and support to the

11 medical team that were looking after her. It's

12 a continuity of care issue as well, and to maintain

13 contact with any families that wanted some support, as

14 well. And I feel very strongly that that is my job.

15 **Q.** Entirely understanding your answer, but just bringing it

16 back to my question, if I can. Are you trained to do

17 that or is that something off your own ... your own

18 decision making, given the role you've taken on and how

19 you choose to use your occupation?

20 **MS LINGARD:** So I don't remember doing a training course

21 around visiting other hospitals, but it speaks to MDT

22 working and collaboration and collegiate working which

23 does form part of nurse training, and leadership and

24 kind of managerial. I suppose, I did take it upon

25 myself probably to go the extra mile.

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1 I mean did it go to the Trust generally?

2 **MS LINGARD:** I can't recall. It was quite a number of years

3 ago. I can't recall. But there would have been an

4 incident review, a reported investigation, given the

5 seriousness of it.

6 **Q.** That's another of the following-on questions. Was any

7 learning or its dissemination documented?

8 **MS LINGARD:** It would have been but I can't recall the name

9 of the document, I'm afraid.

10 **Q.** But is the effect of your evidence that you anticipate

11 that it went wider than just the ward? It would go to

12 the Trust generally?

13 **MS LINGARD:** Yes.

14 **THE CHAIR:** Can I ask a question just before we move much

15 further from this. You told us that it had a -- the

16 ward had a 9999 system --

17 **MS LINGARD:** Mm-hm.

18 **THE CHAIR:** -- because you needed an outside line. In that

19 case, you told us that it hadn't been an issue, staff

20 knew about it. In the other cases that you've been

21 aware of which you've told us about, has that need for

22 an outside line caused issues?

23 **MS LINGARD:** No, not to my knowledge, no.

24 **THE CHAIR:** Thank you.

25 Sorry to interrupt.

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1 **Q.** That's you supporting --

2 **MS LINGARD:** Yes.

3 **Q.** -- the patient. What about support for you and the

4 other staff members who were involved within the

5 emergency response? Do you remember, was there support

6 for you, either individually or collectively, after the

7 incident had settled?

8 **MS LINGARD:** There was support. There was a debrief. And

9 the Borough Lead Nurse at the time, so the person doing

10 my role, he came down during the incident and supported

11 practically, and then helped myself and the Consultant

12 Psychiatrist debrief the team that had been impacted.

13 **Q.** And from this particular incident, do you remember, was

14 there any learning that was then disseminated from this

15 particular emergency resuscitation?

16 **MS LINGARD:** So what I can recall is it started as a choking

17 incident and the service user had got a diagnosis of

18 learning disability and I think there's a well-known

19 kind of recognition that choking in learning

20 disability -- patients with learning disability might be

21 more at risk of that. So that was picked up as

22 a learning, yes.

23 **Q.** And can you help us, please: that being picked up as

24 a learning, was that disseminated any wider than the

25 ward that you were working on at the time, by which

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1 **MR WAKERLEY:** Thank you, Chair.

2 Just on learning generally, please. Your

3 paragraph 44 of your statement. I wonder if we could

4 just put up Ms Lingard's statement at paragraph 44,

5 please. Page 12. You say there:

6 "As far as I am aware the resus officer would deal

7 with any safety alerts, learning notice", et cetera.

8 Who is the resus officer, please? Can you just help

9 us with that?

10 **MS LINGARD:** It's the Trust-wide resus officer.

11 **Q.** Is that the same as the resuscitation lead or is it

12 different?

13 **MS BRADLEY:** (The witness nodded).

14 **MS LINGARD:** (The witness nodded).

15 **Q.** Ms Bradley, you can help me with that?

16 **MS BRADLEY:** Yes, it is.

17 **Q.** It is? That's the resuscitation lead, just another

18 description?

19 **MS BRADLEY:** Yeah.

20 **Q.** Thank you.

21 Ms Bradley, while I have you, please, can you help

22 us in general terms, not the specific now. How does the

23 Trust ensure that lessons are learned following the sort

24 of incident that we've just been hearing about, please?

25 **MS BRADLEY:** Yeah, so we have our patient safety response

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1 framework, and that is a Trust-wide national framework
 2 that we're working within to really promote learning.
 3 So, you know, to try to avoid a blaming culture, but
 4 actually promote system-wide learning, and within ELFT
 5 we have our Incident Reporting Team, so any incident is
 6 scrutinised, and an independent panel will look at that,
 7 and then the learning is taken forward and we will
 8 engage appropriate professionals, the resuscitation
 9 lead, the relevant specialists, to actually really look
 10 into the detail of the incident and then take that
 11 within our governance structures, take that forward to
 12 the Resuscitation Committee. We have a Patient Safety
 13 Forum, we have a Director of Patient Safety, which is
 14 quite a recent role within ELFT in the last few years,
 15 and then we will escalate to our Quality Committee to
 16 inform any policy change that we need to make as a
 17 result of lessons learnt, and we -- sorry.

18 **Q.** I'm just going to get you to slow down just a little
 19 bit, please, because I think people are going to try and
 20 keep a note of what you're saying, but I'm sorry to
 21 interrupt you. But you told us that the Director of
 22 Patient Safety is a fairly recent --

23 **MS BRADLEY:** Yes.

24 **Q.** That's a new role?

25 **MS BRADLEY:** It is.

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1 track that would identify that sort of thing?
 2 **MS BRADLEY:** Yeah, we do have the ability to track that and
 3 really trying to build stronger systems, as well, within
 4 the organisation, supported by more digital approaches.
 5 But also, within ELFT there is an improvement culture so
 6 our quality improvement systems really support some of
 7 that learning across the organisation. But within our
 8 governance structures through the Resuscitation
 9 Committee sharing that learning at the Patient Safety
 10 Forum, which are regular forums, taking it forward in
 11 that way, and then really trying to embed it back into
 12 education and training.

13 **Q.** Thank you.

14 Ms Lingard, I want to ask you now, please, and
 15 I think you've already touched upon this, but I want to
 16 ask you about the impact of emergency resuscitation
 17 incidents upon staff members. And you tell us in your
 18 statement at paragraph 26 -- I don't need that to be put
 19 up -- that even with regular training, that staff find
 20 medical emergencies of whatever nature, you say,
 21 incredibly stressful. Do you stand by that description?

22 **MS LINGARD:** Yes, I do.

23 **Q.** Can you help us, please, why do you think it is that in
 24 spite of regular training, staff would still find it
 25 incredibly stressful?

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1 **Q.** Can you help us with when abouts that came in?

2 **MS BRADLEY:** My recollection is around three years ago.

3 **Q.** And you were in position at that time.

4 **MS BRADLEY:** I was.

5 **Q.** So can you tell us, what was the rationale behind the
 6 creation of that role, please?

7 **MS BRADLEY:** I think, you know, a proactive approach within
 8 ELFT to actually have more oversight around patient
 9 safety and the lessons that the organisation had learnt
 10 through some incidents, Preventing Future Deaths notices
 11 that we'd received, but I think really trying to take
 12 that forward and moving into a new national approach to
 13 patient safety, working within a new framework, which
 14 was so much more about system learning. So actually, to
 15 have a leader to coordinate that across the Trust who is
 16 a medic, they are a psychiatrist by background.

17 **Q.** You told us that the -- following these sort of
 18 incidents, the learning is identified. It's documented,
 19 is it?

20 **MS BRADLEY:** It is, it is. So documentary reports, there's
 21 a whole sort of reporting system which may include
 22 a sort of patient safety serious incident review.

23 **Q.** What about trying to identify if any particular issue is
 24 repeating? So it might be described as systemic rather
 25 than an individual. Is there something in place to

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1 **MS LINGARD:** Medical emergencies and resus events are,
 2 thankfully, relatively infrequent so when they do
 3 happen, there is that impact on staff. And I think
 4 I also spoke about the impact of seeing somebody that
 5 you've looked after over a longer period of time and the
 6 relationships that you develop with them and their
 7 families and that has a layer of stress to it, as well;
 8 it can be quite distressing for colleagues.

9 **Q.** Do you think there are features of a mental health
 10 inpatient ward that cause particular issues or stresses
 11 on staff in relation to some sort of emergency issue?

12 **MS LINGARD:** I think it's the complexity of managing and
 13 supporting the ward whilst you're also responding to a
 14 resus event. Our service users aren't lying in bed like
 15 you would imagine with an acute Trust. You know, they
 16 are mobile, they're walking around freely. There are
 17 already levels of patient dynamics that we are attuned
 18 to in terms of how we help them manage their
 19 relationships with each other. So that's already
 20 a difficult and challenging dynamic that we have to
 21 navigate with them on a daily basis. Then you add in
 22 a stressful scenario. And also, they are friendly and
 23 become friends, and like each other as well. It's not
 24 just discourse at times. So, you know, you've got that,
 25 also people getting distressed because they can see

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1 somebody that, you know, they're in hospital with, is
 2 also, you know, is needing to have, you know, medical
 3 intervention. So that's worrying. That's really
 4 worrying.
 5 **Q.** Presumably the very fact that the patient's in peril
 6 must --
 7 **MS LINGARD:** Yes.
 8 **Q.** -- add to the sentiment?
 9 **MS LINGARD:** Yes, absolutely. So there's lots of work that
 10 we must do to support the service users away from the
 11 area whilst our response is taking place.
 12 **Q.** You say that your view is that even with the training,
 13 the staff find it incredibly stressful. Do you see any
 14 form of lack of confidence in the staff when this sort
 15 of emergency takes place?
 16 **MS LINGARD:** Yeah, I do and I think that's because they're
 17 not utilising those skills every day so they have --
 18 mental health nurses and healthcare support workers have
 19 different sets of skills they utilise every day as a
 20 mental health practitioner but we don't have the number
 21 of resus and medical emergencies with which you would
 22 hone your skills.
 23 **Q.** That leads on to my next question. Do you think that
 24 training and, for example, simulations, help with that
 25 impact?

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1 by "staff can freeze"?
 2 **MS LINGARD:** They don't know what to do. They don't know
 3 how to react. They don't know how to respond. They're
 4 frightened. That's what I mean by "freeze".
 5 **Q.** I've already asked you, I think, but again, just to
 6 touch on it, we've also got, of course, the other
 7 service users, and the impact upon them, I think you've
 8 already told us, can create its own level of difficulty
 9 for staff when an emergency takes place in the view of
 10 other service users.
 11 Ms Bradley, can you tell us, does the Trust have
 12 a means of monitoring the impact upon staff members or
 13 upon service users of these sort of incidents,
 14 monitoring it?
 15 **MS BRADLEY:** Sorry, could you repeat?
 16 **Q.** Does the Trust have a means of monitoring that impact,
 17 assessing it? We have heard Ms Lingard telling us about
 18 the sort of impacts. Is that something that the Trust
 19 can monitor, or does?
 20 **MS BRADLEY:** They can monitor through looking at those
 21 incidents.
 22 **Q.** Through?
 23 **MS BRADLEY:** Through looking at the incidents and looking at
 24 the training. So yes, they can look at the impact of
 25 that, and actually then how it impacts on future

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1 **MS LINGARD:** Definitely. And that's the direction of
 2 travel. So for City and Hackney, we do simulations on
 3 resus events and medical emergencies, deteriorating
 4 patients.
 5 **Q.** And we'll come on to that in due course, but do you
 6 think that those training and/or simulations can have
 7 the same impact, whether they are spontaneous and
 8 unexpected, or pre-arranged?
 9 **MS LINGARD:** I think for training, for somebody to learn the
 10 subject matter that you're delivering and for them to be
 11 able to take it away and utilise in practice, that has
 12 to be a very supportive learning environment. And staff
 13 in training need to be able to have the opportunities to
 14 learn and make mistakes in the training, and the
 15 old-fashioned drills, if I could use that as
 16 a terminology, just don't offer that supportive learning
 17 environment and staff can feel quite deflated.
 18 **Q.** You use that term, don't you, in paragraph 45. You say
 19 that in unannounced drills, which is the term you use
 20 there --
 21 **MS LINGARD:** Yeah.
 22 **Q.** -- staff can, you use the term "freeze" and become
 23 deflated.
 24 **MS LINGARD:** Yes.
 25 **Q.** And I think it's probably obvious but what do you mean

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1 practice, and -- that we haven't currently got that --
 2 **Q.** Is the Trust able to identify themes, for example, and
 3 then take those forward in terms of how it reflects in
 4 policy?
 5 **MS BRADLEY:** So we've actually done a piece of work looking
 6 at resuscitation in emergency response, and actually,
 7 generated some themes from that. We looked at incidents
 8 where resuscitation attempts had been made and actually
 9 looked at some of the learning, the importance of
 10 simulation and the value of that, and also looked at
 11 some of the leadership within resuscitation
 12 -- (overspeaking) --
 13 **Q.** And we'll look at some of the new policy or the
 14 adoptions or amendments that have taken place, and I'll
 15 come back to you on that.
 16 Ms Lingard, I'm going to ask you now, please, about
 17 your own training but perhaps in fairly general terms,
 18 please. Your current role as Borough Lead Nurse
 19 requires you to have what level of training, please?
 20 **MS LINGARD:** Basic life support.
 21 **Q.** So BLS, basic life support? And as I understand it,
 22 that is in person?
 23 **MS LINGARD:** Correct.
 24 **Q.** And takes two hours?
 25 **MS LINGARD:** Correct.

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1 Q. And requires annual refresher training?
 2 MS LINGARD: Correct.
 3 Q. When you were working as a Registered Nurse on the
 4 inpatient wards, you undertook a higher level of
 5 training?
 6 MS LINGARD: That's correct.
 7 Q. Immediate life support, ILS; is that right?
 8 MS LINGARD: Correct.
 9 Q. And although not required to, you have maintained your
 10 ILS training until as recently as this year?
 11 MS LINGARD: Yes.
 12 Q. Can you tell us, why did you choose to take on
 13 additional training?
 14 MS LINGARD: I think two reasons. I think when I started
 15 this role as Borough Lead Nurse, I think a matter of
 16 weeks later we were hit by the Covid pandemic and
 17 everything changed then. We had to be very focused on
 18 physical health and supporting our population through
 19 the pandemic, and I took a personal decision to continue
 20 with my ILS training because of that.
 21 Q. Can I stop you. Did you think that, if you can answer
 22 this, did you think that basic life support training
 23 wasn't enough?
 24 MS LINGARD: I don't think that was the decision I came to.
 25 I think just for me personally, as a nurse practitioner,

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1 life.
 2 You say you'd ensure the crash trolley and medical
 3 emergency equipment is brought to scene, items such as
 4 the defibrillator, oxygen, request a duty doctor
 5 summonsed, Duty Senior Nurse coordinates the Rapid
 6 Response Team to meet the crash team from the Homerton,
 7 escorting them to the location. You then add this:
 8 "Another member of the Rapid Response Team,
 9 collecting a separate crash trolley, which aligns with
 10 the Homerton standards, and includes a manual
 11 defibrillator to ensure compatibility with Homerton's
 12 clinical practice."
 13 So that's current.
 14 MS LINGARD: Correct.
 15 Q. Just helping us, please, obviously you have told us
 16 previously about an automatic external defibrillator?
 17 MS LINGARD: (The witness nodded).
 18 Q. Why here would the Homerton crash trolley have a manual
 19 defibrillator? Can you help us?
 20 MS LINGARD: For clarity, all of the resus trolleys at the
 21 City and Hackney Centre for Mental Health, they all
 22 align with the Homerton, we have a service level
 23 agreement and we have access to their resus team. So we
 24 use the same equipment. The additional crash trolley
 25 with the manual defibrillator was a request from the

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1 I wanted to continue doing the ILS, particularly because
 2 it was during Covid and all the implications around
 3 physical health that we had to respond to.
 4 Q. Your training, however, you talk about and I would ask,
 5 please, can we put up page 4 of your statement,
 6 paragraph 16. Page 4. Paragraph 16, you tell us this
 7 and this where the incident you describe to us was
 8 a choking person?
 9 MS LINGARD: Mm-hm.
 10 Q. And here you're providing us information about your
 11 training on finding an unresponsive person. And you say
 12 this, don't you:
 13 "... on finding an unresponsive person the first
 14 thing to do is pull my alarm and summon assistance by
 15 shouting and indicating there's an emergency."
 16 You again talk about the access of staff to alarms.
 17 The alarm summons a Duty Senior Nurse and the Rapid
 18 Response Team, made up of nursing staff, one from each
 19 ward. And we will look at the rest of that paragraph
 20 a little later on, if we may.
 21 But you say this, in paragraph 17 down at the bottom
 22 of the page: you would then approach the unresponsive
 23 person, assessing for any risk or danger, then commence
 24 your ABCDE assessment, establishing signs of life and
 25 initiating CPR immediately if there are no signs of

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1 Homerton because it more aligns to their interventions
 2 and their level of skill. So they approached me and
 3 requested that I -- we provide that, and that's what
 4 we've done.
 5 Q. The staff on ward would not be familiar with its use, or
 6 its operation?
 7 MS LINGARD: No, it's purely for the resus team.
 8 Q. Purely for that.
 9 MS LINGARD: And it's very clearly stored and there is
 10 posters all around so people are very aware that that
 11 piece of equipment is for the resus team only.
 12 Q. You then tell us in paragraph 18 that you're taught not
 13 to leave an unresponsive person alone if at all
 14 possible.
 15 MS LINGARD: Mm-hm.
 16 Q. And the only reason would be to summon help, but that if
 17 a member of staff is to be left alone with
 18 an unresponsive patient the preference is it's
 19 a Registered Nurse rather than anyone unregistered?
 20 MS LINGARD: Correct.
 21 Q. And Ms Bradley, I'll come to policy again in a moment,
 22 please.
 23 But just this lastly, please, on your own training,
 24 Ms Lingard. Paragraph 21, please. At the bottom of
 25 page 5. You told us about doing immediate life support,

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1 ILS. And you say here:
 2 "The ILS, the scenarios include scenarios -- "
 3 Sorry: ILS level 3 training include scenarios which
 4 cover ligature and choking in that list; yes?
 5 **MS LINGARD:** Correct.
 6 **Q.** So are we to understand those are not scenarios that are
 7 covered by basic life support?
 8 **MS LINGARD:** I couldn't -- I'm not quite sure about the
 9 answer to that question, I'm afraid. What I could say
 10 is that the ILS training is not limited to those
 11 scenarios. Those are examples of scenarios.
 12 **Q.** They're examples?
 13 **MS LINGARD:** (The witness nodded).
 14 **Q.** But can you help me from your own experience, basic life
 15 support, does that cover ligature scenario or ligature
 16 removal?
 17 **MS LINGARD:** Yes.
 18 **Q.** It does?
 19 **MS LINGARD:** I believe it does, yes.
 20 **Q.** I'd like then, please, to move to Trust policies,
 21 Ms Bradley.
 22 You've provided the Resuscitation Policy in place
 23 from 2017 to date. They apply across the Trust but you
 24 point out in your paragraph 6 -- I don't need it put up,
 25 thank you -- that local operational arrangements are

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1 definitely, yes.
 2 **Q.** You identify particular groups in which you think that
 3 strengthening was required. Can we in fact put up your
 4 statement page 30, paragraph 76, please. Page 30,
 5 paragraph 76, please. At the top there:
 6 "Needs to be strengthened in relation to patients
 7 with obesity, a physical disability."
 8 So we understand, that's the Trust developing the
 9 guidelines that RCUK has issued.
 10 **MS BRADLEY:** (The witness nodded).
 11 **Q.** Are there other groups beyond obesity that you can help
 12 us with?
 13 **MS BRADLEY:** I mean, people with learning disability which
 14 has previously been mentioned, and also people with
 15 darker skin tones, as well.
 16 **Q.** Understood. Can you help us at all with how were those
 17 improvements or gaps identified within the Trust? How
 18 were they picked out?
 19 **MS BRADLEY:** So our resuscitation lead has identified those.
 20 And some of that is through their scrutiny of incidents.
 21 So actually looking at what has happened, in particular,
 22 resuscitation attempts. And getting that feedback
 23 through the training, as well. So staff often, when
 24 they're going through the training, will identify that
 25 gap also.

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1 developed, which can reflect site-specific criteria.
 2 **MS BRADLEY:** (The witness nodded).
 3 **Q.** But you tell us that the overarching policy is based on
 4 the Resuscitation Council UK, RCUK, guidelines?
 5 **MS BRADLEY:** Yes.
 6 **Q.** You tell us that the Trust's resuscitation lead is an
 7 advanced life support instructor.
 8 **MS BRADLEY:** Yes.
 9 **Q.** And you tell us in your paragraph 76 that whilst the
 10 policy aligns to RCUK guidelines, that resuscitation
 11 lead has helped to develop a bespoke emergency in mental
 12 health programme.
 13 **MS BRADLEY:** (The witness nodded).
 14 **Q.** And you refer to that as strengthening?
 15 **MS BRADLEY:** (The witness nodded).
 16 **Q.** Does that mean that the Trust viewed the RCUK guidelines
 17 as in some way deficient if they needed strengthening?
 18 **MS BRADLEY:** So our resuscitation lead has been working with
 19 the education provider to strengthen them, yes. It
 20 isn't that the guidelines are deficient, and with the
 21 core skills, training framework, as well, that we work
 22 with, as well, all our learning and development for the
 23 training is compliant with both of those. So the
 24 Resuscitation Council Guidelines and also the training
 25 framework. But it was felt to need to be strengthened,

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1 **Q.** And if it's been something that your Trust has picked up
 2 upon, would you anticipate that perhaps it would
 3 similarly affect other Trusts?
 4 **MS BRADLEY:** My opinion is yes, it would, and there could be
 5 shared learning and benefit from that.
 6 **Q.** For example, on that shared learning, have you shared
 7 your modifications with RCUK, for example, to show them
 8 how you've developed their guidelines?
 9 **MS BRADLEY:** I'm not aware of any formal sharing but I am
 10 aware that our resuscitation lead is well connected with
 11 the Resuscitation Council, and -- but we haven't done
 12 that formally, as far as I'm aware.
 13 **Q.** You told us a moment ago also there's been some
 14 strengthening in relation to the recognition of clinical
 15 deterioration --
 16 **MS BRADLEY:** Yes.
 17 **Q.** -- across diverse skin tones? And that work has been
 18 done to enhance guidelines?
 19 **MS BRADLEY:** Yes.
 20 **Q.** And I think this is right: that in your statement, you
 21 refer to that being expected, but in fact, we now know
 22 that you have in place a new deteriorating patient's
 23 policy; is that right?
 24 **MS BRADLEY:** Yes.
 25 **Q.** Again, just before we break, Chair, I'd just like to

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1 look at aspects of that, please, with you. Could you
2 put that up, please.

3 It is the Deteriorating Patient Physical Health
4 Policy. I can provide the URN number if required but
5 I think I see a shaking head.

6 So on the first page we can see it was approved,
7 date approved, fourth line down, on 17 July of this
8 year, and we can see it was ratified as recently as
9 2 September of this year. Can you put up page 2,
10 please, just to look at the control summary. Looking at
11 the comment box, please:

12 "The new policy reflects evidenced practice aligned
13 with NEWS2, the ABCDE approach, neurological assessment
14 principles, stroke recognition, delirium assessment and
15 medication-related neurological emergencies, and
16 includes a neurological escalation pathway, appendices,
17 governance structure, monitoring framework, and clinical
18 escalation standards."

19 I'd like to just take you to one or two of the
20 aspects, please. Firstly, what's described on the
21 bottom of the right-hand corner of the pages as "page 9
22 of 2". Thank you.

23 Just give me a moment, please.

24 **THE CHAIR:** While he's looking for that, can I just be clear
25 in my own mind. You've mentioned modifications to
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1 ago?

2 "Response team including the doctor to prepare for
3 medical emergency."

4 And:

5 "Call an ambulance 999 or 2222 (City and Hackney
6 Centre for Mental Health only)".

7 And I think that is a reference to the four 2s.

8 **MS BRADLEY:** Yes.

9 **Q.** Can we then look at 5.6 lower down the page:

10 "If the patient is deteriorating, the ABCDE
11 approach."

12 And you set out there what that relates to, I don't
13 want to go through that, thank you. Everyone can see
14 it. But over the page, please, 5.7. Non-contact
15 observations. You say this, towards the end of the
16 first paragraph:

17 "They must also be carried out and recorded every 15
18 minutes after the administration of rapid
19 tranquillisation or if there is a significant risk of
20 violence.

21 "At the minimum, non-contact vital signs should
22 consist of monitoring, measuring and recording of
23 respiratory rate, level of consciousness ... and
24 hydration."

25 You then list a number of items which can indicate
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1 training. Can you just be clear with me about what
2 level of training you expect from your registered
3 nursing staff? Is that ILS?

4 **MS BRADLEY:** It is for the inpatient unit, across mental
5 health.

6 **THE CHAIR:** And for HCAs? For healthcare assistants?

7 **MS BRADLEY:** So that would be basic life support, unless
8 they're working in Luton and Bedfordshire. So for our
9 band 4 support workers, they actually do ILS as well.

10 **THE CHAIR:** In Luton and Bedfordshire?

11 **MS BRADLEY:** Yes, very specific to the specific sites.

12 **MR WAKERLEY:** Chair, we will come on to that in due course
13 if we have time.

14 Just looking at that page please, we can see under
15 5.4 under the heading "Medical emergency" and really I'd
16 like to look at the last three bullet points of that,
17 referring back to that which Ms Lingard referred to --
18 no, we've moved away now, I'm afraid. Page -- it's 5.4.
19 Page 9. No, 5.4, page 9, please. Thank you.

20 We see at the bottom of page 9 the first two bullet
21 points, but can we go then over to page 10. So the last
22 three bullet points:

23 "Registered Nurse to stay with the patient."

24 **MS BRADLEY:** Yes.

25 **Q.** So that's something Ms Lingard told us about a moment
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1 that a patient's condition is deteriorating. And
2 I don't intend to go through those altogether.

3 But at the bottom, particular attention should be
4 paid to airway compromise, respiratory depression,
5 over-sedation, airway obstruction and aspiration risk,
6 and reduced consciousness following rapid
7 tranquillisation.

8 Can I ask you this, please: are there other specific
9 protocols, or training to those charged with monitoring
10 patients who have received rapid tranquillisation?

11 **MS BRADLEY:** So we have training, two-day training, about
12 physical health care, and deterioration. And that
13 includes the NEWS2 score, as well, and training on that.
14 So the two-day physical health training is very
15 comprehensive, walk-through, identify deterioration and
16 all sort of physical health factors that need to be
17 considered for the -- for patients with serious mental
18 illnesses.

19 **Q.** Thank you. You say on 5.8 in relation to documentation,
20 one of the things that must be documented
21 contemporaneously must be -- and we're looking over the
22 page, please -- not only the interventions commenced,
23 but also discussions with family/carers. There is
24 a mandatory, an obligation, to record contemporaneously
25 discussions that have taken place with family members or
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1 with carers.
 2 Is that right?
 3 **MS BRADLEY:** Yes. Yes, that is the expectation, standard.
 4 **Q.** The expectation is that it must be done?
 5 **MS BRADLEY:** Yes.
 6 **Q.** You told us a moment ago about work that had been done
 7 on diverse skin tones.
 8 **MS BRADLEY:** Mm.
 9 **Q.** So could I just briefly look at that, please. 6.2,
 10 page 12. 6.2 at the bottom of the page there, "Darker
 11 skin tones":
 12 "Extra care should be taken when assessing patients
 13 [or] service users with darker skin tones as some of the
 14 most common changes to the skin [which are then listed]
 15 are not as easy to distinguish as in those patients with
 16 lighter skin tones.
 17 "Patients/service users must be assessed in areas
 18 with appropriate lighting, and healthcare professionals
 19 should look for areas of skin which may be showing
 20 a change in colour to the rest of the skin."
 21 Then there is a list of matters that are described
 22 as important to note in those who have darker skin
 23 tones. So specific guidance given as part of this
 24 policy to that topic; is that right?
 25 **MS BRADLEY:** Yes.

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1 But over the page, please, on 21, there's a table
 2 that tells us that registered nurses have recognition
 3 and management of the deteriorating patient every
 4 two years; healthcare support workers, recognition of
 5 deterioration every two years; medical staff recognition
 6 assessment and management annually.
 7 **MS BRADLEY:** (The witness nodded).
 8 **Q.** And then bank, agency and temporary staff, local
 9 induction, including recognition of deterioration, and
 10 then we see the frequency on the right.
 11 **MS BRADLEY:** (The witness nodded).
 12 **Q.** Just helping us please, registered nurses, obviously
 13 that makes sense as to who that's aimed at.
 14 **MS BRADLEY:** Mm.
 15 **Q.** Healthcare support workers again?
 16 **MS BRADLEY:** (The witness nodded).
 17 **Q.** Medical staff. Who is that intended to apply to?
 18 **MS BRADLEY:** So doctors that may be responsible for
 19 responding to the patient on identifying deterioration
 20 and they would be taking that lead clinical role in
 21 managing the patient who's considered to have
 22 deteriorated.
 23 **Q.** And how was the time, the frequency? How was that
 24 decided, that every two years was regarded as sufficient
 25 for this particular training?

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1 **MR WAKERLEY:** Chair, I'm told that perhaps that's an
 2 appropriate time to take a break.
 3 **THE CHAIR:** Thank you. 15 minutes?
 4 **MR WAKERLEY:** Fifteen minutes, yes please.
 5 **THE CHAIR:** Thank you, 15 minutes.
 6 (3.28 pm)
 7 (A short break)
 8 (3.42 pm)
 9 **THE CHAIR:** Mr Wakerley.
 10 **MR WAKERLEY:** Thank you, Chair.
 11 Ms Bradley we're going back to the new document
 12 page 20, please. Just on training.
 13 Do you have that?
 14 **MS BRADLEY:** Yes.
 15 **Q.** Was that training as regards this document as opposed to
 16 training more generally?
 17 **MS BRADLEY:** It supports this document.
 18 **Q.** This document?
 19 **MS BRADLEY:** It does, yes.
 20 **Q.** So we can see:
 21 "All relevant clinical staff must complete training
 22 appropriate to their role which may include recognition
 23 of deterioration ..."
 24 And then perhaps a little lower down, rapid
 25 tranquilisation and monitoring.

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1 **MS BRADLEY:** So that would have been a decision taken by the
 2 medical leadership within the organisation and our
 3 Learning and Development Department.
 4 **Q.** Yes. Does -- I mean, again, obviously by the fact that
 5 it's there, the Trust considers that having this
 6 particular training every two years for registered
 7 nurses or healthcare support workers is sufficient?
 8 **MS BRADLEY:** Yes.
 9 **Q.** And this would be in person or otherwise? Do you know?
 10 **MS BRADLEY:** Some of that training is virtual and some is in
 11 person.
 12 **Q.** Page 28 of your witness statement, please, I don't need
 13 it put up, but you refer there to something called
 14 "Alert training" that takes place within community
 15 health services.
 16 **MS BRADLEY:** (The witness nodded).
 17 **Q.** Is that something used in wards, please?
 18 **MS BRADLEY:** Not currently, but it is something we're
 19 considering to be used so within our community health
 20 services, the physical health nurses within the
 21 organisation, we put that in place around three years
 22 ago but it is something that's been very beneficial and
 23 we would hope to roll that out for ward staff, as well.
 24 **Q.** So that's something which is actively under
 25 consideration, or is going to happen?

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1 **MS BRADLEY:** Under consideration.
 2 **Q.** Under consideration?
 3 And then within your statement at page 12 -- sorry,
 4 no, it's page 9, paragraph 12, you refer to NEWS2
 5 implementation with training that was introduced in
 6 2019. Can you tell me, were healthcare support workers
 7 or healthcare assistants, were they included within that
 8 training at the time, do you know?
 9 **MS BRADLEY:** At 2019, I haven't got that information but
 10 they are now. So anybody that has responsibility for
 11 making that assessment has to have the training.
 12 **Q.** So they are now but unclear as to whether they were back
 13 in 2019 -- (overspeaking) --
 14 **MS BRADLEY:** Yes, that's right.
 15 **Q.** I'd like to move on, please, because I understand we
 16 have a time limit today as with all days, but can I ask
 17 you, please, specifically about grab bags.
 18 Just briefly, please, you say in paragraph 9(f) of
 19 your statement that you are moving to implement a new
 20 system, a digital equipment assurance platform called
 21 MyKitCheck. Is that right?
 22 **MS BRADLEY:** That's right.
 23 **Q.** That's not in place at the moment but it's coming?
 24 **MS BRADLEY:** Yes, that's right.
 25 **Q.** When do you expect that to be in place?
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1 MyKitCheck data?
 2 **MS BRADLEY:** So that will be the Registered Nurse who are
 3 currently doing the daily checks.
 4 **Q.** So whoever it is that currently does it in a more manual
 5 form --
 6 **MS BRADLEY:** Yes.
 7 **Q.** -- will do it via a digital process?
 8 **MS BRADLEY:** Yes.
 9 **Q.** And so the expectation is that will improve the current
 10 system?
 11 **MS BRADLEY:** Yes.
 12 **Q.** By again strengthening, as I understand it?
 13 **MS BRADLEY:** Yes.
 14 **Q.** So again, if it's not abundantly clear, that will
 15 replace daily audit check lists signed off weekly sent
 16 to the Resuscitation Team to allow Trust-wide assurance.
 17 The digital MyKitCheck will, in effect, do that job?
 18 **MS BRADLEY:** Yes, it will, and we'll have Trust-wide sight
 19 of that data.
 20 **Q.** In terms of Grab Bag training, is there specific
 21 Grab Bag training?
 22 **MS BRADLEY:** Yes, so that is held at local level as well as
 23 in the training. And -- but there's the expectation
 24 that locally, familiarity of the grab bag takes place,
 25 and in our simulation training we would expect to become
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1 **MS BRADLEY:** We're hoping it to be in place October of this
 2 year.
 3 **Q.** Well, we're in October now. You're hoping it's going to
 4 be in this month?
 5 **MS BRADLEY:** Yes.
 6 **Q.** And can you encapsulate for us what that is? What is
 7 MyKitCheck?
 8 **MS BRADLEY:** It's a digital tool. So currently the practice
 9 is very manual in terms of checking the resuscitation
 10 equipment on a daily basis, which is overseen on
 11 a weekly basis by the Ward Manager, the Sister.
 12 **Q.** Yes, you set that out in the statement.
 13 **MS BRADLEY:** Yeah.
 14 **Q.** That's in terms of checking that everything is in the
 15 right place and is working?
 16 **MS BRADLEY:** Yes, and this digital system will now allow the
 17 data to be submitted centrally so we can see that the
 18 checks have been done, but also the quality of the
 19 checks and the length of time that's taken. So we've
 20 got a much better sort of surveillance.
 21 **Q.** So that will replace the current system --
 22 **MS BRADLEY:** It will.
 23 **Q.** In its entirety?
 24 **MS BRADLEY:** Yes.
 25 **Q.** And who is it that will be responsible for entering the
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1 familiar with the grab bags.
 2 **Q.** Ms Lingard, I see you nodding and I'm reminded that we
 3 can't record a nod. That's your experience in City and
 4 Hackney, is it? Hackney and City?
 5 **MS LINGARD:** Yes, I can help with Ruth's answer, as well.
 6 So absolutely. So my Physical Health Lead Nurse is very
 7 key on ensuring that there is really good knowledge and
 8 awareness of what's in the grab bags. He has a dummy
 9 trolley set up which he will take around the ward and
 10 he'll do small briefing sessions, teaching sessions,
 11 including student nurses, bank staff and regulars, just
 12 to make sure that people are familiarising themselves
 13 with the equipment and they're taking it out and having
 14 a look.
 15 **Q.** And is that documented?
 16 **MS LINGARD:** I believe so. I believe my Physical Health
 17 Lead does document activities. I would need to check
 18 that, though.
 19 **Q.** Would that be available to non-registered staff?
 20 **MS LINGARD:** Yes.
 21 **Q.** So health support staff?
 22 **MS LINGARD:** Correct.
 23 **Q.** Healthcare assistants or --
 24 **MS LINGARD:** Correct.
 25 **Q.** -- healthcare workers? And does the grab bag training
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1 fall under the umbrella of either BLS or ILS, or
 2 neither? Do you know? Either of you?
 3 **MS LINGARD:** Yeah, I can remember on my ILS training being
 4 taught using examples of equipment that would be found
 5 in the grab bag, yes.
 6 **Q.** So within ILS training?
 7 **MS LINGARD:** Yes, yeah.
 8 **MS BRADLEY:** (The witness nodded).
 9 **Q.** But the training that you've just described, perhaps,
 10 a little less formal, it's something done on a ward
 11 level?
 12 **MS LINGARD:** Yes, it is informal.
 13 **Q.** It is informal?
 14 **MS LINGARD:** Yeah.
 15 **Q.** So again, can we have some sort of idea; is that
 16 something that would take place monthly? Would it be
 17 more frequently than that, to your experience?
 18 **MS LINGARD:** I'm not sure I could say, actually. I think
 19 our Physical Health Lead Nurse is very good at working
 20 with the teams on the ward and working to see, you know,
 21 if they needed a particular session. So he's quite
 22 bespoke in his approach to training.
 23 **Q.** In terms of, for example, a separate topic, the training
 24 of the administration of oxygen, for example, again, is
 25 there -- does that fit within BLS?

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1 **Q.** Understood. So there's possibility for further change
 2 to the policy going forwards to help clarify what it is
 3 that's meant by that?
 4 **MS BRADLEY:** Yes, yes, it's sort of to review and see how
 5 that could be explicit but -- (overspeaking) --
 6 **Q.** I'd like, please, Ms Bradley to move on, please, to the
 7 development of the local emergency procedures. And you
 8 tell us in paragraphs 36 and 37 that there are such
 9 local emergency procedures, that they are reported
 10 through the Trust's Resuscitation Committee governance
 11 arrangements, and are ratified by the Chief Medical
 12 Officer?
 13 **MS BRADLEY:** (The witness nodded).
 14 **Q.** But you also tell us at paragraph 43 that there is no
 15 separate centrally maintained register which lists all
 16 of those individual ward-specific emergency procedures,
 17 protocols, periods of operation, local pathways across
 18 the sites?
 19 **MS BRADLEY:** For the different sites.
 20 **Q.** I beg your pardon?
 21 **MS BRADLEY:** For the different sites.
 22 **Q.** For the different sites?
 23 **MS BRADLEY:** Yeah.
 24 **Q.** So is that changing? Are you going to change that?
 25 **MS BRADLEY:** That hasn't been decided at this point, but

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1 **MS LINGARD:** Yes.
 2 **Q.** It does. Ms Bradley, you say within your statement
 3 that, in terms of training issues, you say that
 4 persistent or repeated issues can be escalated through
 5 local governance and reported to the Resuscitation
 6 Committee; is that right?
 7 **MS BRADLEY:** Yes.
 8 **Q.** And I just wanted to press you if I can, please, on how
 9 you define "persistent" or "repeated" as set out in the
 10 policy. Does that mean simply more than once, or is it
 11 something more than that?
 12 **MS BRADLEY:** My recollection of the policy is where the word
 13 "persistent" is used in relation to particular symptoms,
 14 seizures, for example, or depleted oxygen levels. So in
 15 defining "persistent" they're -- in one of the appendix,
 16 it does refer to certain parameters of persistence. So
 17 that is my understanding of that.
 18 **Q.** Is it -- it's a subjective assessment, is it, rather
 19 than a defined? There isn't a definition of what
 20 "persistent" means within the policy?
 21 **MS BRADLEY:** In the sort of supporting appendix it does
 22 refer, for example, a seizure, if it exceeded five
 23 minutes or repetitive seizures. So it's defined but
 24 probably having looked at the policy, might need to be
 25 a bit more explicit in the main body of the policy.

154

1 it's certainly something for consideration.
 2 **Q.** Paragraph 44, perhaps you could put up page 19,
 3 paragraph 44. You say there, 44:
 4 "As part of the continuous improvement programme for
 5 resuscitation there will be a coordinated programme to
 6 hold all local unit specific procedures for oversight
 7 ..."
 8 So did you mean that?
 9 **MS BRADLEY:** Yes, yes. I did.
 10 **Q.** So is there such a programme anticipated to come into
 11 effect?
 12 **MS BRADLEY:** Yes, anticipated. So that's part of the
 13 improvement work that we intend to do.
 14 **Q.** Because the question flows which, in the absence of it,
 15 some sort of central maintained register, how board or
 16 committee-level ELFT were satisfied that each were
 17 consistent with Trust policy and fit for purpose?
 18 **MS BRADLEY:** Yeah. So the approach is to make sure local
 19 arrangements all work within the Resuscitation Policy
 20 within that. Local arrangements are defined, and held
 21 locally, but the aim, the intention, will be to have
 22 a coordinated approach so we've got sight of all those.
 23 **Q.** I'm going to move on again. I'm moving on to the topic
 24 of specific training and Ms Lingard, you have told us
 25 about your role and how you currently require BLS, basic

156

1 life support?

2 **MS LINGARD:** Yes.

3 **Q.** And that's mandatory, isn't it?

4 **MS LINGARD:** It is.

5 **Q.** And is in person?

6 **MS LINGARD:** Yes.

7 **Q.** You tell us in paragraph 25 that it's less complicated

8 than ILS training. Does basic life support training

9 cover mental health-specific scenarios?

10 **MS LINGARD:** It does, but not in -- not exclusive to that

11 of, you know, monitoring or assessing the physical

12 deterioration of a patient.

13 **Q.** What about -- I may have asked you this before the

14 break. What about ligature, ligature removal? Is that

15 part of BLS?

16 **MS LINGARD:** I believe so, yes.

17 **Q.** Ms Bradley, you tell us that the Trust uses external

18 trainers to provide its training --

19 **MS BRADLEY:** (The witness nodded).

20 **Q.** -- and you set out who those are. But you also talk

21 about a needs analysis --

22 **MS BRADLEY:** Yes.

23 **Q.** -- that was done in 2018. Why was that done, do you

24 know, that needs analysis?

25 **MS BRADLEY:** I'm not aware of what drove it, but I think,

157

1 are not trained?

2 **MS BRADLEY:** No. That's the people that require the

3 training.

4 **Q.** And that's a lower number than the 9,504, because

5 there's obviously a certain number who don't require the

6 training at all?

7 **MS BRADLEY:** Yes, that's right.

8 **Q.** Over the page, please. You set out for us in a table

9 form "Course duration", number of staff that require it.

10 And we can see in that the adult basic life support with

11 AED.

12 **MS BRADLEY:** Yes.

13 **Q.** And anaphylaxis. 5,528 members of staff, with 36

14 spaces.

15 **MS BRADLEY:** (The witness nodded).

16 **Q.** What does 36 spaces mean?

17 **MS BRADLEY:** Those that can attend so it can accommodate --

18 **Q.** So on any given day when a course is run, 36 people can

19 attend it?

20 **MS BRADLEY:** Yes.

21 **Q.** And there are over five and a half thousand staff who

22 need it on an annual basis?

23 **MS BRADLEY:** Yes.

24 **Q.** Immediate life support, 916 staff,

25 a seven-and-a-half-hour course and just six places

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1 you know, as a Trust-wide approach for resuscitation,

2 there was a need to map out the different training

3 requirements. That did pre-date us having our current

4 resuscitation lead, as well, so it was very much led by

5 the Learning and Development Team seeking advice from

6 external trainers and at that time we had some subject

7 matter expert input, as well, to that.

8 **Q.** You help us at paragraph 69 of your report -- of your

9 statement. I'd be grateful if you could put up page 25,

10 paragraph 69 and you told us about this at the start of

11 your evidence that ELFT is a fairly substantial sized

12 Trust, and you say here that the number of staff

13 requiring statutory resuscitation training has grown

14 from 5,976 to 8,136. You then say that currently there

15 is a total of 9,504 staff, including bank, and a total

16 7,528 who require life support training. Yes?

17 **MS BRADLEY:** Yes.

18 **Q.** Just helping us with those numbers, does that -- what do

19 those -- what does the figure 7,528 mean? That's all of

20 the staff who will need to be trained and repeat their

21 training --

22 **MS BRADLEY:** Yes.

23 **Q.** -- according to the Trust's policy?

24 **MS BRADLEY:** Yes.

25 **Q.** That's not meaning that there are that many people who

158

1 available per course?

2 **MS BRADLEY:** Yes.

3 **Q.** And again the other numbers can be seen for themselves.

4 But in terms of managing that, does that mean that there

5 are members of staff who know that they need the

6 training, but can't get access to a course?

7 **MS BRADLEY:** There is access to courses, and in fact the

8 Trust commission has a 10% margin over, so we can

9 actually accommodate everybody's training.

10 **THE CHAIR:** It looks as though -- my maths is not very good

11 but it looks as though there will be a course run every

12 single day, practically?

13 **MS BRADLEY:** I can't recall the frequency but they are very

14 frequent, yes.

15 **MR WAKERLEY:** Do you, similarly, or does the Trust, possess

16 somewhere the sort of information here on numbers of

17 staff who are not compliant with that training?

18 **MS BRADLEY:** Yes.

19 **Q.** You do?

20 **MS BRADLEY:** And we've got better oversight of that now. We

21 have recent developed, through one of our digital

22 systems, a live record of who has done training, and

23 then our managers can actually drill down and see,

24 actually, which members of their team may not have done

25 the training.

160

1 Q. Is that the PowerBi tool?

2 MS BRADLEY: It is, it is.

3 Q. Is that a new tool?

4 MS BRADLEY: I can't remember the exact date when we applied

5 it for the training but it has been in the organisation

6 probably for about four years, but more recently applied

7 to education.

8 Q. But even with that, is it fair to say that it still

9 presents difficulties to a Trust to ensure that all

10 staff are completing training when they need to?

11 MS BRADLEY: It can be a challenge, yes.

12 Q. I say that mindful of the recent CQC report on your

13 Trust that no doubt you're aware of --

14 MS BRADLEY: Yes.

15 Q. -- I think in July of this year, where again there were

16 concerns expressed about compliance with training

17 levels, weren't there?

18 MS BRADLEY: There was.

19 Q. Including basic life support?

20 MS BRADLEY: (The witness nodded).

21 Q. Has the Trust done anything about that to try and

22 improve those numbers?

23 MS BRADLEY: They have, and the numbers have improved, and

24 our reporting is more frequent, so internally our

25 resuscitation training compliance is reported at our

161

1 are on duty, new staff, what stage of the induction

2 programme they're in. So they have that responsibility

3 locally.

4 THE CHAIR: What happens after the three months?

5 MS BRADLEY: Three months, so they will have had their

6 training.

7 THE CHAIR: And if they haven't?

8 MS BRADLEY: If they haven't then we would escalate that.

9 That would have to be done.

10 THE CHAIR: Would you stop them from working on the ward if

11 they hadn't had their training?

12 MS BRADLEY: I don't have that information to hand but yes,

13 we wouldn't allow them to work beyond. The policy is

14 three months, so we'd need to escalate that, stop them

15 working until we can get the training done.

16 MR WAKERLEY: Looking at your paragraph 74, please, if we

17 can put that up. Page 27. 74:

18 "Where staff fail to complete required training

19 within the required time limit, this is escalated

20 through line management and governance ... persistent

21 non-compliance may result in restrictions on undertaking

22 certain clinical duties until training requirements are

23 met."

24 Now Ms Bradley, there's that word "persistent"

25 again. It doesn't just say "non-compliance will result

163

1 weekly directors huddle, and the reports that are

2 generated from the Learning and Development Department

3 are monthly but looked at frequently, but also the live

4 PowerBi is making a big difference per departmental

5 site.

6 Q. Your paragraph 84, please. Can we put that up. 84,

7 sorry. Page 32:

8 "At ELFT, all staff must undertake their statutory

9 and mandatory training within three months of their

10 start date of employment which includes all

11 resuscitation training."

12 Does that mean that for a possible period of three

13 months there are staff who have started employment, are

14 working and yet have not undertaken their training?

15 MS BRADLEY: That is a possibility. We endeavour to get

16 people trained as soon as possible. And often, staff

17 have had previous resuscitation training when they join

18 the organisation. But what we endeavour to do is ensure

19 they're never working where they'd be expected to make

20 that response. They'd be supported by the team. And so

21 there would always be, you know, sufficient members of

22 staff on duty that can make the emergency response.

23 Q. And how is that monitored?

24 MS BRADLEY: At departmental level. So our senior nursing

25 leads have a working knowledge of exactly which staff

162

1 in restrictions"; it says, "persistent ... may result".

2 Can you help us? How -- when does staff failing to

3 comply with training become persistent? Can you help

4 with that?

5 MS BRADLEY: I think if they miss more than one attendance

6 at training, if there is a second occasion that would be

7 considered persistent.

8 Q. And is that policy, is that actually within the policy,

9 that a staff member could miss one training but no more?

10 MS BRADLEY: No, it's not specified.

11 Q. It's not specified. Do you think it ought to be?

12 MS BRADLEY: It would be helpful. People have to achieve

13 their annual training. If there is a delay, then that

14 would be helpful.

15 Q. Just then looking at the table on paragraph 83, page 31,

16 put that up, please. This is a table explaining which

17 ward staff received which training; yes?

18 MS BRADLEY: Yes.

19 Q. And we're can see adult immediate life support, ILS. In

20 London, that is "All inpatient registered nurses Band 5

21 and above"?

22 MS BRADLEY: Yes.

23 Q. The same course in Luton and Bedfordshire is "All

24 inpatient nursing staff Band 4 and above."

25 MS BRADLEY: Mm.

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1 Q. So a lower level?

2 MS BRADLEY: Yes.

3 Q. Why is it that in Luton and Bedfordshire, lower level

4 staff require higher levels of training?

5 MS BRADLEY: A configuration of the inpatient unit across

6 Luton and Bedfordshire, some are on isolated sites. So

7 as a safety measure, it was felt important to increase

8 the skill level for the band 4, the more senior

9 healthcare support worker, and also the Duty Senior

10 Nurse may need to travel around those sites, as well.

11 So it was a safety measure to increase --

12 Q. Would those -- sorry to talk over you, but would those

13 be sites that don't have an arrangement with an acute

14 emergency resuscitation crash team?

15 MS BRADLEY: Yes, that's right.

16 Q. And would -- again, it may strike as obvious, but is

17 that arrangement where a ward has an arrangement with an

18 acute service provider, is that the optimal? Would you

19 regard that as the optimal position, that there is an

20 arrangement like that in place?

21 MS BRADLEY: In my opinion, yes.

22 Q. Looking at your table again, though, on page 31, HCAs,

23 healthcare assistants, appear as the target audience

24 across the Trusts, London, Luton and Bedfordshire, for

25 basic life support with AED and anaphylaxis also. Is

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1 MS BRADLEY: Yes.

2 Q. Now, as I understand it, the Duty Senior Nurse has

3 responsibility for role allocation under this training

4 policy.

5 MS BRADLEY: (The witness nodded).

6 Q. So they are the one who tells others what they should be

7 doing is that, as I understand it, correct?

8 MS BRADLEY: Yes, that's best practice.

9 Q. And they also are responsible for the make-up of the

10 Rapid Response Team that Ms Lingard told us about right

11 back at the start of her evidence; is that right?

12 MS BRADLEY: Yes.

13 Q. Again, I think you told us that the Rapid Response Team

14 is made up from members of staff from each ward, one

15 from each ward, and maybe HCAs?

16 MS LINGARD: Correct.

17 Q. Might a Rapid Response Team only comprise HCAs?

18 MS LINGARD: No, the Duty Senior Nurse is responsible for

19 ensuring that there can be a robust response to a

20 cardiac or a medical emergency, including making changes

21 to the team. So allocations are done at the start of

22 the shift and a ward might allocate an HCA to be part of

23 the Rapid Response Team and to hold the equipment. The

24 DSN might overrule and ask them to provide a Registered

25 Nurse as they've assessed the needs across the service.

167

1 that right?

2 MS BRADLEY: Yes. Identifying anaphylaxis --

3 Q. Defined as non-registered --

4 MS BRADLEY: Yes.

5 Q. -- nursing staff.

6 You tell us, Ms Lingard, in your statement that the

7 Trust now has something called "Duty Senior Nurse

8 Medical Emergency Team Leader training"; is that right?

9 MS LINGARD: That's correct.

10 Q. Do you remember when that came about?

11 MS LINGARD: Not specifically, but I think it's a relatively

12 new training offer. It's relatively new, in the last 18

13 months, two years. But I would have to check.

14 Q. And Ms Bradley, can you help with that at all? When

15 that new training, Duty Senior Nurse Medical Emergency

16 Team Leader training came into place?

17 MS BRADLEY: My recollection, it's within the last six

18 months so as part of our improvement work for

19 resuscitation we identified that the role of the Duty

20 Senior Nurse and the leadership role needed some

21 strengthening so it was consistent across the

22 organisation.

23 Q. Again, is that because the Trust had identified that

24 having someone lead an emergency response is key, or can

25 be?

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1 Q. When the DSN is thinking about that, do they have access

2 to the training records of the staff who are on shift on

3 that particular day, to know whether a member of staff

4 is training compliant?

5 MS LINGARD: So the Duty Nurse generally holds a briefing

6 with the response team, usually in person, to make sure

7 that they are fit and they are well and they're

8 commensurate with their responsibilities under this

9 Rapid Response Team, and they also do a check-in around

10 their level of training. I believe the training records

11 are held on PowerBi, and my understanding is that --

12 sorry, access to PowerBi is not restricted. You just

13 have to arrange to have access to that digital platform.

14 Q. Do you agree, Ms Lingard, that it's often healthcare

15 assistants or healthcare workers who are first to, or it

16 can be, the scene of an unresponsive patient -- service

17 user?

18 MS LINGARD: Not always, but it could be. But not always.

19 Q. Do you know how often or does the -- or perhaps you as

20 Borough Lead Nurse first. Do you know how often that

21 occurs: that they are the first responding?

22 MS LINGARD: Not always.

23 Q. Ms Bradley, does the Trust generally have any sort of

24 insight as to how often it's a healthcare worker or

25 healthcare assistant who is first to alert or arrive on

168

1 the scene of a medical emergency?

2 **MS BRADLEY:** We don't currently hold that information. I

3 really believe we don't have that information gathered.

4 **Q.** For example, if it became clear to the Trust that in

5 a significant number of cases it's a healthcare

6 assistant or healthcare worker who is the first to

7 respond, would that perhaps indicate that a higher level

8 of training in terms of emergency life support would be

9 appropriate?

10 **MS BRADLEY:** That's certainly something to consider and take

11 to the Resuscitation Committee for discussion.

12 **Q.** Would it be possible to devise a system by which that

13 information were available, as in who was the first --

14 who discovered this patient, who was the first on scene?

15 **MS BRADLEY:** What we would be able to draw from is the

16 incident reporting system. So every resuscitation is

17 termed -- incident will be recorded on InPhase, our

18 incident reporting system, and it may be that that

19 information is detailed.

20 **Q.** So the information could be there already, it may or may

21 not be, but you tell us that you can see, in principle

22 at any rate, why that information could be valuable?

23 **MS BRADLEY:** It certainly would build a trend, and, you

24 know, that training need. It would certainly inform

25 whether we need to review that.

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1 simulations are intended to embed skills that are

2 learned during the yearly training sessions. You tell

3 us in paragraph 25 that in City and Hackney there are

4 weekly simulations that include deteriorating patient

5 and always include cardiac arrest. Is that right?

6 **MS LINGARD:** That's correct.

7 **Q.** And you say at paragraph 39 that those are delivered to

8 staff from wards who have a substantive role. Does that

9 include HCAs?

10 **MS LINGARD:** Yes, it does.

11 **Q.** You say at paragraph 31 that ward-based resus

12 simulations include cardiac arrest, simulation of

13 ligature incident, and associated loss of breathing

14 cardiac arrest. And you say that only members of the

15 Rapid Response Team participate in those; is that right?

16 **MS LINGARD:** That's correct.

17 **Q.** But that staff are rotated to ensure that all of them

18 are supported and trained?

19 **MS LINGARD:** Correct.

20 **Q.** HCAs are included if they're on the Rapid Response Team?

21 **MS LINGARD:** Correct.

22 **Q.** Is attendance at those simulations mandatory?

23 **MS LINGARD:** Yes, there is an expectation that they

24 participate in the simulations to assist in embedding

25 the training that they've received face-to-face.

171

1 **Q.** In terms of the Rapid Response Team, please, Ms Lingard,

2 is there an ALS member on Rapid Response Team as a

3 matter of course?

4 **MS LINGARD:** The duty doctor would attend any incident,

5 medical emergency.

6 **Q.** So would they be on the Rapid Response Team?

7 **MS LINGARD:** They would be called to -- but they're not part

8 of the Rapid Response Team but they would be called to

9 medical emergencies and resus events.

10 **Q.** And who would be -- they wouldn't be answering the

11 alarm, they would -- (overspeaking) -- be specifically

12 called?

13 **MS LINGARD:** There's a bleep system.

14 **Q.** And as I understand it, the new emergency lead training

15 for the Deputy Senior Nurse -- Duty Senior Nurse?

16 **MS LINGARD:** Duty Senior Nurse.

17 **Q.** Sorry, not Deputy. That would be part of their role, to

18 alert that member of staff?

19 **MS LINGARD:** Correct.

20 **Q.** I'm going to move on if I can. I've asked you already

21 about summoning the emergency services and the numbers

22 and you've told us about the briefing of the emergency

23 services. So I'm going to again move on, please, to the

24 topic of simulations.

Ms Lingard, you tell us at paragraph 28 that

170

1 **Q.** And what you tell us is that after any simulation

2 there's a debrief to capture learning?

3 **MS LINGARD:** Yes.

4 **Q.** Is that written?

5 **MS LINGARD:** Yes.

6 **Q.** And that there's then a second simulation to establish

7 and embed that learning?

8 **MS LINGARD:** (The witness nodded).

9 **Q.** What's the time difference between the two different

10 simulations, please?

11 **MS LINGARD:** The second simulation is conducted almost

12 straight after the first. So the first simulation will

13 take place, there will be discussion, debrief and

14 learning, and then they will have a second attempt at

15 another simulation.

16 **Q.** And is that with the same staff members?

17 **MS LINGARD:** Yes. We do two simulations each week. One is

18 on a deteriorating patient, medical emergency, and the

19 other is specific to resus.

20 **Q.** You tell us at paragraph 32 of your statement that the

21 policy now in place at City and Hackney is that those

22 staff members are identified in advance and that

23 simulations are performed off ward; is that right?

24 **MS LINGARD:** That's correct.

25 **Q.** Can you tell us, do you know why that takes place? Why

172

1 is it off ward?

2 **MS LINGARD:** Yes, I do know why, and it's along side -- what

3 I spoke about earlier, in terms of the impact upon

4 service users, you know, believing that there is a live

5 resus or medical emergency taking place. The wards at

6 times can be quite chaotic and very loud, and if we're

7 wanting to have learning sessions with staff, that means

8 that they can really embed the learning and take it back

9 into practice, having it in an area that isn't chaotic

10 and loud would support their learning, and means that

11 they can bring their learning back into practice much

12 more efficiently.

13 **Q.** And do you -- can you help us, though, for example, if

14 simulations are taking place off ward, then things like

15 the location of medical emergency equipment is

16 different, is it not, to where it would be in real life?

17 **MS LINGARD:** So all of our medical emergency equipment

18 except for one ward is in what we call the treatment

19 room and that's very well-embedded knowledge as part of

20 the training on BLS and local inductions.

21 **Q.** Ms Bradley, again, this concept of off-ward simulation,

22 is that Trust-wide or is that specific to City and

23 Hackney?

24 **MS BRADLEY:** A few, you know, other directorates across the

25 organisation also take it off the ward area. Some have

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1 **Q.** Ms Lingard, you tell us in paragraph 38 that you're not

2 aware, whilst you know about the fact that simulations

3 are taking place weekly, you're not aware as to whether

4 or not there's a policy that dictates how many of them

5 a member of staff must undertake? Do I have that right?

6 **MS LINGARD:** I believe so. If I've understood you

7 correctly. So I --

8 **Q.** If you haven't it's my fault.

9 **MS LINGARD:** So I'm aware of the standard of how many

10 simulation sessions should be run but I'm not aware that

11 there's a Trust standard that states a member of staff

12 needs to participate in, as an example, six simulations

13 a year.

14 **Q.** Right. So I think you've told us that the -- City and

15 Hackney has simulations two a week?

16 **MS LINGARD:** Yes.

17 **Q.** And so perhaps Ms Bradley, you can tell us. Is there

18 a policy which dictates how many of those simulations

19 staff must attend? Is there?

20 **MS BRADLEY:** No. There isn't at this point. So -- and the

21 number of simulations can be variable and what we're

22 trying to do is achieve consistency.

23 **Q.** So is attendance logged at simulations?

24 **MS BRADLEY:** Yes.

25 **Q.** So certainly the Duty Senior Nurse might know who has

175

1 been done within the ward area, but I think the practice

2 that my colleague describes is certainly best practice

3 to cause least distress.

4 **Q.** You say, though, Ms Lingard that they're done on

5 Thursdays and Fridays, not on nights and not at

6 weekends. Does that weaken their effectiveness?

7 **MS LINGARD:** That is definitely an area of improvement that

8 we need to work on. So we're relatively early in our

9 journey around simulation practice and there is going to

10 be an intention to ensure that we're offering

11 simulations at weekends and much more out of hours and

12 at night. So definitely.

13 **Q.** So your view is that's currently a gap that needs

14 fixing?

15 **MS LINGARD:** Quickly.

16 **Q.** And quickly?

17 **MS LINGARD:** Yeah.

18 **Q.** By that you mean there's a real import that it happens?

19 That the simulation might also include weekends or

20 nights?

21 **MS LINGARD:** Correct.

22 **Q.** Ms Bradley, do you have a view on that?

23 **MS BRADLEY:** Yes, I support that. I think it is the

24 direction we should be going in, and it will be brought

25 in to the improvement work for resuscitation.

174

1 recently attended a simulation when assessing the

2 make-up of her or his Rapid Response Team?

3 **MS LINGARD:** I'm not entirely sure that that information

4 would be available in the here and now with the DSN

5 making that decision.

6 **Q.** But again, would it not be sensible if a Duty Senior

7 Nurse is trying to make a robust Rapid Response Team, to

8 know that members of the team who are available have

9 recently undertaken simulation?

10 **MS LINGARD:** Yes, it would be entirely sensible and helpful.

11 **Q.** Ms Bradley? Can you help with that?

12 **MS BRADLEY:** It would be helpful.

13 **Q.** I'm going to move rapidly on as I am running out of

14 time.

15 Induction of new staff to a ward.

16 Ms Lingard, can staff, whoever they are, at City and

17 Hackney, be patient facing without induction?

18 **MS LINGARD:** That does occasionally happen. There is a

19 Trust-wide induction programme, and locally, we have

20 local agreements that new members of staff have a period

21 of supernumerary time on the ward. So the local

22 induction is not working in the shifts and being

23 inducted to local policies and procedures as an example

24 regarding the alarms where the resus equipment is.

25 **Q.** Key information?

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1 **MS LINGARD:** Yes.

2 **Q.** You say in your statement that now there is an induction

3 checklist in situ at City and Hackney --

4 **MS LINGARD:** Yes.

5 **Q.** -- that had previously not been there?

6 **MS LINGARD:** I can't recall when it started.

7 **Q.** And that is policy, Ms Bradley? Is it policy that

8 there's a written induction checklist?

9 **MS BRADLEY:** It's not embedded within policy but it's

10 certainly the expectation that there are checklists

11 locally. That's something to consider.

12 **Q.** Last topic, please. Firstly, recent developments.

13 Ms Lingard, you refer in paragraph 28 to a video that is

14 being launched, you say imminently, that is intended to

15 support revision on resuscitation?

16 **MS LINGARD:** Yes.

17 **Q.** How is that going to be made available?

18 **MS LINGARD:** I believe it's on a digital platform --

19 YouTube, I believe.

20 **MS BRADLEY:** It is.

21 **Q.** Has it now been launched?

22 **MS LINGARD:** Yes, it has.

23 **Q.** Is it simply something that is available to staff, or is

24 it a requirement that staff watch it?

25 **MS LINGARD:** I -- so I think it's about the visibility of

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1 the facilitator training and Duty Senior Nurse. So

2 it -- we're starting to roll that out but we do -- we

3 are at that stage where we need to think, actually, how

4 does this look across the organisation?

5 **Q.** Thank you.

6 Ms Lingard, you offer us, within your statement,

7 a personal opinion that you think formal training should

8 in fact be increased from its current annual level, you

9 think, to a six-monthly basis. And can you encapsulate

10 why you think that would be a good idea?

11 **MS LINGARD:** So it is my personal opinion and I think that,

12 for reasons I've already explained, I think it's

13 about -- they're very infrequent. I have been part of

14 the nursing profession since 2003, and I've only

15 personally been involved in two resus events, one of

16 which I've described today, and I think that anything

17 that we can do to support colleagues to enhance their

18 skills in formal training settings can only be a good

19 positive thing. But I -- reflective of the impact of

20 simulation training and having that helpful, and being

21 very strategic about how we deliver training and how we

22 can make sure and assure ourselves that the training

23 we're delivering is in a way that is supportive of

24 staff, because I don't think -- resus events and medical

25 emergencies, they're very stressful situations for

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1 a new product, a new training offer. That's the work

2 that we need to get into. I'm not sure if it's

3 a specific requirement of any of the training. But

4 clearly, referencing an additional training device into

5 training would be helpful and necessary.

6 **Q.** Does that video include the assessment of deteriorating

7 patients or is it purely resuscitation, do you know?

8 **MS LINGARD:** I haven't seen the video myself. It's only

9 literally out recently. But I believe that it does. It

10 goes through a full resus.

11 **Q.** And Ms Lingard -- sorry, I'm going to ask this of

12 Ms Bradley. Again, is there some method of the Trust

13 knowing who has seen it?

14 **MS BRADLEY:** We know how many people have accessed it on our

15 intranet currently.

16 **Q.** So you can see the number of times it's been watched?

17 **MS BRADLEY:** We can, we can.

18 **Q.** But can you identify the members of staff?

19 **MS BRADLEY:** Not that I'm aware of. And we're at the stage

20 where -- it's recently developed, a really positive

21 piece of work, and we now need to, as part of the

22 improvement programme, think about how that's rolled

23 out, how it's communicated and applied at practice

24 level. So whether it is something that all staff are

25 expected to watch. It is currently being introduced to

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1 everybody involved.

2 **Q.** Ms Lingard, when you see the details -- you presumably

3 had sight of Ms Bradley's statement before today?

4 **MS LINGARD:** Yes.

5 **Q.** When you see the number of staff that require the

6 training --

7 **MS LINGARD:** Yes.

8 **Q.** -- and the number of places that are available for the

9 training, do you still think that it's practically

10 a realistic possibility to effectively double that?

11 **MS LINGARD:** I don't. No, I don't, of course, no. I can

12 see the challenges that doubling that. Mandatory,

13 mandated training, I can understand fully the

14 operational implications.

15 **Q.** Ms Bradley, on the same topic, have you a view on the

16 practical reality of doubling the amount of mandatory

17 training?

18 **MS BRADLEY:** I think it would be very difficult to achieve,

19 and we, you know, we've been proactively trying to boost

20 the compliance rating as it is. So I think that would

21 be very challenging.

22 But the work around simulations and the real

23 practical application of resuscitation attempts, I think

24 is another way of addressing that. And that can be done

25 at local level and led on a much more frequent basis.

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1 **Q.** Ms Lingard, you also refer to your view that there might
2 be more of a need for a skills laboratory on a national
3 level. Can you just help us with what features of the
4 mental health inpatient ward care you say give rise to
5 that need?

6 **MS LINGARD:** Sorry, can you repeat the question?

7 **Q.** You talk about, in your statement, your view that there
8 might be a need for a skills laboratory on a national
9 level. What do you mean by that?

10 **MS LINGARD:** I think I'm talking to carefully considering
11 how we deliver training and what environments we can
12 create. You know, I'm aware that there are simulation
13 laboratories with very sophisticated mannequins, as an
14 example. And I think that given how important it is to
15 be trained to be able to respond, anything that we can
16 do to enhance the learner's experience would be
17 beneficial.

18 **Q.** And insofar as you can help us, the distinction between
19 something watched on a video, for example, versus
20 in-person training or simulation, do you compare the
21 two, in terms of effectiveness?

22 **MS LINGARD:** I think they both have parts to play but
23 I think the in-person training, I'm an experiential
24 learner, so I learn by doing and seeing, but I think
25 there are aspects of training that can be delivered

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1 **MS BRADLEY:** I can get that information for you.

2 **THE CHAIR:** Thank you.

3 **MS BRADLEY:** I'm sorry, I just can't recall that.

4 **THE CHAIR:** It would be helpful to me. Thank you very much.

5 **MS BRADLEY:** Thank you.

6 **MR WAKERLEY:** Thank you, Chair. Could I ask then, please,
7 for ten minutes, just to see if there are any other
8 final questions to ask?

9 **THE CHAIR:** Yes, ten minutes.

10 **(4.39 pm)**

11 **(A short break)**

12 **(4.50 pm)**

13 **THE CHAIR:** Mr Wakerley.

14 **MR WAKERLEY:** Chair, thank you, yes. I've been sent one or
15 two other questions which I will happily ask if I may,
16 please. It won't take me long.

17 Firstly, just in terms of simulation, and the fact
18 that there is not a policy as to how many simulations
19 a member of staff should undertake. Do either of you
20 consider that would be beneficial to have such
21 a policy --

22 **MS BRADLEY:** Yes.

23 **Q.** -- identifying it?

24 **MS LINGARD:** **(The witness nodded).**

25 **MS BRADLEY:** I do, I think that would be beneficial.

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1 digitally, online. I think there's a -- I think there's
2 a place for both of them.

3 **Q.** And Ms Bradley, on that same question, do you have
4 a view on that: that the benefits of in-person training,
5 whether it's training or simulation, versus online?

6 **MS BRADLEY:** I think, for this, for resuscitation, this
7 subject matter I think in-person, but also the -- you
8 know, is preferable. But I do think the video that's
9 been developed is really valuable, as well, that it's
10 got a very practical essence to it. So I think
11 a combination. And people learn quite differently, but
12 I think in person when you're actually trying to develop
13 the skills is really important.

14 **MR WAKERLEY:** Thank you.

15 Chair, those are my questions for now. I don't know
16 whether, Chair, you have any questions at the moment?

17 **THE CHAIR:** I've just got one question. Of your 9,000
18 staff, approximately 9,000 staff, how many are
19 Registered Nurses?

20 **MS BRADLEY:** I don't have that information off the --

21 **THE CHAIR:** Can you give me a rough idea?

22 **MS BRADLEY:** I can certainly get the information for you.

23 **THE CHAIR:** And the proportion, do you know the numbers of
24 healthcare assistants? What's the sort of ratio of
25 registered staff to healthcare assistants?

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1 **Q.** Ms Lingard, you're nodding again, I think.

2 **MS LINGARD:** Apologies, I also agree that would be
3 beneficial --

4 **Q.** That there ought to be something?

5 **MS LINGARD:** Yes.

6 **Q.** And can you help us, is there a number of simulations
7 you have in mind that, for example, a Registered Nurse
8 should attend, across an --

9 **MS LINGARD:** I don't have a number in mind. I don't have
10 a number in mind.

11 **Q.** Monthly?

12 **MS LINGARD:** Um ... I don't know, actually. I think I'd
13 want to have further discussions with colleagues around
14 it and thinking it through. What I wouldn't want to do
15 is set up a system that we can't effectively be
16 successful in. So there's something about, um --

17 **Q.** So the concept of there being a minimum number --

18 **MS LINGARD:** Yes.

19 **Q.** -- is one that both you in practice and you as the Trust
20 can see an advantage in? But the precise number is
21 something you'd want to work on?

22 **MS LINGARD:** Correct, yes.

23 **Q.** Thank you. And presumably that would equally apply to
24 non-registered or health care workers or assistants?

25 **MS BRADLEY:** **(The witness nodded).**

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1 **MS LINGARD:** (The witness nodded).

2 **Q.** Do you discuss the level of simulation with other

3 Trusts, for example?

4 **MS LINGARD:** I'm not aware of that.

5 **Q.** Ms Bradley?

6 **MS BRADLEY:** We haven't to date but our resuscitation lead

7 is very well connected with other Trusts and at national

8 level. I don't know, but I suspect those conversations

9 have probably been had but I've no evidence of that.

10 **Q.** So you suspect that there may be contact but you don't

11 know that there is?

12 **MS BRADLEY:** Yeah.

13 **Q.** But it would be at the level of resuscitation leader?

14 **MS BRADLEY:** At this point in time, yes. But that's not to

15 say that can't widen, certainly, and across Directors of

16 Nursing, and, you know, have more of a system approach.

17 **Q.** And then lastly this, please: you gave evidence about

18 a doctor attending a resuscitation incident, and that

19 you would have thought that the doctor perhaps would

20 have had ALS training. But that it's not necessary for

21 a doctor to be part of the Rapid Response Team. Do we

22 have that right?

23 **MS LINGARD:** No, if --

24 **Q.** We don't have that right?

25 **MS LINGARD:** If there's a medical emergency or resus event

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1 **Q.** Not at City and Hackney?

2 **MS LINGARD:** Yes.

3 **Q.** Where the doctor was there very quickly. Of course,

4 there must be circumstances in which the doctor wouldn't

5 be on site on certain wards; is that right?

6 **MS LINGARD:** On occasion yes, some doctors do cover multiple

7 sites.

8 **Q.** So what happens if that's the situation, when an

9 emergency takes place, they're still bleeped, are they?

10 **MS LINGARD:** Yes, yeah.

11 **Q.** But it would obviously take them a considerably longer

12 period to attend?

13 **MS LINGARD:** Yes. When there's a medical emergency or

14 a resus event that takes place, and thinking about City

15 and Hackney specifically, on the ward, almost everything

16 else stops because that is seen as the most important.

17 So as well as assuring ourselves that the duty doctor

18 responds to that incident, there are other doctors and

19 other levels of doctors that work on the wards. There

20 might be a consultant, for example. So part of being

21 the duty nurse or the team is making sure that we're

22 aware of what resources and can they also come and

23 support.

24 **MR WAKERLEY:** Thank you.

25 Yes, those are the questions. Thank you very much.

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1 happening in the unit, the duty doctor would attend.

2 **Q.** They would attend?

3 **MS LINGARD:** They would attend. They have a bleep system

4 and they would be called.

5 **Q.** But they're not a specific member of the Rapid Response

6 Team but they would attend nevertheless?

7 **MS LINGARD:** Yeah, I --

8 **Q.** Or they are a member of the team?

9 **MS LINGARD:** Operationally the definition of the Rapid

10 Response Team is the Duty Senior Nurse overseeing one

11 member of staff from each of the wards and that's the

12 Rapid Response Team and then you have the duty doctor,

13 that would also support in those situations.

14 **Q.** Yes, and you told us -- I'm so sorry, I talked over you.

15 **MS LINGARD:** There are multiple reasons why the Rapid

16 Response Team are sometimes called and those don't

17 always necessitate the need for a doctor to attend, for

18 example a violent incident or some other reason to

19 support the team.

20 **Q.** We're obviously concerned with an emergency resulting in

21 a resuscitation.

22 **MS LINGARD:** Yes.

23 **Q.** Lastly this: you told us about the incident that you

24 remembered?

25 **MS LINGARD:** Yes.

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1 Chair, those are all of the questions in that

2 regard.

3 **THE CHAIR:** Can I thank you both very much indeed for coming

4 to give evidence. It's been extremely helpful to us and

5 we're very grateful, thank you.

6 **MS BRADLEY:** Thank you.

7 **MS LINGARD:** Thank you.

8 **MR WAKERLEY:** Chair, I think that concludes business for

9 today but the Inquiry will reassemble at 9.30 tomorrow

10 morning.

11 **THE CHAIR:** 9.30 tomorrow. Thank you.

12 (4.57 pm)

13 (The hearing adjourned until 9.30 am the following morning)

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