

Tuesday, 6 October 2026

(9.30 am)

(Proceedings delayed)

(9.32 am)

THE WITNESS: Good morning.

THE CHAIR: Ms Sage, good morning.

MS SAGE: Good morning, Chair. Today, we will be hearing from Mr Nicholas Archer who is Head of Deteriorating Patient Pathways and Resuscitation Training Officer at EPUT, and then from Mr Thomas Simons and Dr Dawn Adamson from NHS England.

Before Mr Archer gives his evidence this morning I will read a summary of Ms Louise Borton's second witness statement to the Inquiry. A wide range of issues will be covered today that are relevant to the topic of emergency response and resuscitation. With Mr Archer, we will focus on EPUT's policies and procedures for cardiopulmonary resuscitation, CPR, and deteriorating patients, what training is provided, and how that has changed over time, the role of simulations in training for emergencies, and how EPUT monitors and audits these matters and learns from emergency resuscitation events.

This afternoon, Mr Simons and Dr Adamson will tell us about NHS England's review of statutory and mandatory training and what is planned in terms of changes to

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those engaging with the Inquiry to feel safe and supported.

Chair, I'll then move to a summary of Louise Borton's second statement which is dated 16 September 2026.

Chair, you'll recall that in July of this year, you heard from Louise Borton, who is a matron at EPUT. Following that evidence, you directed that an additional statement be sought from Ms Borton in relation to resuscitation and emergency response.

Ms Borton provided a second statement to the Inquiry on 16 September 2026. That statement has been provided in full to core participants and a copy will be published on the Inquiry website.

That statement is directly relevant to the matters which Mr Archer will provide evidence on this morning, and therefore, to assist you, Chair, your Inquiry team have prepared a short summary of Ms Borton's statement.

Ms Borton confirms in that statement that she has been employed with EPUT in the role of matron since February 2021. She qualified as a nurse in 2016 and has worked in SEPT and EPUT since qualifying.

Since 2018 Ms Borton has undertaken training in relation to recognising deteriorating patients, emergency response and resuscitation, including Basic

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training relating to resuscitation.

Before we hear any evidence however, I'd like to point to the fact that today's evidence may in part be difficult and distressing to listen to and for some, it may not be possible to sit through this session. Anyone in this hearing room is welcome to leave at any point although we'd like to ask people not to re-enter until a scheduled break in the proceedings.

I'd also like to remind people that emotional support is available for all those who require it. We have support staff from Hestia, an experienced provider of emotional support, here today, and for each day of this hearing. And if they're in their room could they raise their hands? They're outside.

There is a private room downstairs where you can talk Hestia support staff if you require emotional support at all throughout this hearing. The Hestia support staff are wearing orange-coloured lanyards or scarves and you can also speak to a member of the Inquiry team and we can put you in touch with them. We are all wearing purple-coloured lanyards.

If you're watching online, information about available emotional support can be found on the Lampard Inquiry website @lampardinquiry.org.uk under the "support" tab near the right-hand corner. We want all

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Life Support training, grab bag training, Enhanced Emergency Skills training, Immediate Life Support training, and ligature awareness training.

Recently, she also completed Resus Link Practitioner training.

Ms Borton states that the content of training varied depending on the particular training requirements, and a summary of these differences and similarities include the following examples which she provides in her statement. In BLS, EES and ILS training, Ms Borton was taught to call for help, activate the alarm, ensure the grab bag was brought to the scene, call the emergency services, assess breathing and commence CPR.

In EES and ILS training that included the use of AEDs, airway management and oxygen therapy. ILS training referred to the role but not the administration of resuscitation drugs including adrenaline and amiodarone. EES, ILS and ligature awareness training all included scenarios relevant to mental health inpatient settings such as self-strangulation, fixed-point ligatures and serious harm by cutting.

Ms Borton states that the transition from EES to ILS represented for her a substantial change in how training was delivered. For example, EES training was delivered to both qualified and unqualified staff. Ms Borton

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1 states that she considers that this approach supported
2 patient safety because unqualified staff might often be
3 the first individuals to respond to incidents.

4 Ms Borton states that the transition from EES to ILS
5 reduced the level of training received by unregistered
6 staff who were limited to BLS and AED training.

7 Ms Borton considers that staff would benefit from
8 medical simulation emergency exercises throughout the
9 year rather than annually.

10 She further considers that ILS should be mandatory
11 for unregistered staff and that ALS-trained staff should
12 be available across inpatient services and on each
13 shift.

14 Ms Borton suggests that consideration should be
15 given to a more structured approach to emergency
16 responses, where staff starting their shift could agree
17 responsibilities in the event of a medical emergency.

18 In relation to historic emergency drills and
19 simulations, Ms Borton recalls the importance of several
20 learning points. These include a simulation on
21 18 March 2022. At this simulation, there was a failure
22 by staff to activate the pinpoint alarm correctly,
23 delays in staff recognising the nature of the alarm,
24 issues with contacting the duty doctor via the pager
25 system, delays in the arrival of the grab bag and

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1 exercises.

2 Ms Borton further states that she has observed
3 recurring issues arising from simulations taking place
4 in 2026. These include, during a simulation on
5 29 June 2026, the duty doctor and a responder from
6 another ward were unable to hear the radio transmission
7 due to poor radio signal coverage. There were also
8 delays in obtaining equipment and there was a need for
9 clearer leadership.

10 And a simulation that took place on the assessment
11 unit, at Grangewaters Ward at Basildon Mental Health
12 Unit on 6 August 2026. In that simulation, staff did
13 not immediately declare a medical emergency and a doctor
14 did not attend for approximately seven minutes.

15 Ms Borton described that two days later, on
16 8 August 2026, a ligature incident occurring in which
17 a medical emergency call was transmitted over the radio
18 and ward staff, including nurses and medical colleagues,
19 attended and commenced CPR. The Ambulance Service
20 attended and sadly confirmed the patient's death.

21 In June 2018, Ms Borton joined Grangewaters ward as
22 Deputy Ward Manager. At that time, in the event of
23 a medical emergency involving a deteriorating or
24 unresponsive patient, the adult cardiac team from
25 Basildon and Thurrock University Hospital, commonly

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1 aerosol-generating procedure PPE, which was stored
2 separately, and it taking seven minutes to deliver the
3 first shock via the AED.

4 To Ms Borton, this reinforced the importance of
5 reliable emergency communication and alarm systems.
6 Ms Borton made internal recommendations at that time,
7 including that the duty doctor be provided with a pager
8 and radio, ensuring that aerosol-generating producing
9 PPE was attached to the grab bag and the need to
10 prioritise AED deployment.

11 She also speaks about a simulation in April 2022,
12 and at that simulation there were issues in staff access
13 to the ward. This was because staff did not have access
14 to the relevant clinical areas and access cards were
15 required.

16 Ms Borton has provided evidence to the Inquiry in
17 relation to current CPR training requirements.
18 Ms Borton states that EPUT currently requires scenario
19 training and emergency simulation exercises every three
20 months in accordance with its CPR policy.

21 Within the policy there is no requirement nor formal
22 mechanism to record whether individual members of staff
23 have participated in emergency simulation exercises.
24 Ms Borton is not aware of any formal process for
25 managing underperformance identified during simulation

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1 known as the crash team, could be called to respond.
2 This arrangement ended in 2020.

3 Ms Borton recalls that the ward would notify the
4 hospital switchboard who would page the adult cardiac
5 arrest team. The adult cardiac arrest team would
6 usually respond within minutes, often running from
7 Basildon and Thurrock University Hospital to the
8 location of the emergency at the mental health unit.

9 In Ms Borton's view the loss of access to the adult
10 cardiac arrest team had the potential to increase the
11 risks associated with managing medical emergencies
12 within the mental health unit. Ms Borton describes in
13 her statement that she viewed the crash team as an
14 invaluable resource who were trained in Advanced Life
15 Support and able to use equipment and medications in the
16 resuscitation trolley that were not available to staff
17 members without ALS training.

18 Without access to the crash team, the mental health
19 unit was reliant on summoning the Ambulance Service in
20 the same way as any community setting, leaving the unit
21 reliant on ambulance response times and resource
22 availability.

23 Ms Borton further sets out in her statement evidence
24 of her recurring concerns regarding emergency equipment
25 and emergency responses across both emergency incidents

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and simulation exercises. One recurring issue which Ms Borton describes in her second statement is staff having difficulties locating specific items within grab bags. This is an issue that Ms Borton does not feel has been fully resolved. In her experience, the issue was particularly evident in relation to high-concentration oxygen masks and equipment required for oxygen administration.

In 2022, Ms Borton states that she raised concerns about the organisation of equipment within grab bags with Mr Archer, Head of Deteriorating Patient Pathways and Resuscitation Training Officer.

Ms Borton states that she provided Mr Archer with a photo of an example of an alternative bag using community midwifery that had a compartmentalised system.

Following an incident on 19 December 2024, during which staff had trouble locating a high-concentration oxygen mask, Ms Borton states that she raised the issue further with Mr Archer.

In her statement, Ms Borton states that she was advised that the Trust's current resuscitation bags contained less equipment than other clinical environments, and that alternative bag systems were significantly more expensive.

Ms Borton's evidence is that Mr Archer told her that

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he was developing a training video to encourage greater familiarity with grab bag equipment -- familiarity.

At the time that she raised the option of using a compartmentalised bag system, Ms Borton states that she also raised the possibility of considering or piloting a system for high-concentration oxygen masks which could be stored, sealed, with a tubing attached on a hook adjacent to an oxygen cylinder. This was a system that would allow for immediate use and one that Ms Borton had observed at Basildon Hospital.

Ms Borton's evidence is that Mr Archer responded that he could see no objection to this change but that any change would require discussion in the Resuscitation and Deteriorating Patient group. As far as Ms Borton is aware no change has been made and high-concentration masks remain stored within grab bags.

Ms Borton states that in her view the biggest challenges were not deficiencies in basic resuscitation knowledge but issues relating to systems, communication, equipment accessibility, escalation processes and the practical application of learning.

Chair, that concludes the summary of Ms Borton's second statement.

So we are now ready to hear from our first witness this morning, Mr Nicholas Archer, as we've heard, EPUT's

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Head of Deteriorating Patient Pathways and Resuscitation Training Officer.

Could the witness please be sworn.

NICHOLAS ARCHER (sworn)

Questioned by MS SAGE

MS SAGE: Could you state your full name for the record, please.

A. Yes, it's Nicholas Archer.

Q. Mr Archer, you have a folder in front of you. I see it's open. Is it open at tab 5?

A. Yes.

Q. You have provided one statement to the Inquiry, it's dated 1 September 2026. You have that copy of the statement in front of you and have signed the final page of it, which bears a statement of truth. Have you had an opportunity to read that statement recently?

A. Yes, I have.

Q. Now, I understand in respect of paragraph 24 that you want to make a correction to the end of that paragraph, where you say:

"As far as I am aware, there were no deviations or modifications from the RCUK Quality Standards."

And that correction relates to the emergency equipment within resuscitation bags and whether that complies with RCUK Quality Standards on the mental

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health inpatient care equipment and drugs list.

What we will do is note that you wish to make that correction and I will come to the detail of that when we look at emergency equipment later in your evidence.

A. Thank you.

Q. Can you confirm, therefore, that subject to that correction, the contents are true to the best of your knowledge and belief?

A. Yes, that's correct.

Q. And that statement will stand as your evidence to this Inquiry?

A. (The witness nodded).

Q. Could I ask you to turn to tab 6, the next tab.

A. Okay.

Q. And you should see there that the Inquiry also has a copy of the statement you gave to the coroner in the inquest touching the death of Sophie Alderman. That statement is dated 3 April 2024. Again, it bears your signature and a statement of truth and I will refer to that statement in the course of your evidence today.

Finally, in your witness statement, you refer to the corporate statement submitted by EPUT and state that you agree with the contents of that statement. That's at tab 9 of the bundle in front of you.

You have been invited to reread that statement

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1 before today because it was submitted after you signed
 2 your own statement. Do you adopt and agree with the
 3 contents of that statement?
 4 **A.** Yes.
 5 **Q.** And Mr Archer, before we start your evidence,
 6 I understand you would like to say a few words.
 7 **A.** Thank you. I would just like to pass on my condolences
 8 to the families that have been affected with the deaths
 9 that have been investigated over the course of this
 10 Inquiry. So please accept my condolences.
 11 **Q.** Mr Archer, since May 2022 you've held two roles at EPUT:
 12 Head of Deteriorating Patient Pathways and Resuscitation
 13 Training Officer. I can see you're nodding. For the
 14 purpose of the transcript, I need you to answer the
 15 question with "yes" or "no" rather than a nod or shake
 16 of the head; is that okay?
 17 **A.** Yes, that's correct.
 18 **Q.** You are EPUT's Resuscitation Officer for the purposes of
 19 the RCUK Quality Standards, mental health inpatient
 20 care, which we heard evidence about in July from
 21 Mr Benson Clarke at RCUK. That's correct?
 22 **A.** Correct.
 23 **Q.** You also head up the resuscitation service at EPUT. You
 24 are the resuscitation service structure lead, for the
 25 purposes of the RCUK Quality Standards?

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1 **A.** I was part of it, and that was when we were on call, we
 2 would be allocated a role of being part of that crash
 3 team. So for my duration, I participated regularly.
 4 **Q.** You also say that you taught basic life support to
 5 operating theatre staff in that role. When was that?
 6 Was that also the whole of role?
 7 **A.** Pretty much, on and off. It was really when I qualified
 8 as a Band 6, which would have been probably 2009, but it
 9 was on and off. We shared that responsibility with the
 10 Band 6 operating department practitioners.
 11 **Q.** Now, in your statement you refer to that BLS training as
 12 RCUK training. Can I clarify what you mean when you say
 13 RCUK BLS training, because RCUK do not themselves offer
 14 a Basic Life Support training course?
 15 **A.** That's correct. The training was aligned to their Basic
 16 Life Support guidance.
 17 **Q.** So we understand that when you refer to RCUK BLS
 18 training you mean training based on RCUK guidance?
 19 **A.** That's correct.
 20 **Q.** You then joined EPUT in May 2021 and initially,
 21 I understand, you held a role relating to the Covid-19
 22 pandemic before starting your current role in May 2022?
 23 **A.** That's correct.
 24 **Q.** In terms of your qualifications and training it's
 25 correct that your most recent RCUK Advanced Life Support

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1 **A.** Yes, that's correct.
 2 **Q.** Your direct line manager is Rebecca Pulford and she is
 3 the Director of Nursing and Chief Nursing and AHP
 4 Information Officer?
 5 **A.** Yes, that's correct.
 6 **Q.** And you're also directly accountable to Ann Sheridan,
 7 who is the Executive Nurse at EPUT?
 8 **A.** That's correct.
 9 **Q.** And Chair, we'll hear evidence from Ms Sheridan
 10 tomorrow.
 11 You qualified as an operating department
 12 practitioner in 2006.
 13 **A.** Correct.
 14 **Q.** That is a registered clinical role?
 15 **A.** Yes, that's correct.
 16 **Q.** And you're registered with the Health and Care
 17 Professions Council?
 18 **A.** That's correct.
 19 **Q.** You worked in operating theatres, you tell us, for
 20 19 years, at an acute Trust?
 21 **A.** Yes.
 22 **Q.** As part of that role, is it correct that you were in the
 23 hospital crash team?
 24 **A.** Yes, that's correct.
 25 **Q.** Was that for the whole 19 years?

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1 qualification was in 2021?
 2 **A.** Correct.
 3 **Q.** After that, you progressed to become an ALS instructor
 4 in 2022?
 5 **A.** Correct.
 6 **Q.** Since then you've been teaching on both RCUK, ALS, and
 7 ILS courses?
 8 **A.** Correct.
 9 **Q.** Now in 2022, you did a TALK Foundation Clinical Debrief
 10 Instructor course. Can you help us with what that
 11 involved?
 12 **A.** So that is, it's not something that's mandated. It was
 13 part of my CPD. It was something that I identified. It
 14 is a structure and a process that can be adopted to help
 15 form part of a -- it can be used within a clinical
 16 debrief, following a -- any emergency. So it's to
 17 enhance my existing knowledge base.
 18 **Q.** And is that enhancing your knowledge so that you can
 19 teach others about how to do a clinical debrief or
 20 enhancing your knowledge of how you do a clinical
 21 debrief?
 22 **A.** How I would. There is an option to progress to teach
 23 that technique, but that's not something I've adopted.
 24 So it's to assist me in my debriefing skills.
 25 **Q.** Then in 2025, you tell us that you gained the RCUK

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1 Generic Instructor Course. Can you explain to the Chair
2 what that is?
3 **A.** Certainly. So if a candidate successfully passes the
4 Advanced Life Support course, if they are deemed to have
5 instructor potential, so an instructor of the future, we
6 will ask them if they would be interested in taking that
7 offer up. And what that means and what that requires is
8 for the candidate who has just passed their Advanced
9 Life Support to attend an additional two-day course
10 where they are taught all of the basic principles and
11 modalities that are used within the Resus Council
12 Advanced Life Support. So it's teaching the faculty of
13 the future, basically.
14 **Q.** Then in 2025 you say you gained a PG certificate in
15 medical and healthcare education?
16 **A.** That's correct.
17 **Q.** Now, your view, as set out in paragraph 15 of your
18 statement, and can I ask that that is put up. That's
19 page 5 of Mr Archer's statement.
20 Apologies, it's page 5 of his first statement. We
21 can see there at paragraph 15 that you say your opinion
22 is your training clearly qualifies you as having an
23 active and credible involvement in resuscitation. And
24 the relevance of that, is that that is what is required
25 by the RCUK Quality Standards for the lead person

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1 participating, there is an expectation that our
2 knowledge and technical skills are up-to-date and
3 current in order for us to teach on Advanced Life
4 Support.
5 **Q.** Do you accept that whilst you have many qualifications
6 in this area, you no longer have an active involvement
7 in resuscitation events themselves?
8 **A.** Unless I'm physically on a ward when there is a cardiac
9 arrest, I will obviously participate, but the
10 geographical spread of the Trust is such that if there
11 is an incident, if I'm based at Colchester and there is
12 an incident in Thurrock, I will not get there in
13 a timely manner. It is physically impossible.
14 **Q.** So Mr Archer, I understand what you say about that but
15 do you accept, therefore, that you no longer have an
16 active involvement in resuscitation events, as you say,
17 because the geographical spread of EPUT is so large that
18 you can't get to resuscitation events in a timely
19 manner?
20 **A.** Yes, I'm no longer an active part of a Resuscitation
21 Team but I do, as I've previously said, teach.
22 **Q.** Have you had any discussions with EPUT with a view to
23 maintaining an active involvement in resuscitation and
24 how that might -- how you might be able to do that?
25 **A.** Not to date.

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1 responsible for the resuscitation service structure,
2 that they must have an active and credible involvement
3 in resuscitation.
4 **A.** Yes, that's correct.
5 **Q.** You also tell us in your statement that you've not
6 worked directly in the provision of mental health care.
7 **A.** That's correct.
8 **Q.** And you've also not been involved in a resuscitation
9 attempt on a mental health ward.
10 **A.** That's correct.
11 **Q.** And is it also correct that you don't have any
12 qualifications in mental health care directly?
13 **A.** Correct.
14 **Q.** And you haven't been involved in a resuscitation attempt
15 since you joined EPUT in May 2021; is that correct?
16 **A.** That's correct, not directly involved, yeah.
17 **Q.** When was the last time that you attended, responded or
18 participated in a resuscitation event?
19 **A.** So that would have been whilst I was at my previous
20 acute Trust so that would have -- potentially, 2021?
21 **Q.** Do you agree that you should have addressed the length
22 of time since you participated in a resuscitation event
23 clearly in your statement?
24 **A.** I think my credibility comes in the fact that I teach
25 Advanced Life Support training, whilst not physically

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1 **Q.** And do you maintain what you say in paragraph 15, in
2 light of what you've told us about not having an active
3 role in resuscitation events, that you have both an
4 active and credible involvement in resuscitation?
5 **A.** Again, that -- I make reference to the teaching of
6 Advanced Life Support as being active and credible.
7 **Q.** I'm going to come to look at your current role in more
8 detail now. As we know, you're the Head of
9 Deteriorating Patient Pathways and Resuscitation
10 Training Officer. The Inquiry has heard evidence from
11 RCUK and will hear from its expert, Professor Soar, that
12 the best chance of a patient surviving a medical
13 emergency is for intervention to happen before the
14 person is in cardiac arrest, and in your paragraph 48 of
15 your statement you agree that there needs to be a focus
16 on the deteriorating patient to prevent cardiac arrest
17 occurring where possible?
18 **A.** Absolutely, yeah.
19 **Q.** Now, in your role as Resuscitation Training Officer you
20 tell us that you oversee training provision, but as
21 we've -- but you are also the author of EPUT's CPR
22 Policy; that's correct?
23 **A.** Yes, that's correct.
24 **Q.** And you have been since March 2023?
25 **A.** Correct.

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1 Q. And you also have a duty to review resuscitation events
2 and simulation reports?
3 A. Yes, that's correct.
4 Q. Can we then look at the CPR Policy that you author,
5 that's EPUT023452.
6 Mr Archer, this is the primary document governing
7 EPUT's resuscitation service and provision of emergency
8 care to patients, isn't it?
9 A. Yes, that's correct.
10 Q. And this document, which is dated March of this year,
11 it's a consolidated document, and you've consolidated
12 two policies: the CPR Policy, CLP14, and this -- what
13 was the CPR procedure, CLPG14A, and they're now this one
14 policy?
15 A. Yes, that's correct. The Trust made the decision to
16 merge into one document.
17 Q. And we can see there on the first page the author is
18 you, as we've discussed. And there's then, below that,
19 the approval group and committees.
20 Now, the first of those is the Resuscitation and
21 Deteriorating Patient Group. I do not want you to use
22 the names of staff members but can you explain to the
23 Chair what the make-up of that group is in terms of who,
24 what the role is of the person that chairs it?
25 A. So the role of the person that is currently chairing

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1 to that group.
2 Q. Do you attend it every time?
3 A. Yes. Unless there is some reason why I'm physically not
4 on site, I will absolutely attend.
5 Q. That report -- that group reports to the Harm Free Care
6 Group. Now, you do chair that group?
7 A. Correct.
8 Q. Who else sits on that group?
9 A. So that group is made up of tissue viability experts,
10 falls experts, both operational and corporate. There's
11 a wealth of different subgroups that feed into that
12 particular group. They're just two examples.
13 Q. Mr Archer, do I understand this right: you author this
14 policy and you then provide it to the Deteriorating
15 Patient Group who review and approve it?
16 A. That's correct and then that will also be approved by
17 the Harm Free Care Group as well.
18 Q. And you chair the Harm Free Care Group?
19 A. Correct.
20 Q. So you author this policy and is it right that it then
21 comes back to you for approval at the Harm Free Care
22 Group?
23 A. I believe in this instance I referred this to my line
24 manager, because I'm the Chair of the Group.
25 Q. Can we look at page 8 of the document, please. I'm

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1 that meeting is the Head of Clinical Transformation.
2 Q. Mr Smale?
3 A. Yes, correct.
4 Q. And what level of staff attend that meeting?
5 A. There's a variety from operational colleagues to some
6 corporate colleagues. There's a wealth of different
7 staff that dial into the -- that join the bimonthly
8 meetings.
9 Q. When you refer to operational colleagues, what do you
10 mean?
11 A. So nursing staff, so Professional Nurse Educators.
12 There may be community nursing staff. So when I mean --
13 when I -- sorry, when I say "operational", that is
14 nursing.
15 Q. And when you say "corporate staff", what do you mean by
16 corporate staff?
17 A. Some of those that aren't patient facing but have a role
18 in and an interest in physical health and deterioration.
19 Q. You say in your statement that you feed into that group.
20 What does that mean?
21 A. So that was a meeting I used to chair but because some
22 of the actions are assigned to myself, rightly so, it's
23 deemed appropriate that I do not chair it. I will
24 provide updates in relation to resuscitation events, to
25 simulation events. I will -- so I feed in information

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1 going to summarise, but paragraph 3.1 sets out the scope
2 of the policy and it's right that it applies to all of
3 EPUT settings, both inpatient and community?
4 A. Correct.
5 Q. And can we move to paragraph, the section 5, which
6 I think will be on page 10.
7 Mr Archer, this is the section of the policy that
8 sets out the duties, and we can see at paragraph 5.3
9 that your duty is said to be ensuring that all
10 cardiopulmonary arrests are audited and reported on
11 a regular basis to the Resuscitation and Deteriorating
12 Patient Group. That's correct, that's what
13 -- (overspeaking) --
14 A. Correct.
15 Q. If we look at paragraph 5.4, that group, as we have
16 said, reports to the Harm Free Care Group and the
17 Resuscitation and Deteriorating Patient Group, on which
18 you sit, is responsible for those four bullet points
19 listed there, in terms of oversight of resuscitation.
20 So I just want to make sure we understand this, you
21 attend and feed information into the Resuscitation and
22 Deteriorating Patient Group in respect of these matters?
23 A. Correct, yes.
24 Q. And that information then reports up to the Harm Free
25 Care Group, which you chair?

24

1 A. Yes.

2 Q. And it's right that you have other responsibilities as

3 well as monitoring resuscitation events. In due course,

4 we're going to hear that you made the business case for

5 the transition to RCUK Immediate Life Support training

6 for registered nurses, and that you yourself identified

7 the specific staff who required that training; that's

8 correct?

9 A. Yes, that's correct.

10 Q. I'm going to ask you about the background and detail to

11 that later.

12 In terms of your duties, it's also part of your role

13 to consider making -- it's therefore part of your role

14 to consider making recommendations about who should get

15 what level of life support training at EPUT?

16 A. Yes, that's correct, yeah.

17 Q. Have you ever received any pushback from those more

18 senior than you about the level of training you have

19 recommended?

20 A. No. It's the contrary, actually. It's been actively

21 supported.

22 Q. Would you therefore expect EPUT to adopt

23 a recommendation that you make in relation to training?

24 A. There is absolutely every reason why that should be

25 challenged. It is a proposal that I have made but

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1 equipment, it is a passion of mine, patient safety is

2 a passion of mine.

3 Q. And again, is it the case that in respect of changes

4 outside of training, that those more senior to you

5 generally, again, adopt your recommendations for change

6 in those areas?

7 A. So yes, the process I -- our governance sign-off process

8 is for -- I would never make a decision on my own.

9 I would always put that through the Resus and

10 Deteriorating Patient Group for approval, Harm Free Care

11 Group, and then if we need exec sign-off, that will be

12 the process. Because it would be -- it wouldn't be

13 appropriate for me, as one individual, to make

14 a decision on my own.

15 Q. And again, in respect of changes outside of training,

16 have you ever experienced pushback or a refusal to adopt

17 a recommendation that you have made?

18 A. Never.

19 Q. You also refer in your statement to the board member

20 with speciality of resuscitation, Dr Mateen Jiwani; is

21 that correct, that board member?

22 A. Yes, that's correct, yeah.

23 Q. What direct liaison do you have with him, if any?

24 A. I have had some conversations around technology, but

25 it's fairly minimal, to be honest.

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1 obviously I'm mindful that there is an absolute

2 governance process that's followed. It's not just one

3 individual that decides, it is -- there is a governance

4 process to ensure that that review has been carried out.

5 Q. Of course, but you've told us that to date, if you've

6 made a recommendation, you've been supported in it being

7 implemented?

8 A. Yes, that's correct. Yeah.

9 Q. And it's also your role to recommend wider changes to

10 the resuscitation service outside of training.

11 Can we look at paragraph 18 of your witness

12 statement. And that's also on page 5 of the statement.

13 And in this paragraph, you give us some examples of

14 other changes that you have made at EPUT, and that

15 includes matters such as introducing additional

16 equipment, introducing additional tools to policies, the

17 creation of some aide memoires and tools to be used by

18 staff in observing patients, and production of the EPUT

19 resus bag refresher film.

20 So your responsibility, in terms of things that

21 you're recommending and changes that you're making, that

22 goes wider than just training, doesn't it?

23 A. Absolutely. I am absolutely focused on patient safety.

24 So whenever there is an opportunity to improve current

25 practice, whether that be with the use of specific

26

1 Q. Moving then to your role as Head of Deteriorating

2 Patient Pathways, I'm not going to put it up now but in

3 that role you're the policy author for CG87 which is the

4 policy that sets out -- the clinical guidelines,

5 I should say, that set out how EPUT staff should monitor

6 and assess patients' physical health and deterioration?

7 A. Yes, that's correct.

8 Q. What are your other responsibilities, in respect of --

9 in your role as Head of Deteriorating Patient Pathways?

10 A. So it is around the recognition and management of the

11 deteriorating patient. So that would be, for example,

12 we host live events which focus on sepsis. We have --

13 we did one this year where we invited somebody with

14 lived experience, a sepsis survivor, a fellow healthcare

15 professional, that came in to raise awareness around

16 sepsis.

17 We have implemented, as I've said in my statement,

18 a number of aide memoires and the reason we've done that

19 is because we are absolutely aware that our staff are

20 not faced with a deteriorating patient daily, unlike

21 colleagues within critical care, unlike colleagues

22 within the accident and emergency department. So we

23 acknowledge that and as I say, I have an absolute

24 passion for patient safety, so to support the teams in

25 their roles, we've implemented and embedded some aide

28

1 memoirs. We're in the process of embedding another one
2 shortly.

3 **THE CHAIR:** What does that mean, to embed --

4 **A.** To not only share but actually to put in practice. So
5 there would be -- the teams that will be managing the
6 patient are aware of the document and --

7 **THE CHAIR:** How do staff access the document?

8 **A.** So we've made it easy for staff by actually putting
9 it -- putting a copy of some of these documents in the
10 resus bags. So the resus bag follows the unwell
11 patient. So it's easily accessible. A 999 document,
12 for example, is within the bag but it's also on some of
13 the posters in the office. So it's about making it
14 available for staff and not just bearing it on an
15 intranet.

16 **THE CHAIR:** Thank you.

17 **MS SAGE:** Chair, we'll hear more about that later.

18 Mr Archer, as part of that embedding, do you also,
19 in your role, recommend the level of training to be
20 provided to EPUT staff in relation to the application of
21 NEWS2 which is a way of assessing deteriorating
22 patients, and the use of those resources that you've
23 introduced for the management of deteriorating patients?

24 **A.** Yes, we're in the process, and it will be available on
25 the Training Tracker, to make NEWS2 training mandatory

29

1 **A.** We are very similar. We are both operating department
2 practitioners. I've worked closely with Mr Smale for --
3 since 2004, if not earlier. So our roles are very much
4 aligned. We have the same experience.

5 **Q.** Can I ask us to put on the screen the RCUK Quality
6 Standards for Mental Health Inpatient Care. That's
7 RSCUK022529.

8 Mr Archer, we heard evidence about these from RCUK
9 in July but that's the Quality Standards for Mental
10 Health Inpatient Care, isn't it?

11 **A.** Yes.

12 **Q.** Can we turn to page 3, please. Apologies, can we go
13 back to page 2 to see the heading for this section.

14 So the section we're in here and looking at is the
15 Resuscitation Committee/Service Structure Quality
16 Standards section of the document. And if we then turn
17 to page 3 we can see at paragraph 5, that's what you
18 were giving evidence about earlier, about having the
19 lead person responsible for the resuscitation service
20 structure must have an active and credible involvement
21 in resuscitation.

22 And it says:

23 "This person must have the authority to drive and
24 implement change to meet the standards in this
25 document."

31

1 for all staff within an inpatient setting. That will be
2 HCAs and registered nursing staff, we're going to be
3 using an NHS England resource. It's not currently
4 mandated as part of any framework but it's something
5 that as an organisation we feel it's extremely
6 important, so we've taken a proactive approach to
7 actually mandate that for staff. So it's a regular
8 annual refresher.

9 **Q.** But it's not been mandatory to date?

10 **A.** Correct.

11 **Q.** And that's despite your evidence that assessing and
12 understanding that a patient is deteriorating is
13 important to preventing cardiac arrest?

14 **A.** Yes, that's correct.

15 **Q.** In your statement at paragraph 11, you tell us that you
16 do not have a team of people that report to you and help
17 you with resuscitation and physical health matters;
18 that's correct?

19 **A.** So I am supported by the Head of Clinical
20 Transformation, who is another fellow Advanced Life
21 Support instructor and a Generic Instructor Course
22 instructor, as well. We work closely, but that is only
23 the individual that I have regular access and work with.

24 **Q.** Does Mr Smale have experience or training in mental
25 health inpatient care, do you know?

30

1 And you would agree that you have that authority?

2 **A.** Yes, I agree.

3 **Q.** At 6 it says this:

4 "The resuscitation service structure must have
5 administrative support."

6 Given your evidence about not having a team of
7 people to support you, who, if anyone, is providing you
8 with administrative support in your role?

9 **A.** So I'm fortunate enough to lead another team, so if
10 I need administrative support from the Medical Devices
11 Team I'll have that, but also we have another member of
12 the admin team who supports my line manager that we
13 regularly utilise. So they're not dedicated, it's not
14 necessarily within their job description but they
15 support us, they take minutes for the Resus and
16 Deteriorating Patient Group, for example.

17 But that's on top of other duties that they hold,
18 and responsibilities.

19 **Q.** Do you consider you have enough administrative support
20 for your role?

21 **A.** Yes, currently. I think if I needed additional I would
22 obviously make that request. At the moment I deem it to
23 be sufficient.

24 **Q.** I'm going to come back to your role in respect of
25 training later in your evidence. On a day when you're

32

1 not delivering training, you say in your statement that
 2 you're based either at The Lodge in Wickford or
 3 Rivendell in Colchester. You've described those
 4 locations as an "administration space" in your statement
 5 and for those following that's at paragraph 22. That's
 6 not an inpatient unit or ward, is it?
 7 **A.** That's correct. The Lodge is our Trust headquarters and
 8 Rivendell is an administrative building on the site of
 9 one of our CAMHS units.
 10 **Q.** How close is the nearest inpatient unit to The Lodge?
 11 **A.** Brockfield House is probably a third a mile away to the
 12 main entrance, to the main gates.
 13 **Q.** How long would it take to get there?
 14 **A.** If I was to walk, it would probably take me three
 15 minutes, potentially, four minutes. But that's to the
 16 main gates. Then there is a driveway and then there is
 17 access to all of the secure service wards. So that is
 18 literally to the front gate.
 19 **Q.** How long would it take you to get to a ward?
 20 **A.** Seven, eight minutes, potentially. Nine minutes,
 21 depending which ward it is.
 22 **Q.** You said Rivendell is an administrative space at one of
 23 the CAMHS units?
 24 **A.** Yes.
 25 **Q.** How long would it take you to get to an inpatient ward

33

1 a deteriorating patient or indeed a medical emergency or
 2 a CPR event, I will reach out to the teams, to offer my
 3 support in whatever form that takes. I always ask --
 4 I will ask to be invited to any debriefs, and SWARM
 5 huddles. That process has been further improved over
 6 time. I now get invites from the Patient Safety Team
 7 without me necessarily even having to ask for them.
 8 That is a change that has occurred.
 9 I will also actively participate in SWARM huddles,
 10 and debriefs, listen to some of the challenges that the
 11 teams face, offer my support and potentially identify --
 12 and commend examples of good practice because that is so
 13 important. But also help identify key learning from
 14 incidents. Some of that key learning that we've
 15 identified, I hosted -- myself and Mr Smale hosted
 16 a live event last week, another one, I've done a number,
 17 where a lot of the key learning that we have identified
 18 since I've joined was shared again.
 19 But I'll use the example of the SWARM huddle. There
 20 was one particular huddle where the team were concerned
 21 that they couldn't easily identify the positioning of
 22 a particular piece of equipment within the resus bag.
 23 That led to a change and making it easier for the team
 24 to find that by placing it in the mesh pocket within the
 25 resus bag.

35

1 at Rivendell?
 2 **A.** Probably four, five minutes.
 3 **Q.** So eight to nine minutes to four or five minutes. You
 4 can't be there immediately, can you, in the event of an
 5 emergency?
 6 **A.** Sorry, can you define "immediately"?
 7 **Q.** Well, if an emergency happened, you wouldn't be able to
 8 get there in time -- (overspeaking) --
 9 **A.** I would have to walk or run to get that to that facility
 10 unless I was on the ward delivering some training.
 11 **Q.** Now, a significant part of your role is to monitor
 12 resuscitation incidents for learning?
 13 **A.** Correct.
 14 **Q.** Can we have a look at your statement, then, at
 15 paragraph 9, which is on page 3. You tell us at the end
 16 of that statement, you say this:
 17 "In addition, I review the effectiveness of care
 18 processes to identify examples of good practice and
 19 areas for improvement, contributing to the Trust's
 20 culture of learning."
 21 Mr Archer, what does that mean?
 22 **A.** So when a medical emergency happens, there will always
 23 be a Datix incident report that is completed. Part of
 24 my role, every morning I look through the vast number of
 25 Datixes that I receive. If I see one that relates to

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1 There was also concern, we have handheld suction
 2 devices within the resus bag which are great as a first
 3 line piece of equipment, should we need to remove fluid
 4 from a patient's mouth. On this particular example they
 5 needed some additional, an additional piece of equipment
 6 that would provide more suction so that led to me
 7 putting a proposal to the various governance groups and
 8 actually procuring the equipment in light of patient
 9 safety, listening to staff feedback.
 10 And the other, the other thing that came that was
 11 shared, the other thing that I picked up on was that
 12 teams would appreciate more simulations. So simulations
 13 have been in place since way before I started, so again,
 14 we shared all of that information in a safety alert and
 15 that information has been cascaded to the teams, as
 16 well.
 17 **Q.** So that sentence there, in summary, is about the work
 18 that you do through Datix, SWARM huddles and at the
 19 briefs to identify, as you say, good practice and areas
 20 of learning?
 21 **A.** Yes, correct, yeah.
 22 **Q.** You've mentioned there your Datix review. Where are you
 23 physically based when you're doing that review?
 24 **A.** So physically in front of my laptop at whatever site I'm
 25 working out of at that moment in time.

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1 **Q.** So you access the Datix reports on a computer on your
2 laptop?
3 **A.** Yes, on my laptop.
4 **Q.** And you've said you look at them daily. How do you know
5 which ones to look at? Do you have to review all of the
6 reports that have come in overnight?
7 **A.** Yes. I get -- I know which -- I'm looking at keywords.
8 I'm looking at actions, not necessarily every single
9 word within the body of the incident, but I look at
10 everything. There's some that I don't have to do
11 anything with. There are some that I reach out to the
12 teams.
13 **Q.** And you said just now that you look thorough "the vast
14 number". Can you give the Chair an indication of how
15 many reports you have to look through to find the ones
16 that relate to deteriorating patients' CPR?
17 **A.** That's really challenging because I get Datixes that
18 relate to falls, restraints, a whole host of -- it could
19 be -- I could come in in the morning, there could be 40
20 Datixes on top of my other emails that I review.
21 There's a whole host of incidents that are shared with a
22 distribution list that I'm part of.
23 **THE CHAIR:** Can I ask you, does the Datix identify for you
24 what the precise issues are within that particular
25 incident?

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1 specific dropdown will make it easier for the
2 information to be sought. We also, when I first
3 started, in relation to Datix, I sat with the Datix
4 manager. The information that -- pretty much all of the
5 information that is on the Resus Event Form, is also on
6 Datix. So if I don't see a Resus Event Form, the
7 majority is on Datix. There is also -- we also added
8 a dropdown for: was CPR performed? So it makes it
9 easier to source incidents but again, that's if somebody
10 that is submitting the Datix uses the right dropdowns.
11 So that's --
12 **THE CHAIR:** That's helpful, thank you.
13 **MS SAGE:** Your identification of whether a -- whether there
14 is a Datix report relating to your area, so relating to
15 deteriorating patients or CPR, relies on the person
16 filling in the Datix form to select the correct
17 dropdown. So for example, to select CPR on the
18 dropdown; is that correct?
19 **A.** That's part of it. I don't necessarily -- I don't even
20 need to get to that detail to see that there has been
21 a resuscitation attempt, for example. That's captured
22 in the body of the Datix but I can see from the
23 information that's provided at the beginning of the
24 Datix. I can see straight away that that's a medical
25 emergency or that's a resuscitation attempt.

39

1 **A.** Yeah, it's -- yes. It's two parts. So there is almost
2 an issue and an action. So I would look at both.
3 I would read through the incident, the presenting
4 incident, and then the actions taken.
5 **THE CHAIR:** And is there any sort of grading or
6 prioritisation on the Datix as to its seriousness,
7 and --
8 **A.** No, that will be reviewed as part of the Patient Safety
9 Team. So they will look at the Datixes and they will
10 grade those. That's not something that -- there is --
11 the Datix system is useful but it can be very reliant on
12 the dropdown and the topic that the person reporting
13 uses to raise the Datix. So I may not see some, if it's
14 been recorded using a -- am I okay just to expand on
15 that a little bit further?
16 **THE CHAIR:** Yes.
17 **MS SAGE:** Yes, please.
18 **A.** So one of the challenges in relation to deteriorating --
19 acute physical health deterioration is how the incident
20 is recorded. So it could be under a number of different
21 subheadings and categories.
22 So I have made a proposal to include a single
23 dropdown in relation to acute physical health
24 deterioration. So what that means is we have -- I've
25 also asked for a report to be populated and that

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1 **Q.** And you have to do that for every Datix report that
2 comes in?
3 **A.** I review every Datix that comes in to my inbox.
4 **THE CHAIR:** But you're seeking a separate dropdown. Where
5 have you got with that?
6 **A.** So I have submitted a request. There is a governance
7 process to add something to that system. That form has
8 been completed, submitted. I've already had the
9 conversations. I had the conversations a number of
10 weeks ago to make it easier. So I am hoping that -- I
11 believe it's 20 October, I could be wrong, it's the
12 Health and Safety Group that would need to approve that,
13 so I'm -- hopefully by the end of this month if not the
14 beginning of next, that dropdown option will be there,
15 so we can easily draw the data that relates to the acute
16 deterioration of physical health.
17 **THE CHAIR:** Thank you.
18 **MS SAGE:** As I understand that, you say it was a few weeks
19 ago that you made that suggestion. What prompted you to
20 make that suggestion at that time?
21 **A.** My experience over time of being easily able to pull
22 reports around deterioration, because as I've found,
23 it's -- they can be -- the Datixes can be logged under a
24 number of different headings. So whilst I've been able
25 to find it, it's not the easiest thing to be able to put

40

1 your finger on. So I've made it easier for the team to
 2 be able to source that information quickly.
 3 **Q.** But to date, if you've needed to, as you say, pull
 4 a report, it's not easy to do that on the system as it
 5 stands?
 6 **A.** No, I would work with our Datix lead, who also has an
 7 assistant. So if I need particular information I would
 8 ask them to work with me to compile that report. They,
 9 being the administrators for the, you know, for the
 10 incident reporting process, they would support me in
 11 that. It wouldn't just be me. But there are a vast
 12 number of dropdowns.
 13 **Q.** How many are there?
 14 **A.** Oh, to be perfectly honest, I wouldn't be able to answer
 15 that, personally.
 16 **Q.** So to pull a report based on somebody's selection of
 17 dropdown, that person has to, from that vast number
 18 select the correct one; is that correct?
 19 **A.** To make it easy to pull that report. Otherwise you'd
 20 have to scroll through a number of -- well, all the
 21 dropdowns to see if it had inadvertently been inputted
 22 using a wrong dropdown, for example, because it is user
 23 error at the end of the day. I mean, there are a number
 24 of different dropdowns. It's around education, to make
 25 sure that the staff members select the correct dropdown,

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1 of dropdowns --
 2 **A.** Absolutely.
 3 **THE CHAIR:** -- a busy person may not necessarily --
 4 **A.** Absolutely.
 5 **THE CHAIR:** -- identify the right one.
 6 **A.** Correct. Yes, there is a risk that something could be
 7 documented under a different heading, or there is a risk
 8 that something is documented as a patient that is
 9 unwell, following a fall, that then goes into cardiac
 10 arrest. So there is a need to update that Datix. So
 11 what you may initially report may actually turn into
 12 something else.
 13 **MS SAGE:** Mr Archer, we're going to take a break there, in
 14 your evidence, and we're going to come back in 15
 15 minutes, which will be 10.50.
 16 **THE CHAIR:** Thank you. 10.50.
 17 (10.36 am)
 18 (A short break)
 19 (10.53 am)
 20 **THE CHAIR:** Ms Sage.
 21 **MS SAGE:** Mr Archer, before we return to Datix, can I just
 22 ask you, how many resuscitation events have you been
 23 involved in in the course of your career?
 24 **A.** So I've thought about this a good couple of months ago.
 25 I would estimate at least 300, if not 400, perhaps

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1 and as I say, there are dropdowns ranging from estates
 2 and facilities to medical emergencies to restraints, to
 3 choke -- there's -- vast. And then there's
 4 subcategories, as well.
 5 So whilst it's a great tool in order to document and
 6 record an incident, it's not necessarily particularly
 7 easy when you need to find specific information.
 8 Does that help? Sorry.
 9 **Q.** It does, yes. I just want to make sure I understand.
 10 That means, for example, at the moment, if you wanted to
 11 do a report on every deteriorating patient incident that
 12 had taken place in the last six months, that would be
 13 a challenge?
 14 **A.** I would -- it is doable. It's something that's not
 15 necessarily within my skillset but I've got the
 16 relationships with our Datix manager and his team to be
 17 able to pull that information should it be needed.
 18 **Q.** But you can't yourself sit down at Datix and pull that
 19 report?
 20 **A.** It's not within my skillset. That's why I've got good
 21 working relationships with those that have that within
 22 their remit.
 23 **THE CHAIR:** And it's not just an issue for you pulling up
 24 the information; it's also an issue for accuracy of
 25 input, if you're telling me that there are vast numbers

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1 closer to 500. We responded to paediatric medical
 2 emergencies, paediatric cardiac arrests, adult medical
 3 emergencies, and adult cardiac arrests. Whether they
 4 took place on an inpatient ward or whether they were
 5 brought into us, into resus, by an Ambulance Service.
 6 It was not unusual for there to be at least two calls to
 7 the crash team when I was on call. On some occasions
 8 there could be five.
 9 I would also accompany the anaesthetist, the two of
 10 us would accompany critically unwell patients from our
 11 DGH to other hospitals, for example the Royal London.
 12 So anaesthetised patients, we would transfer them safely
 13 in the ambulance.
 14 So whilst exact numbers -- I would say at least 300
 15 if not 400, but it could be closer to 5.
 16 **Q.** Just clarification there, when you say "whether it took
 17 place on an inpatient ward or resuscitation by the
 18 Ambulance Service", inpatient ward there, you are
 19 referring to the inpatient wards at the acute Trust?
 20 **A.** Yes, correct. Correct.
 21 **Q.** Coming back to Datix, what is the new dropdown going to
 22 say?
 23 **A.** "Acute physical health deterioration".
 24 **Q.** And that's what staff will see, "Acute physical health
 25 deterioration"?

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1 A. Yes, and that's what we will signpost. That piece is
2 going to be a challenging piece. So that will be about
3 education, how we land that, that will be discussed via
4 quality and safety meetings, use of our Professional
5 Nurse Educators to remind staff, but at the end of the
6 day it is dependent on the person. So we can do as much
7 as we possibly can to make it easy for the staff member
8 to have access to the most appropriate dropdown, but we
9 can't, we're not there over their shoulder as they go to
10 make the Datix submission, unfortunately.

11 Q. Once that's added, will there still be other dropdown
12 options that a staff member might use in the event of
13 a deteriorating patient?

14 A. I mean, there's a vast number, as I previously
15 mentioned: falls, choking, restraint. There's a number.
16 So we wouldn't eradicate all of the other options but
17 this will make it easier for the individual to select
18 the most appropriate one.

19 Q. Now, when you review individual Datix records, your
20 daily review, do you record your review of each
21 individual event anywhere?

22 A. No, no.

23 Q. The Inquiry is also interested in how you compare the
24 event that you're looking at that day to previous
25 events. You've told us about the problems with Datix.

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1 put in place. So it was really to showcase what we are
2 trying to do to improve patient care.

3 Q. So it wasn't an audit of previous events in that way --

4 A. No.

5 Q. -- it was a document about learning and changes?

6 A. Absolutely -- it was. It was an opportunity to share
7 what we as an organisation are doing, how we are
8 managing the challenges of deteriorating patients within
9 mental health using the processes and the tools and the
10 aide memoires that we've put together.

11 Q. So you don't have a spreadsheet, as you've told us, that
12 you keep up-to-date. You say you rely on access to
13 other teams; you rely on SWARM huddle reports that you
14 remember have been undertaken, is it right to categorise
15 it this way: when you're looking at a new incident,
16 you're relying on your memory of whether there'd been
17 a previous incident that was like the one you're looking
18 at, and what went wrong in a previous event? Or you're
19 relying on other teams putting together information
20 for you?

21 A. A bit of both. So memory, so I can recall some specific
22 themes. I would be able to look in my -- I'm quite
23 specific in the way that my email inbox is set up so
24 I've specific folders, so I can access previous SWARM
25 huddles, for example. So if I feel and I recall that

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1 You can't pull up a reliable report yourself of previous
2 incidents. Do you have a written record of previous
3 events that you compare that new event to?

4 A. It's the knowledge that I've gained since being within
5 the organisation. You know, we've had thematic reviews
6 that I can reference. We have, obviously, the SWARM
7 huddles that are documented. So there is no -- I don't
8 necessarily hold a spreadsheet but I have access to
9 a wealth of information where -- we recently compiled
10 again another review of resuscitation events, and that
11 was shared with colleagues, ICB, for example. So
12 there's many different reports and that information is
13 captured in a wealth of different places but I don't
14 necessarily have a spreadsheet that I keep up to date.
15 I have -- I'm fortunate, I have access to teams that can
16 support me with that information should I need it.

17 Q. You say you compiled another review of resuscitation
18 events and that was shared with colleagues. What were
19 the circumstances of compiling that review?

20 A. That was to provide an update, I believe, to the -- our
21 ICB colleagues around -- it was really about our
22 improvement journey. So whilst there were figures in
23 relation to incidents, what we were keen to share was
24 our quality improvement journey through lots of --
25 through the changes that we've made and the processes we

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1 there is a theme, I can look back at the information
2 that I've saved. So whilst it's not a spreadsheet,
3 I have access to that information. And if there is
4 information that I can't capture readily, I have
5 additional resources that I can use to support me.

6 Q. You're relying on your memory, aren't you, of there
7 being a link to a previous incident, then?

8 A. To a degree, as well as the documents that I have access
9 to.

10 Q. Do you consider that your ability to firstly identify
11 serious patient safety issues, and secondly, provide
12 appropriate advice or intervention, is reliant on the
13 robustness of the Datix recording system, given what
14 you've told us about your use of it in respect of
15 identifying new events?

16 A. I think the Datix incident reporting tool is a tool to
17 report the incident. For me, the learning doesn't
18 necessarily come from the Datix; the learning comes from
19 the debriefs, from the SWARM huddles, from the patient
20 safety investigation. So whilst it's a useful tool to
21 document the incident, I think there is additional
22 learning that's gained outside of Datix.

23 Q. From the evidence you've given this morning, it appears
24 you agree that there are problems with staff accurately
25 filling in Datix reports; is that correct?

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1 A. I wouldn't say there's problems; I think there are
2 a number of options that they can use. We can gain the
3 information but it's not as easy as if there were just
4 one or two dropdowns. I think that's the challenge we
5 face.

6 We don't have problems capturing the incidents, as
7 far as I'm aware; it's just how they are captured. We
8 don't have a culture where staff feel as though they are
9 unable to report an incident; they absolutely do, but it
10 just may be under a different subheading.

11 Q. And do you consider, then, as a matter of principle,
12 that if there is a problem in terms of staff selecting
13 the right dropdown, and accurately recording information
14 on the form, on the Datix report, it's unlikely that the
15 information you are reviewing on Datix is accurate and
16 reliable?

17 A. I see the majority of Datixes so I don't feel as though
18 that's a problem. If I was able to filter it out, for
19 example, because we had only the one or two dropdowns,
20 that would make my life easier, but I review the body of
21 the Datix anyway. So I don't feel as though I'm
22 missing -- I am able to view what's in front of me.

23 THE CHAIR: It sounds to me as though quite a lot of this,
24 as it were, computer and monitoring of physical patient
25 safety incidents relies on you personally. What would

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1 absolutely apparent and I absolutely recall from past
2 events.

3 If there's something that I'm not a hundred per cent
4 sure of, I will do some digging in my -- the documents
5 that I have to hand.

6 THE CHAIR: Okay, thank you.

7 A. Thank you.

8 MS SAGE: Insofar as you suggest that looking at Datix is
9 a choice, something you choose to do, is that correct,
10 in light of the duty that you have to ensure that all
11 cardiopulmonary arrests are audited and reported on
12 a regular basis? Isn't review of Datix incident
13 reporting a fundamental part of that duty?

14 A. That's correct. Sorry. If I'd used the word "choice",
15 it isn't something that I choose to do. It's something
16 that I do.

17 Q. With that in mind, if reviewing Datix incidents is
18 a fundamental part of you discharging your duty to audit
19 and review CPR events, is it not difficult for you to
20 discharge that duty if you cannot easily refer to
21 previous events on Datix?

22 A. I can. I can refer. I can absolutely refer. I have
23 the Datixes, I have incidents sitting in a folder that I
24 could easily -- I could go back to if needed. I think,
25 when I see a Datix come through, there are absolutely

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1 happen if you weren't there?

2 A. I'm just one of many that actually review these. So we
3 have Deputy Directors of Quality and Safety that will
4 review them at a care group level. So it's not just me.
5 It's just something that I choose to do. There's a
6 number of other people that monitor the incidents. We
7 have a Patient Safety Team that will triage the
8 incidents. We have Deputy Directors of Quality and
9 Safety that will also review incidents. I'm just one
10 person. It doesn't sit solely on my shoulders.

11 THE CHAIR: Okay. And your own personal learning and
12 understanding, which is obviously part of the picture,
13 how do you capture that for yourself?

14 A. I personally feel, to make it easier for myself, that's
15 why we've kind of gone down the route of looking for the
16 additional dropdown to make it easier for us to search
17 for specific -- was it -- sorry? I'm sorry ...

18 THE CHAIR: I was thinking about your own experience of
19 these matters. How do you capture that, or do you just
20 carry it around in your head?

21 A. I suppose I've been part of so many different
22 investigations and reviews and debriefs, I capture a lot
23 of that. I remember, I have memory recall, but then, as
24 I say, I have the resources to back it up. It's a bit
25 of both, really. Some things, some themes are

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1 some themes that we are familiar with. As I say, if
2 there is something there that I recall that may have
3 been the contributing factor, that's something I can
4 look back on.

5 Q. What are the themes that you're familiar with?

6 A. Some of the themes, for example, were staff not being
7 able to administer oxygen correctly. Issues relating to
8 calling the emergency services, for example. The use --
9 communication issues when making that 999 call.
10 There's -- they're just a number. There's, you know,
11 there are a number of themes.

12 Q. And a number of themes that repeat across incidents over
13 the time you've been in your role?

14 A. Yes, they have at time repeated, yes.

15 Q. Can we turn, then, to look at the EPUT Resuscitation
16 Event Forms. I'm going to ask that one comes up on the
17 screen. That's EPUT026695.

18 Now, this is the form that should be completed by
19 staff on the ward when a resuscitation event happens.
20 That's correct?

21 A. That's correct.

22 Q. Can we turn over to the second page.

23 Now, right at the bottom, in terms of what is
24 supposed to happen with this report, we can see at 8:

25 "Place a copy of this form in the patient notes and

52

1 attach to the Datix?"

2 And at 10:

3 "Send completed form to" -- now the email address

4 has been redacted but it's your email address that

5 appears at the bottom of this form, isn't it?

6 A. Yes, when I started the role it was a colleague that was

7 the Nurse Consultant for Physical Health. It was her

8 email address that was there, but then when we reviewed

9 the policy, which would have been in 2023, we made the

10 change. So, yes.

11 Q. At paragraph 55 of your statement you say these forms

12 are attached to Datix incident forms. They've also got

13 your email addresses. Which is right or is it both?

14 Are they attached to Datix and emailed to you?

15 A. Yes, both. They should be -- they should be. They

16 should absolutely accompany the Datix and they should be

17 shared with me as well.

18 Q. Then if we could look at what the CPR Policy says about

19 these documents.

20 So that's EPUT023452, and can we turn to page 15,

21 please.

22 So if we look, then, at paragraph 8.3, it says this:

23 "The Head of Deteriorating Patient Pathways and

24 Resuscitation Training Officer will confirm if the

25 Resuscitation Event Report Form has been completed

53

1 A. So the teams will reach out and they will -- an example

2 I can give: I hadn't even got to the Datix when I'd seen

3 emails from the Senior Leadership offering support to

4 the staff that were involved in the medical emergency.

5 So it's not -- they must absolutely be captured on

6 Datix. They should be shared with myself as well but

7 I will also see -- I will pick up examples like that, as

8 well, so I would hope that I'm aware of every

9 resuscitation event.

10 Q. You hope?

11 A. And if -- unless they do not Datix it and do not send a

12 complete -- a resus event form and none of the Senior

13 Leadership Team make me aware, I mean that's -- I've not

14 known that, to be perfectly honest.

15 Q. Do you consider that there's a risk that resuscitation

16 events are happening without your knowledge at EPUT?

17 A. Well, no, because there are other teams, as I mentioned

18 earlier. I am not the only person that looks at these

19 incidents. We have a patient, a specific Patient Safety

20 Team. I have close working relationships with our

21 Deputy Directors for Quality and Safety. So I'm not

22 a single point of failure. It's something that I review

23 as part of my role but if I was sick these would be

24 picked up by somebody else.

25 Q. When you receive a resuscitation event form, what do you

55

1 following a resuscitation event, and review in order to

2 identify examples of good practice, any knowledge or

3 technical/non-technical skills shortfalls and potential

4 lessons identified."

5 And then it moves on to talk about your contribution

6 to attending SWARM huddles or debriefs, which we'll come

7 back to.

8 Are you confident, Mr Archer, that you receive one

9 of these forms every time there is a resuscitation

10 event?

11 A. There are occasions when I don't get sent the form, and

12 as part of my review of the incidents that come through

13 I will reach out to the teams to ask them to share that

14 with me.

15 Q. So if you see an incident on Datix and you haven't got a

16 form, you will contact the team to ask for one?

17 A. I will reach out and that's something that -- yes.

18 Q. In that sense you're reliant on the incident either

19 being reported on Datix, or you being emailed

20 a Resuscitation Event Form. Is there any way for you to

21 check that you've been told when a resuscitation event

22 has happened in the event, you know, if you -- if

23 there's no Datix and there's no Resuscitation Event

24 Form, will you know that a resuscitation event has

25 happened?

54

1 do with the information that's on that form? Do you

2 record it anywhere for --

3 A. No, I review it to see if there's anything that -- if

4 there's any immediate learning, for example a delay --

5 I'm using this as an example I've just made up --

6 a 15-minute delay in calling for an ambulance or

7 a 20-minute delay in -- or, or 30- or 40-minute delay in

8 the ambulance crews attending a category 1 call. So

9 there is some learning on there that can be gained, but

10 the majority, it's a tool that accompanies the Datix

11 submission. You get more learning and an ability to

12 identify key learning and examples of good practice,

13 through the subsequent events that take place, so the

14 debriefs and the SWARM huddles.

15 So it's useful for glaringly obvious bits and pieces

16 but you may get more information, and even more key

17 learning, from being part in and engaging with the SWARM

18 huddle.

19 Q. And in terms of considering whether any issues in that

20 Resuscitation Event Form have occurred before, is it the

21 same as when you review Datix? You're relying on your

22 memory of incidents and themes that have occurred

23 before?

24 A. Yes, and we will talk within the Patient Safety Team and

25 our DDQS colleagues, we will talk about those things.

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1 Q. Can we turn to page 19 of this CPR Policy.
 2 Mr Archer, I want to look at the first paragraph,
 3 marked 13.3 on that page. And that refers to the
 4 assessment of compliance with the policy. Two of the
 5 items are this:
 6 "Review of completed Resuscitation Event and Datix
 7 Incident Forms following a CPR event."
 8 And then the third one:
 9 "Use of correct documentation both preceding and
 10 during a resuscitation event."
 11 Now, is it right that a significant part of
 12 assessing compliance with this policy, in respect of the
 13 policy, relies on all incidents being reported through
 14 one of those two means?
 15 It says there "Review of the completed resuscitation
 16 event and Datix Incident Forms."
 17 A. Yes.
 18 Q. And can we look, whilst we're here, at paragraph 13.5.
 19 So another way that this policy is monitored is,
 20 it's said, through an annual report of resuscitation
 21 events and patient outcomes.
 22 Now, that sentence has been in the CPR, it used to
 23 be in the CPR Policy document. It's been there since
 24 2017, before you joined EPUT. The Inquiry has not been
 25 provided with any annual reports of resuscitation events

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1 happens is the incident is reported, we will have the
 2 hot debrief, the cold debrief, we'll have the SWARM
 3 huddle. Then there will be, as part of the PSIRF
 4 framework, there will be a Patient Safety Investigation.
 5 I am regularly called in to assist in, if there is an
 6 element of resuscitation, I will be asked to populate
 7 a timeline. So I will be looking at timings, for
 8 example, how quickly the team responded, how quickly the
 9 defibrillator was attached, how quickly the oxygen was
 10 administered.
 11 So that can only be gained as that's something we
 12 have to request the footage for the -- of the CCTV or
 13 the Oxevision that sits within a patient's bedroom.
 14 Q. And if there's no footage available, how does that
 15 impact on your ability to review incidents?
 16 A. I would need -- you can talk to staff. Staff, because
 17 of the nature of the events, find it very challenging,
 18 can find it very challenging to recall timings. As
 19 I say, it's not something our team see very regularly.
 20 It's very stressful, it's very emotional. So memory
 21 recall can be really challenged in one of these
 22 situations. It's significantly easier if we have
 23 a time-stamped Oxevision footage that I can review.
 24 I can ask questions but teams will be reliant on
 25 their memory recall in a medical emergency.

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1 and patient outcomes. Have you ever prepared one?
 2 A. I acknowledge that the wording says "annual reports".
 3 That will be changed. What we do provide is quarterly
 4 updates to the Care Committee, and that is -- they go
 5 into our Executive Medical Director. So this is --
 6 there are some elements of the documentation that we
 7 will be amending but I agree, it's not a specific annual
 8 report, but the reports go in in different formats.
 9 Q. So despite this sentence being in the policy since 2017,
 10 there's never been an annual report of resuscitation
 11 events and patient outcomes prepared, to the best of
 12 your knowledge?
 13 A. I'm not sure what was prepared before I joined EPUT.
 14 Q. But since you joined there's never been an annual
 15 report?
 16 A. Not -- that's legacy, so correct. The reports go --
 17 apprehend in a different format. And I acknowledge
 18 that.
 19 Q. One of the other things you tell us you do in your
 20 statement is reviewing CCTV or LIO footage. Is that
 21 review of the footage linked to the Datix reports or
 22 resuscitation events you're reviewing or is that a
 23 separate task in respect of other patient safety
 24 incidents?
 25 A. So that will be linked to an incident. So what normally

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1 Q. Can we now look at paragraph or look again at
 2 paragraph 10 of your witness statement, which is on
 3 page 4, the top of page 4 ... you tell us in the fourth
 4 line -- the third line:
 5 "I am also responsible for carrying out reviews of
 6 allocated Policies and Clinical Guidelines as the named
 7 author ..."
 8 Are the policies that you review the CPR Policy and
 9 the CG87 clinical guidelines on the use of national
 10 early warning systems? Is that correct? Do you review
 11 any other policies?
 12 A. The Physical Health Guidelines.
 13 Q. And in terms of the reviews, is that a daily task,
 14 a yearly task? How does that -- how often are you doing
 15 that?
 16 A. So at a minimum, it will be a 3-year review, but they
 17 are reviewed should there be any key learnings, should
 18 there be change in legislation, guidance. Change, for
 19 example, we've made some interim amendments when we've
 20 implemented the specific aide memoire tools. They were
 21 before the end of -- they were before the 3-year review.
 22 So as and when there is a need to amend it. But at
 23 a minimum, it's three yearly.
 24 The Policy Team will provide a one-year reminder to
 25 the named author. I've also been named as some of the

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1 other authors, and challenged that I'm not actually best
2 placed to be the author. And that, again, has been
3 acknowledged and accepted. But I will get a 12-month
4 reminder. I will then get, I think, it's a 6-month
5 reminder.

6 If there are challenges with the policy being -- the
7 review being completed for whatever reason, we have
8 processes in place where extensions can be requested.
9 **Q.** You also say in this paragraph, you talk about chairing
10 the Harm Free Care Group, which you've given evidence
11 about already today, and the Resuscitation.
12 Deteriorating Patient and Medical Devices Group, and
13 then you say you also feed into other forums, and you
14 list them there. What does reporting into forums mean
15 in the context of the forums you've listed? Is that
16 attending or sending a report to those meetings?
17 **A.** I will attend. I will attend those and I will provide
18 information. There's not a written report for these
19 particular groups, unless one is requested.
20 **Q.** You also tell us in your statement that you provide
21 help, advice, and support to operational staff as
22 required, and in paragraph 14 of your statement on the
23 next page, you tell us that elements of your role
24 include proactive and reactive teaching, mentoring,
25 supporting and debriefing of staff.

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1 **Q.** How many walk-around assurance visits have you done?
2 **A.** Probably -- I don't know, approximately ten. That was
3 predominantly in the west of Essex. But we've also
4 identified some equipment improvements, as well. So
5 that has meant that I've met the team at one of our
6 sites at Epping, and I've bought the rep on site and
7 we've talked through the improvements that could be
8 made. So there's a number of reasons why I would attend
9 an inpatient ward.
10 **Q.** And you say at the end of that paragraph you can be on
11 a ward five days a week or once every three weeks, it's
12 solely dependent on circumstances, can you help us with
13 how many times you do go onto a ward in an average week?
14 **A.** It could be that I'm not on an inpatient ward one week,
15 but then there could be the following week that I have
16 a series of planned refresher sessions, like we did with
17 colleagues at Epping and Harlow. So every week for
18 a number of weeks, a significant number of weeks,
19 I would be on one of the two sites. So it does vary.
20 **Q.** Could you say how often in an average month, or is it
21 the same answer?
22 **A.** It's -- I mean, it's the same. I could say that two,
23 three, four times a month. It could be more, depending
24 on if there is an incident, obviously. And then what
25 comes out of the incident, as well, if there's

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1 Those elements of your role, they can involve going
2 onto an inpatient ward, can't they?

3 **A.** Yes, correct. Absolutely.
4 **Q.** And is it right that you would go on to a ward in these
5 situations: if you were invited to deliver ward-based,
6 additional training?
7 **A.** If I was invited or if I offered support as part --
8 following an incident, for example.
9 **Q.** You might also go on to a ward because you've been
10 invited to deliver or co-facilitate a simulation?
11 **A.** Yes.
12 **Q.** As you said, you might go on because you were attending
13 a debrief or SWARM huddle after an incident?
14 **A.** Yes, correct.
15 **Q.** Is there any other reason you might go onto an inpatient
16 ward?
17 **A.** On some of the inpatient wards in the west of Essex
18 I work closely with a Deputy Director of Quality and
19 Safety and we did a series of assurance walk-arounds.
20 So we looked at environment, we talked to staff, we
21 talked to patients, we looked at the completion of NEWS2
22 charts and as a team, as a walk-around team, we found
23 anything that could be improved, that was actioned. So
24 I have, from time to time, been part of a walk-around
25 assurance visits.

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1 additional support that the teams need, say, for example
2 refresher sessions, I'll make sure that I'm available to
3 support them.
4 **Q.** In terms of attending after an event, can you help us:
5 how often is there an event that you then go and attend
6 the ward for?
7 **A.** If there is a medical emergency or if there's
8 a resuscitation attempt, I will either attend the SWARM
9 huddle face-to-face or I will join virtually and then,
10 obviously, depending on the additional support that's
11 identified, I'll attend as and when needed.
12 **Q.** I think my question wasn't very clear, then. I was
13 asking how often events happen that you need to attend?
14 **A.** How often? It could be once a month, it could be twice
15 a month, it could be three times a month. I mean, it
16 varies. It's not just resuscitation, anything around a
17 deteriorating patient, and also it's around, as I've
18 previously said, recognising examples of good practice
19 as well. There is a -- and if I'm able to share
20 a couple of examples, I think staff need to be made
21 aware when they've done a really good job. There is an
22 example where a patient had an unwitnessed fall. They
23 had a compromised airway and the team managed that
24 compromised airway with the insertion of a particularly
25 specific piece of equipment that is taught on ILS. But,

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1 actually, that intervention, that timely intervention,
 2 prevented possible deterioration. That could have led
 3 to a respiratory arrest, it could have led to a cardiac
 4 arrest. So that is one example of really good practice,
 5 but that's because we're investing in our teams. We're
 6 going above and beyond just the one-day-a-year training.
 7 The simulations that we are now actively monitoring and
 8 feeding into the quality and safety groups, the
 9 refresher sessions we're delivering, the close working
 10 links we've got with Professional Nurse Educators. Some
 11 teams are doing something around the deteriorating
 12 patient or resuscitation weekly. We're not mandating
 13 that. That's something that they as a team feel really
 14 strongly about, which is amazing. And it is all about
 15 patient safety, it's doing what we can using the
 16 resources that we've got and the techniques and the
 17 sessions we can deliver to help improve patient safety.

18 **THE CHAIR:** You started that by telling us that staff need
 19 to have good practice recognised. How do you do that?
 20 **A.** So I will absolutely -- in SWARM huddles, I will
 21 absolutely make that clear that that is a really good
 22 example of good practice. I think that is so important.
 23 We also have had really great feedback from a coroner.
 24 If I can just expand on it a bit further, myself and
 25 Mr Smale were part of a physical health conference. It

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1 to the patient about how they managed their COPD, the
 2 patient deteriorated quite quickly, the team had already
 3 allocated somebody to scribe and record the incident
 4 because that is what we shared in the simulation. They
 5 proactively used their professional curiosity to apply
 6 the defibrillator pads. The patient wasn't in cardiac
 7 arrest, but they were concerned enough to apply the
 8 pads.

9 The patient deteriorated into cardiac arrest, the
 10 pads were in place, the team was there, the doctors were
 11 there. We ended up with a return of spontaneous
 12 circulation, so a pulse, which is in -- in-hospital,
 13 cardiac arrest is 25% survival rate. What that meant
 14 was the team -- and I believe HEMS arrived and
 15 transported the patient to the acute Trust which was
 16 within the same footprint and what that enabled and
 17 facilitated was an opportunity for loved ones to come
 18 and be with their loved one. The patient sadly
 19 deteriorated even further and sadly passed away, but
 20 that's a real example of watching something that we're
 21 actively promoting and learning from that and recalling
 22 important things, and actually making a difference.

23 The outcome probably would never have changed but we
 24 potentially provided the loved ones with an opportunity
 25 to come and spend the last few minutes, which I think is

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1 was hosted in Southend with a Deputy Director of Quality
 2 and Safety that has left for another Trust.

3 We were asked to spend a bit of time talking about
 4 deteriorating patients and we chose to use a simulation.
 5 There were a number, there was a lot of people, staff
 6 from EPUT that attended the conference. There was one
 7 particular ward that had a number of their clinicians
 8 present. We facilitated a simulation. We shared all of
 9 the examples of good practice, prompts, things that we
 10 should do, things we need to do, things we need to do
 11 quickly.

12 The following week -- we spoke about professional
 13 curiosity, as well. This is a challenge, because you
 14 have a NEWS2 chart which generates a score, but it's
 15 bigger than that. It's looking at the patients in front
 16 of you and thinking, as we would do with a loved one at
 17 home, and saying, "You don't look well. I've got a tool
 18 in front of me that is generating a score of 1 but
 19 I know that you're not well."

20 And it's honing in on that professional curiosity.
 21 And what they did was they thought back to what we'd
 22 spoken about. They thought about calling the doctor
 23 early -- getting as much help as possible. The patient
 24 was unwell, they weren't in peri-arrest, they weren't in
 25 cardiac arrest, they were unwell. They had been talking

66

1 amazing.

2 **Q.** Mr Archer, you've told us about debriefs and about SWARM
 3 huddles this morning. Can you explain what they are and
 4 how they differ?

5 **A.** So there's a couple of different approaches to this. So
 6 a debrief initially, at the time of the incident, after
 7 it's finished, there is a hot debrief. So it's an
 8 opportunity to make sure everybody's okay. Because
 9 they're stressful, they're challenging, they're remote.
 10 People have built up a relationship with the patient
 11 potentially. It's an unpleasant, doesn't matter how
 12 many times you've seen it, it's not a nice thing to be
 13 part of.

14 So that's your hot debrief.

15 There is an opportunity for a cold debrief. So
 16 a couple of days later, whilst offering the signposting
 17 to the support services and making sure staff are okay,
 18 it's an opportunity for staff to ask questions to talk
 19 about what happened, to share how it felt, because
 20 that's really important, but also to ask questions.
 21 Should I -- we did this, was that appropriate?

22 Sometimes, and I've delivered -- I've attended both.
 23 I've attended debriefs where the teams have said,
 24 "Please, Nick, can you come and provide some support?"
 25 I've proactively offered that support as well. I've

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1 also attended sessions where we've actually merged the
2 two. So the SWARM huddle and the nature as it says on
3 the tin, really, is an opportunity to bring everybody
4 that was involved, all of the MDT, whether that be
5 a domestic on the ward that might have raised the alarm
6 through to the person that was delivering the chest
7 compressions through to the doctor that was called, an
8 opportunity to bring everyone together.

9 The Patient Safety Team, as I say, they may have
10 come questions that they are looking to put to the team.
11 I attend them as well to provide some support and if
12 there's some things that I need clarification on, having
13 reviewed the incident, then that's an opportunity. But
14 that's where -- for me, that's where the learning is
15 generated, listening to the teams.

16 The SWARM huddles, as I say, we've already procured
17 equipment off the back, additional equipment to
18 improvement patient safety off the back of a SWARM
19 huddle. We've changed where equipment is stored to make
20 it easier for staff. So they're really important.

21 **Q.** And what is the output of a SWARM huddle? Does it
22 result in any -- in a document being completed?

23 **A.** There is a document. Whoever is facilitating the SWARM
24 huddle will contemporaneously complete a document. That
25 document will be reviewed, the Patient Safety Team, the

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1 actually have a SWARM huddle that is the formal output?
2 I think ... I think there is a difference between
3 a debrief and a SWARM huddle. I think, personally, the
4 debrief is an emotional -- to ensure everybody's okay.

5 If there were some things that came out of the
6 debrief, I would -- they would be captured in the
7 official SWARM. But I think they're very delicate, the
8 debriefs. I would absolutely need a wider conversation
9 with clinicians to talk that one through.

10 **Q.** We've heard -- yesterday we heard some evidence about
11 how stressful the reality of one of these events is.

12 You say, in your statement, that they are inherently
13 high pressure and emotionally demanding situations. And
14 that's correct?

15 **A.** Absolutely. 100 per cent.

16 **Q.** You haven't yourself attended a resuscitation event on
17 a mental health inpatient ward?

18 **A.** Correct.

19 **Q.** When you're attending after an incident, that means
20 you're not bringing with you any direct experience of
21 what those staff will have been through during the
22 emergency, are you?

23 **A.** I challenge that. Having been part of at least 300,
24 I can absolutely feel what the staff are feeling. So
25 I do have to challenge that. And actually, as I say,

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1 relevant Senior Leadership Team, there may be some
2 follow-up actions that directly come as a result of the
3 SWARM huddle. If the patient is deceased, for example,
4 that will form part of the patient safety investigation
5 that comes. So it's an opportunity, as I say, to
6 recognise and acknowledge examples of good practice but
7 also to identify potential key learning.

8 **Q.** And in debriefs, at paragraph 55 of your witness
9 statement, you say that you're unsure if debriefs are
10 documented.

11 **A.** I'm not sure. SWARM huddles definitely are. I'm not
12 sure, because of the nature of the debrief. I think it
13 can be very emotional, things -- it's not as formal as
14 a SWARM huddle.

15 **Q.** And my question was going to be: why are you unsure if
16 they're documented? Which I think you've answered. Do
17 you have any view on how that problem can be addressed
18 so they are documented?

19 **A.** I think you have to be mindful of the nature of the
20 conversations that happen, personally. They could,
21 I mean the matron may choose to document those or
22 whoever is facilitating the debrief, for example.

23 I would welcome having a conversation with our teams
24 to seek additional clarity on that and actually, is that
25 something that we feel needs to be documented, when you

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1 it's probably nearer 500 and that is children, babies,
2 adults. I've witnessed everything. Traumatic cardiac
3 arrests, deliberate acts that have caused cardiac
4 arrest. So I do have to challenge that.

5 **Q.** Do you consider that your lack of experience working in
6 mental health care directly limits your ability to
7 participate in Patient Safety Investigations when an
8 incident occurs on a mental health ward or --

9 **A.** No.

10 **Q.** -- involves a psychiatric patient?

11 **A.** No.

12 **Q.** And without attending incidents on the wards, how can
13 you be assured that practice is consistent and effective
14 across all 52 inpatient units?

15 **A.** Um --

16 **Q.** Or can you be?

17 **A.** Me personally? Or --

18 **Q.** Yes.

19 **A.** I'm not sure how I could do that unless I had CCTV on
20 each inpatient ward that I could review like a Ring
21 Doorbell. I'm not there. I can't, it's only come --
22 that comes from incidents. So when there is some --
23 a process that isn't followed, for example, or there is
24 a failure to rescue a patient, that's how I would -- I
25 can't physically be on every single ward, but we do that

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1 have relationships, really close relationships -- and
 2 sorry -- with our Professional Nurse Educators that will
 3 escalate things of concern. We have great working
 4 relationships with our Ward Managers, our Matrons.
 5 I feel as though staff are comfortable and prepared to
 6 escalate concerns. I personally don't think that there
 7 is ever an incident where a staff member would feel
 8 uncomfortable, and we actively promote that. That's my
 9 opinion.

10 So I think that's probably how I would seek
 11 assurance. And not only that, we have lots of -- we use
 12 a Tendable audit, for example, that has many
 13 different -- that's the platform, the electronic
 14 platform, that has a number of different audits attached
 15 to it. So our assurance is gained by actually the audit
 16 submissions. They generate a dashboard, all of the care
 17 groups have oversight of it. So whilst I personally am
 18 not on the wards, we have the processes in place to
 19 capture that assurance.

20 **THE CHAIR:** What is it monitoring? What is it capturing?

21 **A.** It can be anything; it could be environmental checks.
 22 The fact that the medication fridge is checked
 23 regularly, the fact that the resus bag checks have been
 24 carried out. It can be the fact that every one of the
 25 patients has a NEWS2 chart in place and that escalations

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1 August of this year?

2 **A.** Correct, yeah.

3 **Q.** You've explained, this morning and in your statement,
 4 that you can't attend every resuscitation event. You
 5 say -- and perhaps we can look at it, it's paragraph 21
 6 of your witness statement. And that's on page 6.

7 We can see there that you say:

8 "Whilst I am Resuscitation Officer, given that the
 9 Trust operates across 52 inpatient wards across a vast
 10 geographical area it is not practicable for me to
 11 respond to or participate in cardiac arrest management
 12 in person."

13 Am I understanding this correctly: EPUT is too big
 14 for you to attend every resuscitation event?

15 **A.** It's just the geographical locations of our inpatient
 16 sites. We have 20 inpatient sites. We have probably a
 17 total of 200 if you include community sites. They range
 18 from Clacton, in the north, down to Thurrock, in the
 19 south, which is, I have no idea how many miles that is.
 20 It's a long way. And, for example, and I did use this
 21 example earlier, if I am at Colchester, at the
 22 St Aubyn Centre, for example, and there is a cardiac
 23 arrest in Thurrock, the patient is probably in the acute
 24 Trust by the time I get there. It's just down to the
 25 vast geographical spread.

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1 are made. For example, in relation to the NEWS2 audit,
 2 the question relating to: has each patient got a NEWS2
 3 chart in place? That ranges between 94 and 97% but
 4 that's just one part of it.

5 There is also -- the form is great, but if it's
 6 generating a score -- excuse me, for example, we want
 7 that escalated. So we've got escalation guidance on the
 8 reverse of the form. But the Tendable audit actually
 9 captures that so I think the -- I think it's the Ward
 10 Manager will review the forms, will review the
 11 escalations, and that sits at around 94%, as well.

12 The other thing that we've added around, and we'll
 13 probably talk about simulations in a little while, is
 14 another question that I added, which was around: has
 15 a medical emergency simulation been carried out within
 16 the last three months? So that assurance now is sitting
 17 at 91%, so 91% of our wards have. The others that have
 18 not either responded or have not said yes, that's
 19 captured now as a standing item on the Quality and
 20 Safety meetings for the care groups and that's
 21 challenged. So we have really good oversight of that
 22 now.

23 So again, that's using technology to provide some
 24 assurance.

25 **Q.** And that question, we will come to it, it was added in

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1 **Q.** Can I check in respect of Mr Smale, who is also ALS
 2 trained, do you know whether he's ever attended a
 3 resuscitation event on a mental health inpatient ward?

4 **A.** No, not that I'm aware of.

5 **Q.** I'd like to put up the RCUK quality standard that relate
 6 to this point.

7 So that's RCUK022529, at page 6, and we can see
 8 there paragraph 14, it says this:

9 "In order to maintain standards and clinical
 10 credibility, it is recommended that responding to and
 11 participating in cardiac arrest management is an
 12 integral part of the RO's clinical responsibility. ROs
 13 who have a clinical role must have appropriate clinical
 14 supervision and support."

15 Is it your evidence, then, that the size and
 16 geographical scope of EPUT means that EPUT is not able
 17 to implement this recommendation?

18 **A.** I mean, the -- surely the clinical credibility sits with
 19 the fact that I teach Advanced Life Support, the fact
 20 that I am not personally involved ...

21 **Q.** Mr Archer, apologies. I'm not asking you about your
 22 clinical credibility. The question is, this is
 23 a recommendation in the Quality Standards, and it's
 24 a recommendation about responding to and participating
 25 in cardiac arrest management. And I'm asking whether

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1 it's your evidence that it's the geographical scope and
 2 size of EPUT that means it's not possible for you to
 3 respond to and participate in cardiac
 4 -- (overspeaking) --
 5 **A.** Potentially, yeah. If I put it into perspective, the
 6 acute Trust that I worked with was under one roof. All
 7 of the wards were on three different floors. I could --
 8 yes, of course. I could get there in a timely manner,
 9 but it would be a significant challenge for me to get to
 10 Thurrock from Epping in three minutes in order to, you
 11 know, to get the defibrillator attached. It's just --
 12 that's why we upskill our staff.
 13 **Q.** One of the locations you do your administrative work
 14 for, we've heard, is at Rivendell, which is -- is that
 15 at the St Aubyn Centre?
 16 **A.** Close to it, yeah.
 17 **Q.** Has any consideration been given to locating you for
 18 your administrative work at one of EPUT's larger mental
 19 health inpatient sites, for example the Linden Centre?
 20 **A.** Not that I'm aware of.
 21 **Q.** So it's not something you've discussed with your
 22 managers at EPUT?
 23 **A.** I mean, I could, but then there is absolutely no
 24 guarantee that the cardiac arrest would occur in that
 25 particular building. We've got -- we have 20 different

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1 on, as well. We're looking for paragraph 15.
 2 Paragraph 15, the Quality Standards are talking about
 3 team leading, in resuscitation events. And it says
 4 there:
 5 "Ideally, the role of team leader in a Resuscitation
 6 Team should be undertaken by a person who is current
 7 Advanced Life Support provider."
 8 Again, this is a recommended standard. It's not one
 9 of the mandatory standards in the quality guide; that's
 10 correct?
 11 **A.** Yes.
 12 **Q.** And EPUT doesn't currently provide ALS training to any
 13 of its inpatient registered nurses or doctors or other
 14 staff?
 15 **A.** We are unable to provide that as an organisation. Some
 16 of our staff may be ALS providers, for example, some of
 17 the junior doctors that are on rotation may have just
 18 come from an acute Trust where they've just done
 19 Advanced Life Support.
 20 **Q.** Do you keep a track of which of those doctors have ALS
 21 training?
 22 **A.** The medical staffing team would. I personally don't.
 23 **Q.** So the medical staffing team at EPUT would have --
 24 **A.** Yeah.
 25 **Q.** -- information about that?

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1 sites. I think -- I'm not sure how I could achieve
 2 that. It's an option, it definitely is an option, but
 3 it's very dependent on where the incident takes place.
 4 **Q.** Can we turn to page 15 of this document, please,
 5 Mr Archer, so we're now in the section of the Quality
 6 Standards that relate to resuscitation teams and
 7 responding personnel.
 8 In paragraph 2 there you can see it says:
 9 "The resuscitation service structure must determine
 10 the composition of the Resuscitation Team/responding
 11 staff."
 12 It's right there's no specific Resuscitation Team at
 13 EPUT, is there?
 14 **A.** Correct. What we -- sorry, if I can just expand on that
 15 further. The Resuscitation Team is actually, at the
 16 start of a shift you will have what they class as rapid
 17 responders. So whilst we don't have a dedicated resus
 18 team like you may have because we haven't got the
 19 medical registrars, the anaesthetic registrars, we have
 20 a response that is predetermined at the start of
 21 a shift. That will be our --
 22 **Q.** Yes, so there's no EPUT-wide Resuscitation Team; instead
 23 what there are is responding staff?
 24 **A.** Absolutely.
 25 **Q.** Can we turn to the next page. I'm sorry, another page

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1 Do you agree or consider that the reason that the
 2 RCUK Quality Standards include this recommendation for
 3 the attendance of someone trained in Advanced Life
 4 Support to lead a team is because it would be beneficial
 5 for an ALS-trained staff member to be there?
 6 **A.** It may be beneficial. We don't have the equipment in
 7 order to, for example pacing is covered in Advanced Life
 8 Support when you need to externally provide pacing to
 9 keep the patient's heart rate at a certain level. That
 10 requires a specific piece of equipment. We have that in
 11 an acute Trust. We don't have that because our staff
 12 aren't trained to that advanced level. So whilst it may
 13 be appropriate, there are things that are covered in
 14 Advanced Life Support that are also covered in Immediate
 15 Life Support. Advanced life support, we teach airway
 16 management, as a specific skill station. It's exactly
 17 the same for Immediate Life Support.
 18 We teach leadership, the non-technical skills that
 19 are required in resuscitation. That's taught in
 20 Immediate Life Support.
 21 So it could be beneficial but it wouldn't be
 22 problematic if we did not have an Advanced Life Support
 23 provider.
 24 **Q.** Taking into account what you say about the equipment
 25 that would be available on an inpatient ward, can you

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1 explain what would be the advantages, the specific
2 advantages, of having an ALS-trained staff member there?
3 **A.** So as part of your A to E assessment, if you recognise
4 that the patient needed transcutaneous pacing, so pacing
5 that can only be administered with a specific piece of
6 equipment, if you had the equipment and an ALS provider,
7 you can do that. That's not -- that doesn't -- we are
8 not mandating our staff to be Advanced Life Support
9 providers. That is a skill and that is an enhanced
10 skill. That could be -- that could be an example of
11 when an Advanced Life Support provider and the relevant
12 equipment could be beneficial. However, for us, it's
13 about recognising the patient is unwell, escalating
14 early so, actually, the paramedics will come and they
15 would be your Advanced Life Support providers with the
16 equipment that could potentially carry out that pacing.

17 Another example. We teach the insertion of
18 a supraglottic airway in Immediate Life Support. We
19 teach the same thing on Advanced Life Support as well,
20 because it's easy to use and you get a similar result.

21 On Advanced Life Support, we've kind of moved away
22 from teaching -- we don't teach laryngoscopy, the
23 insertion of an endotracheal tube. If that is a skill
24 that an anaesthetic registrar will possess, that's
25 absolutely fine because that's something that they do

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1 It's -- our passion is to constantly strive to
2 improve and by bringing in these two practitioners with
3 a wealth of knowledge, one is part of the trigger
4 response team in an acute Trust. So when a patient
5 deteriorates, they will be part of that team that
6 responds before a medical emergency, so they bring
7 a whole wealth of knowledge and experience.

8 The other is currently delivering a number of
9 different trainings but they have a background as
10 ambulance personnel. So, again, they bring some -- they
11 bring a huge wealth of experience.

12 **Q.** Has there been any discussion about locating them at
13 larger inpatient units so that if you were also located
14 at a larger inpatient unit, there'd be one of you across
15 three of the units?

16 **A.** Not to date, but that is something that I would be more
17 than happy to talk through with our clinical colleagues.

18 **Q.** And do you consider that three resuscitation officers is
19 enough for a Trust the size of EPUT?

20 **A.** I would love to have 52. I would love for one to be on
21 site every single time, but that's a significant
22 challenge. I think what we bring is our passion for
23 learning, and identifying when things don't quite go to
24 plan, but proactive -- bringing proactive -- our passion
25 for being proactive. We are not reactive. We like to

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1 regularly, so they will have the equipment for that on
2 the crash trolley, we don't, and that will come with
3 significant risk. It's not the time and place to start
4 learning laryngoscopy in a cardiac arrest.

5 **Q.** EPUT is now recruiting two additional Resuscitation
6 Training Officers who will be ALS instructors and
7 therefore automatically ALS providers. Has there been
8 any discussion about whether there's an intention for
9 them to be available to attend resuscitation events or
10 is it the same? They won't be expected to attend?

11 **A.** Again, so if I can provide a little bit of oversight.
12 For us, part of their role will be to deliver the Resus
13 Council ILS in-house. That comes with a whole host of
14 benefits. That's something that I've been working on
15 since I first started. Because of the organisational
16 knowledge and the key learning that we've identified,
17 there is a risk with outsourcing it that that isn't
18 captured as part of the training. So that's one reason
19 we've created the physical health faculty, but it's
20 bigger than that. Because our patients now come in with
21 a whole host of comorbidities, complex medical
22 conditions that need management and need support. This
23 faculty are going to support us in our physical health
24 training as well, so it's not just resuscitation
25 training; it's bigger than that.

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1 stay ahead of the curve as much as we possibly can.
2 I would absolutely love for a resus officer on each one
3 but, you know, that ... that's not in the plan at the
4 moment as far as I'm aware.

5 **Q.** Mr Archer, you were in the room earlier when I was
6 reading a summary of Ms Borton's statement, second
7 statement, in which she tells us about the Basildon
8 Hospital crash team, and the agreement that used to be
9 in place between the crash team and the mental health
10 unit at Basildon, and that agreement is no longer in
11 place and ended before you started your role.

12 Where an inpatient unit is co-located with an acute
13 hospital, would your preference be to have an
14 arrangement for the crash team to attend?

15 **A.** I think that comes with risk, the risk being that
16 acute -- as I say, my experience of working as part of
17 a crash team, there could be three resuscitations going
18 on at the same time. If our team are reliant on waiting
19 for help to come from outside, I believe there's a risk
20 that they may be waiting. That my personal risk.

21 I think whilst we are co-located, if we put it into
22 perspective, if I'm at the King's Wood Centre in
23 Colchester, for the team at Colchester District General
24 Hospital to get to us, whilst it is on the same
25 footprint, ten minutes to walk. And then they've got to

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1 bring, if they choose to bring their equipment, unless
 2 we have specific equipment aligned for them, there is
 3 a risk that they're going to damage the equipment
 4 bringing it across to site.
 5 I personally feel that that comes with a risk. What
 6 I think is most important is upskilling our staff to
 7 recognise a deteriorating patient and then to do the
 8 basics right. And what I mean by that is checking for
 9 a response, calling for help early, delivering those
 10 effective chest compressions, delivering the shock in
 11 a timely manner.
 12 Today, you can have ambulance response times
 13 seven minutes, for example. It could take ten minutes
 14 for the team to come from Colchester, so I think that's
 15 a risk that would need real -- that would need a risk
 16 assessment, that would need a conversation with our
 17 clinical colleagues because I would be uneasy with that,
 18 because of how -- knowing how busy they are.
 19 **Q.** And can I take it from that that since you started your
 20 role in May 2022, you -- that's not something you've
 21 discussed with your managers, in terms of implementing,
 22 or you have?
 23 **A.** No, not at the moment. The conversations that are
 24 happening at the moment are -- because when a patient is
 25 in cardiac arrest, there's potentially missed

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1 **THE WITNESS:** Thank you.
 2 **THE CHAIR:** 12.20, thank you.
 3 **(12.04 pm)**
 4 **(A short break)**
 5 **(12.23 pm)**
 6 **THE CHAIR:** Ms Sage.
 7 **MS SAGE:** Can we have on screen the CPR Policy and the
 8 Clinical Guidelines on the Use of National Early Warning
 9 System, that's EPUT023441 and EPUT023452.
 10 Mr Archer, we've seen these before today. These are
 11 the two policies that you author or two of the policies
 12 that you author. These documents, once ratified,
 13 they're put up on a system called SOPHIA; is that
 14 correct?
 15 **A.** Yes, correct.
 16 **Q.** As a member of staff, do you receive a notification to
 17 tell you when a new or updated policy has been uploaded
 18 to SOPHIA?
 19 **A.** That information is shared by the Policy Team so I see
 20 indications of what has -- I have seen that in the past.
 21 **Q.** The CPR procedure, or policy, now consolidated is
 22 41 pages. It's got 20 pages of policy and then
 23 appendices which are a mix of hyperlinks and text
 24 included in the policy, and within that policy, there's
 25 also a list of other policies that relate to it or

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1 opportunities. What we're focusing on is the
 2 deteriorating patient. So the conversations that are
 3 happening now are in relation to the support that could
 4 be provided from our acute Trusts on the same footprint
 5 that aren't necessarily two minutes away walking
 6 time-wise, but the advice and support they can gain. So
 7 it's about building those relationships and I'm aware
 8 that our Chief Medical Officer is -- our Executive
 9 Medical Officer is having conversations. They are
 10 taking place.
 11 Because I think, for those patients, they're the
 12 ones that we need to -- we need real advice. We need to
 13 decide whether it's something we can manage in-house or
 14 whether it's something that we need to transfer. And
 15 then, if we do need to transfer, there is massive risk
 16 with putting our cohorts of patients in a busy A&E
 17 waiting room. So we need an appropriate pathway, SDEC,
 18 for example, is a potential, but that would need
 19 planning.
 20 **Q.** Sorry, SDEC?
 21 **A.** Same day emergency care. That's a provision within --
 22 sorry -- within an acute introduced.
 23 **MS SAGE:** Thank you.
 24 Mr Archer we're going to have a break there. We'll
 25 break for 15 minutes so we'll come back at 12.20.

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1 should be read in conjunction with it. And the same
 2 applies in respect of the Clinical Guidelines Document,
 3 it's a number of pages with hyperlinked appendices and
 4 references to other documents.
 5 When staff are looking at this -- these policies on
 6 SOPHIA, are you expecting them to click through to all
 7 the other policies that are listed as well?
 8 **A.** There is an expectation that they're aware of them.
 9 **Q.** Are you expecting staff to follow each of the
 10 hyperlinked appendices to see each appendix?
 11 **A.** I think it's good practice to look at the hyperlinks.
 12 **Q.** And do you expect staff to read all of the guidance and
 13 standard documents that are referred to in each policy?
 14 **A.** It's there for information. Again, I think it's good
 15 practice.
 16 **Q.** You say -- I won't ask for it to be put up -- in
 17 paragraph 34 of your witness statement that monitoring
 18 whether new or temporary staff are made aware of Trust
 19 policies is not within your remit; that's monitored as
 20 part of the induction programme.
 21 Have you ever taken any steps to check whether your
 22 expectation that staff are being made aware of these
 23 policies at induction is correct?
 24 **A.** I have not, no.
 25 **Q.** Turning, then, to look at the CPR Policy in some more

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1 detail. That's intended to apply to community and
 2 inpatient services, isn't it?
 3 **A.** Correct.
 4 **Q.** So it applies to what happens in someone's home and it
 5 also applies to what happens on the ward. It's catering
 6 for those very different scenarios.
 7 **A.** Correct, and we have community settings where medication
 8 is administered on -- within an EPUT property.
 9 **Q.** Now, can we keep the CPR Policy on the screen and put up
 10 next to it the NICE Guidance NG10, which is NICE026961,
 11 please.
 12 Mr Archer, this is the NICE Guideline NG10, it's in
 13 respect of Violence and aggression: short-term
 14 management in mental health, health and community
 15 settings.
 16 Can we turn to page 5 of this document because
 17 I think this is the first time we're seeing it in these
 18 hearings. And it gives there an overview and it says
 19 who it's for. And in respect of the overview it says:
 20 "The guideline covers the short-term management of
 21 violence and aggression in adults ... young people ...
 22 and children. It is relevant for mental health, health
 23 and community settings."
 24 This document is relevant to inpatient mental health
 25 settings, isn't it?

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1 directly replicated in the EPUT policy, is it?
 2 **A.** I believe, from memory there is additional mention of
 3 that requirement within this document. Obviously that's
 4 just one particular paragraph we're looking at.
 5 **Q.** We can look at what it says about doctors. That's on
 6 page 13 at paragraph 7.2. Let's turn to that in the CPR
 7 Policy.
 8 Is that what you're referring to there,
 9 paragraph 7.2:
 10 "It is essential that the duty doctor is informed
 11 and they may need to contribute to the resuscitation
 12 event".
 13 **A.** No, sorry, I was referring to NG10 where there is
 14 mention of ILS-trained staff. Sorry. I know the cursor
 15 is on 1.4.4 but there is obviously other pages to that
 16 document. Sorry, am I misunderstanding what you're
 17 saying?
 18 **Q.** No, no, it's fine. Perhaps I'll put it this way.
 19 Your -- the CPR Policy -- sorry, EPUT's CPR Policy does
 20 not require a doctor to be immediately available to
 21 attend an emergency, does it?
 22 **A.** The doctors are expected to attend.
 23 **Q.** They are, but the policy doesn't say they must attend
 24 immediately, does it? It says this:
 25 "It is essential that the duty doctor is informed

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1 **A.** Yes, correct.
 2 **Q.** Can we then turn to page 33, please. You can see at
 3 paragraph 1.4.4, it says this:
 4 "Staff trained in immediate life support and
 5 a doctor trained to use resuscitation equipment should
 6 be immediately available to attend an emergency if
 7 restrictive interventions might be used."
 8 On a mental health inpatient unit, restrictive
 9 interventions might be used. That's correct, isn't it?
 10 **A.** Correct.
 11 **Q.** Can we look, in terms of the CPR Policy, at
 12 paragraph 1.5, please. And that should be possibly on
 13 page 3. Ah, next page, page 4. Sorry, there. Page 7.
 14 Paragraph 1.5 says this:
 15 "In 2020 the Care Quality Commission published
 16 a document entitled 'Brief guide: Immediate Life
 17 Support' [et cetera]. The document describes how the
 18 National Institute for Health and Care Excellence ...
 19 Clinical Guidelines ... recommends that any setting
 20 where restrictive interventions (rapid tranquillisation
 21 or restraint or seclusion) are used, have to have
 22 immediate access to staff trained in Immediate Life
 23 Support and to appropriate ILS medication and
 24 equipment ..."
 25 The NG10 requirement in paragraph 1.4.4 is not

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1 and they may need to contribute to the resuscitation
 2 event."
 3 **A.** Absolutely, they must be informed and there is pro --
 4 communication processes. There is an expectation that
 5 they will attend as soon as possible. They -- so some
 6 of our -- just to put that into perspective, some of our
 7 on-call doctors may cover -- they may be situated,
 8 they're on-call or may be within the footprint of our
 9 Colchester site, but they also provide out-of-hours
 10 support to the teams at Clacton as well, so they're not
 11 physically there, but the expectation is that doctors
 12 must attend.
 13 **THE CHAIR:** Apart from the arrangement you've just told us
 14 about with Colchester having to cover Clacton which
 15 would rule out adherence to this particular requirement
 16 of the NICE Guidelines, do all the other facilities, all
 17 the other units across Essex have the presence of a duty
 18 doctor?
 19 **A.** Yes, and during the day there could be as many as three
 20 doctors, if it's a ward round -- sorry.
 21 **THE CHAIR:** So day and night, there is always a duty doctor
 22 on each site? Apart from Clacton?
 23 **A.** Yes, the others are, for example Harlow, the Derwent
 24 Centre, the on-call room will be on site at the Derwent
 25 Centre, there's two wards there, but they will also

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1 provide support to Epping. So those mid, the on-call or
2 the duty doctor out-of-hours is situated within the
3 Linden Centre that has a number of wards.

4 **THE CHAIR:** Sorry, I'm not understanding that. Are you
5 suggesting that there is at Epping also an issue that
6 there won't be a duty doctor there 24 hours a day?

7 **A.** There may be but they may physically be on the other
8 site.

9 **THE CHAIR:** How far away is that?

10 **A.** 10 miles.

11 **THE CHAIR:** Right, okay. So that's another area where this
12 NICE guideline wouldn't necessarily be fulfilled?

13 **A.** As per the current staffing provision, yes.

14 **THE CHAIR:** Yes, is there anywhere else? So we've got
15 Clacton, we've got Epping. Anywhere else?

16 **A.** No, not as far as I'm aware, the majority of the other
17 sites are -- the on-call doctors are located within that
18 footprint.

19 **THE CHAIR:** Okay. Thank you.

20 **MS SAGE:** Mr Archer, in terms of the CPR Policy document,
21 EPUT's CPR Policy, you're obviously familiar with the
22 content of that document. You'd agree that in that
23 document there's no reference to the time in which
24 a doctor or an ILS Registered Nurse must attend an
25 emergency at an inpatient unit, is there?

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1 attendance is not embedded in policy so that when
2 ILS-trained staff read the policy, they're clearly
3 informed they should be at a patient's site within the
4 first minute, that gives rise to a patient safety risk?

5 **A.** I think that's something that we could absolutely
6 consider to add. As I say, in all of the teaching that
7 we carry out, we always say "as soon as possible".

8 **Q.** My understanding is that you have read Professor Soar's
9 report before giving your evidence today; is that
10 correct?

11 **A.** Correct.

12 **Q.** He observes at paragraph 4.8(a) of part 2 of his report
13 that there is no requirement in this policy or in any of
14 the documents that he has reviewed for a member of
15 ILS-trained staff to be on every inpatient shift and
16 available 24/7. It's correct that that's not in this
17 policy, is it?

18 **A.** Not specifically prescribed in this policy.

19 **Q.** Professor Soar has also observed in his report at
20 paragraph 3.7(c) that the policy doesn't contain any
21 duty relating to monitoring whether there is an
22 ILS-trained individual available 24/7 for each inpatient
23 ward, and he's correct about that, isn't he?

24 **A.** In this particular document.

25 **Q.** Is that monitoring taking place?

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1 **A.** That's correct. I think there is a risk with putting
2 timings. The timing -- there is a timing associated
3 with the application and defibrillation of a patient
4 within three minutes. We even on Advanced Life Support,
5 we don't put a maximum time, we will put "As soon as
6 possible".

7 **Q.** The only place where there's a time for attendance set
8 out in relation to this document is in appendix 16, the
9 Medical Emergency Simulation Practice Report and that
10 asks the question whether an ILS Registered Nurse or the
11 duty doctor attended in three minutes, doesn't it?

12 **A.** Yes, and that is in relation, as I say, to the timing
13 around the expected defibrillation time. So not
14 necessarily -- that's -- I accept that that may be
15 interpreted differently but that's where the 3-minute
16 would have come from.

17 **Q.** And would you agree that during an emergency event where
18 CPR is required, every second counts and so whilst
19 "immediately" is not a specific time in the NICE
20 guidance, taking three minutes to attend an emergency
21 situation is not immediate attendance, is it?

22 **A.** Correct, but that isn't what we teach and I absolutely
23 accept that that is in there for the reasons given, but
24 we never, ever say "within three minutes".

25 **Q.** Do you agree that if a requirement for immediate

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1 **A.** Yes. So I can give some context. Whilst it's not
2 prescriptive within this policy, we have a Safer
3 Staffing Model, which is our operational model, that is
4 specific in relation to the ratio of registered nurses
5 to non-registered nurses. Currently, we are 50/50, so
6 three registered nurses to three unqualified or
7 non-registered staff. That flexes, depending on acuity.
8 So whilst it's not captured in this policy, there is
9 absolutely an operational model. And as a result of
10 that operational model, our registered nurses are all
11 Immediate Life Support-trained. So there is -- and what
12 you may have is three registered nurses on this
13 particular ward who will be supported by at least one,
14 if not two or potentially three doctors, potentially
15 supported as well, by the site coordinator, who may also
16 be supported by nursing staff from an additional ward.

17 So whilst the challenge was that there is a risk
18 that there may not be Immediate Life Support provision
19 in place, that's captured within our Safer Staffing
20 Model which is regularly audited and regularly managed
21 and all of those risks are escalated through the
22 processes.

23 It isn't specific within this policy, I absolutely
24 agree, but that is captured outside in documents that
25 Professor Soar may not have had oversight of.

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1 Q. In respect of that Safer Staffing policy, just to
 2 understand, when they're setting up the skill mix for
 3 the ward, is it about checking -- is it about a mix of
 4 registered staff and non-registered staff? Do they
 5 specifically check whether the registered staff have ILS
 6 training or is it assumed that they will?
 7 A. That would be at a local level. So rosters, there is, I
 8 believe there is a flag that can be added on ESR, which
 9 is our monitoring tool. Those assurances will be held
 10 at a local level with mitigation, as well.
 11 So, for example, in a rare occasion where there was
 12 a concern around ILS training, that would be managed
 13 locally. That would be mitigated and that would be
 14 escalated, as well. So it's not captured within this
 15 policy but that system is in place already.
 16 Q. So it's not in this policy, you're relying on the -- you
 17 rely on the Safer Staffing Model and local level
 18 assessment of the staff on shift that day to ensure that
 19 there are 24/7 ILS staff on the ward?
 20 A. Correct.
 21 Q. Can I ask that two earlier versions of the CPR procedure
 22 are put up. So one, the version from March 2023, which
 23 is EPUT023459. And the other, the version that that
 24 replaced, which is EPUT023464, please.
 25 So on the right-hand side, Mr Archer, we've got the

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1 Q. No, but you changed it to refer to the guidance?
 2 A. Yes.
 3 Q. The correct guidance?
 4 A. Yes.
 5 Q. Yes. Now, in terms of what's required in respect of the
 6 defibrillator, it's a core RCUK standard, isn't it, that
 7 the defibrillator is applied within three minutes of
 8 collapse?
 9 A. Yes.
 10 Q. And you'd agree that for defibrillation to take place
 11 within three minutes the defibrillator has to reach the
 12 patient before then?
 13 A. Yes.
 14 Q. Now, the CPR Policy, it doesn't say within three
 15 minutes, does it: it says the defibrillator must be
 16 there "as soon as possible"?
 17 A. Yes.
 18 Q. We can look at if --
 19 A. Yes, I'm aware of that.
 20 Q. Why doesn't it say that it has to be there within three
 21 minutes?
 22 A. I think that could be deemed to be a play on words.
 23 I get that the regular -- I get that the guidance is in
 24 place. Again, I think there could be a risk with staff
 25 saying, "Well, I've got three minutes so I'm going to

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1 first policy that you authored, which is March 2023, and
 2 on the left-hand side, the policy that it replaced.
 3 Could we go down to paragraph 1.4 of those two policies.
 4 Sorry, back one page -- yes, and the same on the
 5 other one.
 6 Mr Archer, on the left-hand side, paragraph 1.4
 7 stated that:
 8 "NICE Guideline ... requires that any setting where
 9 restrictive interventions may be used can access staff
 10 trained to Basic Life Support standards ..."
 11 On the right-hand side, that's the paragraph --
 12 that's the same as the paragraph we looked at earlier
 13 and it refers to "immediate access to staff trained in
 14 Immediate Life Support."
 15 In the left-hand side on that policy, that was
 16 a mistake which you corrected; is that right? The
 17 reference to Basic Life Support?
 18 A. Having reviewed it, I've brought this policy in line
 19 with the guidance. So I am unable to comment on why
 20 that wording was used. That was before I was in post.
 21 When I reviewed it, looking at all the guidance that was
 22 available, that's when we procured Immediate Life
 23 Support, Resus UK accredited Immediate Life Support to
 24 bring it in line with guidance. I can't comment on the
 25 other document.

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1 leave it." In my personal opinion, it's important to
 2 get it attached as soon as possible. I absolutely take
 3 it on board that we could, when this document is due for
 4 review, we could provide additional clarity. I am
 5 concerned that by putting time frames on you could have
 6 somebody that says, "Well, I've got three minutes and
 7 I'm current at two minutes", I'm using that as an
 8 example.
 9 I am a keen -- my opinion is that we get that
 10 attached as soon as possible. I absolutely agree that,
 11 I acknowledge that we can provide additional clarity and
 12 that's -- I take that on board.
 13 Q. The final point on this policy relates to the appendix
 14 that you added, I believe, the "Calling 999 in an
 15 emergency" document. That's a document you authored and
 16 added to the policy?
 17 A. I, when I joined the organisation, that piece of work
 18 was in its infancy. So I worked with our patient safety
 19 colleagues to help put that document together. And
 20 that's something that we've embedded within the policy.
 21 Q. Can we go to the policy, that's EPUT026724, the current
 22 CPR Policy. Apologies, no, it's not. It's EPUT -- put
 23 that document up, that's the appendix. So EPUT0267 --
 24 excellent.
 25 Now, paragraph 7.6 of the CPR Policy tells the

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1 reader where this document should be and it says it
 2 needs to be in the front of the resuscitation bag or
 3 stored with the resuscitation trolley.
 4 I think earlier in your evidence you said sometimes
 5 it's kept in the nurses' office. There's no requirement
 6 in the CPR Policy, is there, for this to be kept in the
 7 nurses' office or next to, for example, a cordless
 8 telephone?
 9 **A.** There's no requirement but I've seen it on the wall. So
 10 we have -- we've had issues that have been identified
 11 previously where a staff member has called 9999 from
 12 a DECT phone, which is located away from the patient.
 13 So there has been a significant piece of work to adopt
 14 DECT phones, so portable phones that can be brought to
 15 the patient.
 16 This piece of information is with the resus bag
 17 which is with the sick patient. This will guide the
 18 person who's making the phone call who is positioned
 19 adjacent to the patient, guide them through what
 20 information we need to share.
 21 **THE CHAIR:** Have you now got the DECT phones as you describe
 22 it --
 23 **A.** I believe so, yes.
 24 **THE CHAIR:** -- in every ward?
 25 **A.** Yes, a portable --

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1 which is covered in the corporate statement whereby the
 2 ILS-trained member of staff made a phone call from the
 3 office and wasn't at patient side? That piece of work
 4 that you've been talking about, was that done after that
 5 incident?
 6 **A.** I can't be one hundred per cent certain when that piece
 7 of work was carried out. I can't -- I don't have access
 8 to that date-wise, sorry, I'm not sure.
 9 **Q.** Do you think it was in the last year?
 10 **A.** I don't think so. I think it would fall outside the
 11 year, definitely.
 12 **Q.** Was it possibly before the incident that occurred in
 13 June, or -- in June 2025, or you can't say?
 14 **A.** I can't honestly say, I have a feeling it may have been
 15 slightly before but I can't be assured.
 16 **Q.** And if it was before, does that mean that, in that case,
 17 and contrary to what the piece of work was, the
 18 ILS-trained staff member left the patient and made the
 19 call from the office instead?
 20 **A.** Um --
 21 **Q.** Contrary to the piece of work that had been done, and
 22 the guidance?
 23 **A.** Yes, that's what happened, yeah.
 24 **Q.** Now -- we can take that down.
 25 At the outset, of your evidence this morning you

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1 **THE CHAIR:** Portable, so it can be --
 2 **A.** Phone --
 3 **THE CHAIR:** -- with the patient.
 4 **A.** Yes.
 5 **THE CHAIR:** Thank you.
 6 **A.** That was a piece of work that the Lessons Team led on
 7 and then obviously worked with IT colleagues.
 8 **MS SAGE:** And I think at the bottom of, on the right-hand
 9 side you can see there's a reference to making a call
 10 from the Trust phone that can be taken to the
 11 inpatient -- to the patient if possible. It says, "if
 12 possible". Based on the evidence you've just told us,
 13 should it be "it's required to make the call from a
 14 Trust phone that can be taken to the patient in an
 15 inpatient unit"?
 16 **A.** Yes, I think this particular piece of guidance came out
 17 before the piece of work that was carried out with the
 18 DECT phones but I acknowledge that. But I think the "if
 19 possible", some, someone may have inadvertently dropped
 20 the phone and it may not be possible because it may not
 21 be working, but now, it is expected that a portable
 22 phone would be taken to the patient. So as I say, this
 23 document came out before the piece of workaround the
 24 DECT phones.
 25 **Q.** There was a CPR event in June of 2025, wasn't there,

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1 indicated that you wished to make a clarification to
 2 paragraph 24 of your witness statement. You explained
 3 that you had in fact identified deviations between the
 4 guidelines set out in the RCUK Quality Standards and the
 5 equipment contained in the EPUT adult resus bag. And
 6 these differences, they'd already been noted by
 7 Professor Soar when he reviewed the EPUT documentation,
 8 hadn't they?
 9 **A.** He identified the same things that I picked up on.
 10 **Q.** Now, it's right to say that Professor Soar confirmed
 11 that the bag matches the -- most of the immediate items?
 12 **A.** (The witness nodded).
 13 **Q.** But he could not identify a stethoscope, a laryngoscope,
 14 a pocket mask or a clock or timer, and he explained that
 15 many clinical settings have now moved away from using
 16 pocket masks and that the absence of IV cannulation
 17 equipment was, in his opinion, more readily explicable.
 18 Can you help us with why the other items are missing?
 19 **A.** So a laryngoscope is a piece of equipment that needs to
 20 be used by those that are competent to do it, those that
 21 undertake that task of laryngoscopy. So that's, just
 22 for clarity, it's a piece of equipment that is used to
 23 manoeuvre the anatomy within the mouth to vocalise the
 24 vocal cords, so you can pass an endotracheal tube
 25 through. We do not have endotracheal tubes, we do not

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1 have anaesthetists, we have some anaesthetists within
 2 our ECT suites but they have a different, a different
 3 trolley, and that's based on what they are familiar with
 4 in their environment. But, for the whole, our nursing
 5 staff on an inpatient setting will not be expected to
 6 undertake laryngoscopy.

7 **Q.** Is that rationale and decision making that you've
 8 explained here documented anywhere?

9 **A.** I'm not sure if it's documented.

10 **Q.** Can we move then to the deteriorating patients policy,
 11 and that's EPUT023441.

12 Now, whilst that's being put on the screen,
 13 Mr Archer, you've talked about NEWS2 this morning
 14 already. Can you explain why the NEWS2 assessment is so
 15 important in this context?

16 **A.** Of laryngoscopy?

17 **Q.** No, in the context of deteriorating patients?

18 **A.** Oh sorry, I've already mentioned that the NEWS2 chart is
 19 a tool that can aid identifying deterioration. It
 20 generates a score, the score generates a specific
 21 response that we provide but there's more to that.

22 So the unwell patient needs -- you have to work your
 23 way through a systematic top-to-toe, A to E approach.
 24 That's something that's taught on Immediate Life
 25 Support. It starts with an airway assessment, a

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1 first is the use of NEWS2 and the second is the use of
 2 a document called the Non-Contact Observation Tool and
 3 that's a document you've developed; is that correct?

4 **A.** Yes, that document is to support a staff member working
 5 their way through the A to E assessment which is taught
 6 on Immediate Life Support training. And that goes back
 7 to us being proactive because our staff aren't expected
 8 to do that on a daily basis. They're not on a surgical
 9 ward or a medical ward in a busy acute hospital. So
 10 whilst they're taught the immediate -- the A to E
 11 assessment within Immediate Life Support, this is an
 12 aide memoire to guide them through how to carry out that
 13 assessment.

14 **Q.** And there's also the Assessing a Critically Unwell
 15 Patient document, the aide memoire. Can we just put
 16 those two documents we just referred to up. So
 17 EPUT026703 and EPUT026714.

18 The other one is going to come up but as you say and
 19 as we can see, these documents, these tools, they're
 20 based on the ABCDE assessment that's taught on the RCUK
 21 ILS course, aren't they?

22 **A.** Yes, correct.

23 **Q.** Are you expecting non-registered healthcare assistants
 24 to use these documents?

25 **A.** The first one would be the Registered Nurse who is

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1 breathing assessment, circulation, disability, exposure.
 2 If any life threatening conditions are identified,
 3 they're treated at the time of identifying before moving
 4 on. So that forms part of our assessment of the
 5 critically unwell patient.

6 **Q.** Can we turn to page 2 of this document. And we can see
 7 there the changes that you made -- that you've made
 8 whilst you've been an author, and in the version for
 9 12 March 2025 you removed the reference to grab bag
 10 training. Now, grab bag training was phased out from
 11 September 2022. Why was it only removed in
 12 March '25 from this policy?

13 **A.** There would have been a transition period where,
 14 initially, whilst we were procuring back in 2022, there
 15 would have been a transition period when staff would
 16 still be receiving it.

17 **Q.** Now, this policy applies again to community and to
 18 inpatient settings. And it also applies to all
 19 healthcare professionals who measure, record or act on
 20 the findings of patients' physiological observations.
 21 So this applies to registered nurses and it applies to
 22 non-registered clinical staff, doesn't it?

23 **A.** Yes.

24 **Q.** And there are two ways that this policy states that
 25 deteriorating health can be assessed, principally. The

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1 carrying out that robust A to E assessment because that
 2 is what is taught in ILS training.

3 **Q.** Yes, and healthcare assistants don't receive ILS
 4 training, do they?

5 **A.** No, but they are familiar with the tools and that forms
 6 part of the refresher sessions that we deliver. So we
 7 raise awareness of the approach and why it's being done,
 8 but they don't necessarily receive that A to E training
 9 which is mandated but it's provided as part of our
 10 drop-in -- our refresher sessions.

11 **Q.** So I just want to make sure I'm clear on this.
 12 Healthcare assistants, non-registered clinical staff,
 13 they don't receive mandatory training on A to E
 14 observations; that's correct?

15 **A.** Correct, so the A to E assessment is part of the Resus
 16 Council Immediate Life Support training.

17 **Q.** But they are expected to be able to use these tools to
 18 do an ABCDE assessment of a patient, and you say you
 19 give them training on that on the non-mandatory drop-in
 20 sessions that you hold?

21 **A.** I wouldn't be expecting the non-registered staff, that's
 22 why we've got -- that's why we've got our Safer Staffing
 23 Model. The expectation isn't that our HCAs are carrying
 24 out a robust top-to-toe assessment of the patient.

25 **Q.** Can we turn to paragraph --

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1 **THE CHAIR:** Sorry, I'm confused. You said that they're
 2 given the tools. Do you mean they're given these
 3 documents? The HCAs are given the documents we're
 4 looking at which -- what did you mean by they're
 5 given --
 6 **A.** When we deliver sessions on the deteriorating patient we
 7 will make reference to these documents.
 8 **THE CHAIR:** But they won't actually be equipped to do
 9 anything about it themselves?
 10 **A.** Not necessarily. Some will, some will have
 11 undertaken -- may have undertaken ILS training as part
 12 of another role. As a whole, that A to E assessment
 13 needs that underpinning knowledge of anatomy and
 14 physiology because you are making an assessment and
 15 potentially having to make an intervention. So --
 16 **THE CHAIR:** So you're telling them that this is what
 17 somebody else will be doing, but they're not actually
 18 being expected to do it --
 19 **A.** Yes, it is about raising awareness that this tool
 20 actually is in place.
 21 **THE CHAIR:** Right, thank you.
 22 **MS SAGE:** Can we turn to paragraph 74 of your witness
 23 statement, please, which is the last paragraph on the
 24 last page of your statement.
 25 You say here:

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1 knowledge of anatomy and physiology that non-registered
 2 staff don't have that level of knowledge.
 3 **A.** Some do, and I am by no means being disrespectful. The
 4 HCAs receive a vastly different type of training to
 5 registered nurses. Anatomy and physiology forms part of
 6 the Registered Nurse's training. I absolutely agree
 7 that staff, non-registered staff can, but I would
 8 absolutely, if that was something that we as an
 9 organisation decided to do, I would want to put
 10 something in place, from an anatomy and physiology
 11 model, to support them, because it isn't just about the
 12 A to E. The ILS is more than that. The ILS is about
 13 working your way through a robust head-to-toe assessment
 14 of the patient but it's also working your way through
 15 your four Hs and your four Ts: reversible causes of
 16 cardiac arrest. If I asked my wife, who has never had
 17 any anatomy and physiology training --
 18 **Q.** Mr Archer, I'm going to stop you there.
 19 **A.** Okay.
 20 **Q.** Let's see what you say about this in your statement.
 21 Can we turn to paragraph 35 and 36 which is on page 10,
 22 please.
 23 Now you're clear in paragraph 36, at the end, that
 24 you do not consider that ILS training is appropriate for
 25 non-registered staff and you say:

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1 "Given the limited exposure that staff in mental
 2 health settings have to physically deteriorating
 3 patients, annual training in the identification and
 4 management of the deteriorating patient is, in my view,
 5 essential. This training should be provided to both
 6 registered and non-registered staff, recognising that it
 7 is frequently the non-registered staff who are tasked
 8 with undertaking physical health observations and
 9 completing the NEWS2 chart."
 10 Now, those are the staff, the non-registered staff,
 11 who are not being taught the ABCDE assessment because
 12 they are not attending the ILS course, are they?
 13 **A.** That's right. They will be taking the physical health
 14 observations, the blood pressure the temperature, et
 15 cetera, et cetera, plotting that information on a NEWS2
 16 chart, and there is clear guidance as to what they need
 17 to do with that score. We are not expecting our HCAs to
 18 carry out a robust top-to-toe assessment of the patient,
 19 for this particular patient it's important they
 20 recognise the patient is unwell and call for the support
 21 of the registered staff who have the additional training.
 22 **Q.** One of the reasons that you're not teaching the A to E
 23 assessment to HCAs is that you consider, and it's your
 24 opinion that the HCAs can't attend the ILS -- RCUK ILS
 25 course because to do so they require an underlying

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1 "Since the training requires an understanding of
 2 human anatomy and physiology, which is not a competency
 3 that can be assumed unless they've received training
 4 elsewhere."
 5 And in the paragraph before, you say that:
 6 "An underlying knowledge of anatomy and physiology
 7 is required to carry out a robust assessment prior to
 8 insertion ..."
 9 And you're talking about supraglottic airway
 10 devices, iGels there.
 11 And also:
 12 "The A to E assessment process, which is taught
 13 during the RCUK ILS training requires an appropriate
 14 baseline knowledge of anatomy and physiology to carry
 15 out an accurate and thorough assessment."
 16 And that's your opinion, isn't it?
 17 **A.** Yes, HCAs can attend, when you look at the guidance
 18 shared by the Resus Council UK, they can attend but it
 19 isn't mandated. It isn't a mandatory recommendation;
 20 it's something that would sit with the organisation.
 21 **Q.** It's not mandatory, but we, as you know, heard evidence
 22 from Mr Benson Clarke in July that healthcare assistants
 23 could undertake RCUK ILS training, indeed that members
 24 of the public can undertake it.
 25 **A.** They can.

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1 Q. And Professor Soar in his report tells us that
2 non-clinical staff such as fire officers, military
3 personnel, police officers, and cabin crew have all
4 undertaken ILS training and that the pass rates are
5 close to 100%. So there is in fact no need for somebody
6 undertaking the RCUK course to have an underlying
7 knowledge of anatomy and physiology, is there?

8 A. I don't know what other training they would have
9 received. They may have supported modules in relation
10 to anatomy and physiology before they joined. I don't
11 know. My personal experience is, it would be unfair if
12 we are expecting somebody to identify tension
13 pneumothorax if they've never heard of the terminology,
14 and how to treat a tension pneumothorax to potentially
15 save a life. I think that would be unfair. If that is
16 something that we think is important, I would absolutely
17 say that we need to support anybody going on that
18 course, that has never heard of a tension pneumothorax,
19 if they're expected to lead a cardiac arrest and
20 identify potentially reversible causes, I think there
21 needs to be something in place to support them.

22 THE CHAIR: And could there be?

23 A. You could put a module assigned, thinking about
24 deteriorating patients, I'm aware that obviously, in
25 relation to review of life support training, there is

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1 recommendation for RCUK ILS training to be provided to
2 registered nurses, there were other training -- EPUT
3 delivered other training. It delivered for a time
4 a type of training that was called Enhanced Emergency
5 Skills Training and that was being provided to
6 registered clinical staff and to non-registered clinical
7 staff including healthcare assistants, wasn't it?

8 A. It was.

9 Q. Can we put the course materials up. They're EPUT023413.

10 And this is the full course. There's also
11 a refresher course but this is the full course. So we
12 can see some of the topics that were covered on EES. At
13 the bottom of that page:

14 "Recognition and prevention of deterioration using
15 the ABCDE approach."

16 When EES was being used, that was being taught to
17 non-registered clinical staff, wasn't it?

18 A. It was before my time but I believe so.

19 Q. And if we turn to the next page, you can see that they
20 were also being taught CPR with a bag valve mask,
21 weren't they?

22 A. Yes, according to the lesson plan.

23 Q. And they were being taught how to insert supraglottic
24 airway devices or iGels and oral pharyngeal airways,
25 that's the next one down; is that correct?

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1 mention of a deteriorating patient module which I think
2 is fantastic. We are -- literally ours will go on the
3 training tracker hopefully in November. There could be
4 a module to support. And I think it would be an
5 appropriate supportive measure, because if I asked
6 somebody to talk me through the four Hs and four Ts and
7 they've never ever had any anatomy and physiology
8 training they would not -- they would fail. I can't see
9 how you can identify reversible causes if you don't know
10 what they are.

11 MS SAGE: But they don't fail, do they? That's what we
12 know: that non-clinical staff can undertake the ILS
13 course and pass it.

14 A. I don't know what training they would have had
15 beforehand. That's not clear. They may have a specific
16 module. It's my personal opinion -- I'm not being
17 disrespectful to the profession -- we can't exist
18 without HCAs, but I think if we are going to mandate
19 training, specific training, we would need to support
20 them. That's my opinion.

21 I totally understand that they can go on it. We --
22 I would absolutely -- I would think that there needs to
23 be some additional support potentially put in place --
24 which can be done.

25 Q. Now, before you started in your role and made the

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1 A. That's correct.

2 Q. And if we turn over the page, that session also, there
3 was a lecture on O2 cylinders including safe opening and
4 closing, draining of the regulator. So they were being
5 taught about safe opening and operating of O2 cylinders.

6 A. Yes.

7 Q. They were being taught correct mask selection for the
8 delivery of airway interventions, and if we turn over to
9 the next page, you can see they're also being taught how
10 to check the contents of a grab bag, weren't they?

11 A. Yes, yeah.

12 Q. And then on the second day of the training, which is on
13 the next page, page 5, they were being taught about a
14 number of potential causes of deterioration and cardiac
15 arrest. And then this course also included AED training
16 and assessment, and that training was being provided
17 after the merger at EPUT until December 2019, that's
18 correct, isn't it?

19 A. As far as I'm aware, correct.

20 Q. And then from January 2020 until September 2022, grab
21 bag training was being provided. Again, that's being
22 provided to all inpatient clinical staff including
23 registered and non-registered staff, and there was
24 a phaseout, as you've told us, when ILS training was
25 introduced; is that correct?

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1 A. Yes, correct.

2 Q. That was a one-day programme. I'm going to ask for us
3 to look at the slides that were used, which are
4 EPUT029015.

5 If we go to page 5 of this document, we can see
6 there the course outline and the skills that were being
7 taught and the skills are similar to the EES training
8 and include, for example, bag valve mask and iGels,
9 oxygen and safe use of it, and reasons for and causes of
10 cardiac arrest that are relevant to inpatient units;
11 that's correct?

12 A. Yes, according to the document.

13 Q. According to the document.

14 Now, Mr Archer, assuming that these documents are
15 representative of what was being taught on an EES course
16 and then on grab bag training, it is correct to say that
17 before you were in post HCAs were being trained on
18 precisely the skills that you now say they don't have
19 sufficient knowledge of anatomy and physiology to be
20 taught, weren't they?

21 A. That's my personal opinion. But at the time of the
22 training delivered, that would have been an
23 organisational decision.

24 Q. Has anything changed since September 2022 in respect of
25 the background knowledge that HCAs would have about

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1 disrespectful to any of the staff, and at the time of --
2 before I joined, that would have been the organisation's
3 choice of training.

4 Q. And, yes, when you joined, you made the recommendation
5 that nurses, registered nurses, start attending the RCUK
6 ILS-trained course. You made the business case for that
7 and you consider it to be the gold standard training on
8 ILS?

9 A. Yes, with the support of a Director of Nursing. So,
10 again, it wasn't just solely my decision. This went to
11 our executive team. It doesn't -- the decision doesn't
12 sit with me. It's a proposal that I work through with
13 a -- the Director of Nursing at the time, and that was
14 the Trust's view. It would be wrong for me to make
15 a decision, you know, on my own. That's why we have
16 governance processes.

17 Q. And you, as part of that, you identified that registered
18 nurses should go on, in your view, ILS training.
19 I think you told us earlier that's to ensure that EPUT
20 was compliant with national guidance such as NG10 and
21 the RCUK Quality Standards?

22 A. Yes, there is specific mention in those documents of
23 Resus Council UK accredited ILS providers being
24 accessible, and that is to bring us in line. There is
25 a statement from the Resus Council around alternative

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1 anatomy and physiology, do you know?

2 A. There is, for those coming through, they do receive
3 a basic understanding of -- some will receive a basic
4 understanding of physical health.

5 Q. But nothing has changed between what they were learning
6 in 2019, 2020, 2021, 2022, when they were being trained
7 on these skills and now, when they're not?

8 A. No.

9 Q. So we know that RCUK, as the course provider of ILS,
10 considers healthcare assistants can do the course, and
11 we've seen that EPUT used to put its healthcare
12 assistants through training which included those skills
13 that you consider they don't have sufficient knowledge
14 to be trained on, and we've also seen what you say at
15 paragraph 74 about the fact that non-registered staff
16 are tasked with undertaking physical health observations
17 and completing the NEWS2 chart.

18 Do you agree that that is evidence that
19 non-registered staff are involved in clinical tasks
20 including vital signs observations?

21 A. Can I just clarify? Sorry. That is my personal
22 opinion: that whilst it's not mandated, staff could
23 attend if that was the organisation's choice. I would,
24 as I've said, I would absolutely welcome a module to
25 support anybody that's going into it. I'm not being

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1 courses which obviously you're welcome to read, but we
2 went with the gold standard which is the Resus Council
3 UK ILS.

4 Q. And as a result of moving the registered nurses to Resus
5 Council ILS training, what happened to healthcare
6 assistants, as we've said, is that they have moved to
7 having BLS training only and so they're no longer
8 trained on, for example, the airways skills such as bag
9 valve mask and insertion of iGels.

10 Now, on one view, that is a decision to downgrade
11 the training for HCAs from this course to BLS training.
12 Were you involved in that decision?

13 A. That would have gone through with the support of the
14 Director of Nursing and that would have been presented
15 to the executive colleagues. I think it's important to
16 note, as well, Basic Life Support is more than basic.
17 We are actively promoting, on Basic Life Support, to
18 recognise somebody that is in cardiac arrest, to call
19 for help, to administer effective chest compressions to
20 ensure that the defib arrives within three minutes and
21 to deliver a shock. That is not being disrespectful to
22 HCAs. That is such an important role. What we are
23 saying is that our registered nurses, who will be there
24 as part of the Safer Staffing Model, who have had that
25 underpinning anatomy and physiology training, can

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1 provide some additional.

2 The difference with Basic Life Support and Immediate
3 Life Support is that really robust A to E assessment,
4 the identification of the reversible causes in a cardiac
5 arrest, and team leadership. We are not being
6 disrespectful by downgrading them. The BLS, we need to
7 focus on getting the basics right. We could have
8 everybody trained to Advanced Life Support. If we don't
9 get the basics right, we fail from the offset. So that
10 was the rationale for the decision.

11 It isn't -- they don't necessarily do everything in
12 their training that our registered nurses do, but
13 that -- there was a rationale provided for that.

14 **Q.** Was the rationale for that decision written down
15 anywhere?

16 **A.** That would have been discussed as part of that
17 presentation. I personally didn't present the paper.
18 But I worked with -- worked with the Director of Nursing
19 to put that paper -- the business case and the proposal
20 together.

21 **Q.** Now, this Inquiry has heard evidence that HCAs are often
22 the first person responding to an emergency; they're
23 likely to be the people who are on one-to-one obs with
24 a patient. In those circumstances, do you consider that
25 providing ILS training to HCAs, and in particular

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1 themselves in an incredibly stressful situation, and
2 want to respond as best they can?

3 **A.** I agree, and actually, I talk about it, the basics are
4 so important. So getting the basics right. But
5 I suppose adversely, almost forcing an individual to
6 carry out some training that they are well out of their
7 comfort zone, I think comes with a risk, as well. So
8 you could really, you could potentially damage
9 somebody's confidence if it's not something that they're
10 used to doing. So I absolutely take that on board.
11 I think there's probably two views on that.

12 I think some HCAs may appreciate the additional
13 training because there will be an expectation for them
14 to lead a cardiac arrest as part of ILS training. Some
15 of our non-registered staff would run a mile if I asked
16 them to. So I think it's about pitching it
17 appropriately. For us, we have that support on site.
18 If things change in the future, and that's something
19 that we are expecting our staff to do, we will have to
20 make sure that we don't damage confidence and we provide
21 them with all the skills to lead a cardiac arrest, for
22 example. Because ILS is more than inserting an iGel;
23 it's around that thorough, robust, physical health
24 assessment, identifying the reversible causes and
25 leading the team in this really stressful medical

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1 providing them with that A to E assessment training,
2 would enhance their ability to immediately respond to
3 medical emergencies by giving them the broadest possible
4 skillset for their role?

5 **A.** I think the immediate response in Basic Life Support is
6 not working your way through your four Hs and four Ts.
7 Regardless of whether it's Basic Life Support or
8 Immediate Life Support, the initial response is calling
9 for help, which our HCAs are taught to do, delivering
10 effective high-quality chest compressions, which our
11 HCAs are absolutely taught how to do; applying the
12 defibrillator and delivering a safe shock, which they
13 are taught to do. The rest unfolds as part of that
14 medical emergency.

15 When a patient appears to be unwell, not in cardiac
16 arrest, unwell, there is access to registered nurses at
17 all times that will be able to support. Currently, as
18 it is at the moment, that is the way that our responses
19 are set up.

20 **THE CHAIR:** Is there something about the confidence that it
21 gives the individual HCA? I agree that in an ideal
22 situation, they'll hand over to a nurse, a Registered
23 Nurse. But making them feel that they have got skills
24 is also part, isn't it, of encouragement and support of
25 the individual nurse who -- HCA -- who may find

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1 emergency.

2 So I think there is a risk, if we don't do it in
3 a supportive way, that we could cause concern and unease
4 for staff.

5 And as I say, I'm not being disrespectful to HCAs in
6 any way, shape or form. And I say that in every forum.

7 **MS SAGE:** Mr Archer, HCAs aren't attending ILS, as we have
8 covered, and they aren't learning the skills that way.

9 You do touch on skills such as insertion of an iGel
10 and on the A to E assessment in your refresher sessions,
11 and we have the slides and maybe we'll go to them after
12 lunch. But isn't it right, then, that non-registered
13 staff are attending a training session with you where
14 you cover things like the A to E assessment and the use
15 of airway devices, rather than attending the RCUK ILS
16 gold standard course on those matters?

17 **A.** I think the reason we do those sessions is whilst the
18 expectation of the staff member is not to size up an
19 oral pharyngeal airway, they may be asked as part of the
20 response, to pass equipment to the person that is
21 carrying out that invasive task.

22 So it's around familiarisation. It's nice for one
23 of our HCAs to know why we're choosing to put that
24 particular airway in. Although we are not expecting
25 them to do it, it is around familiarisation with

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1 language, it's around familiarisation with equipment
 2 because it is a team effort. When there is a medical
 3 emergency you will have a team leader but you will have
 4 a selection of doctors, nurses, HCAs. So it's really
 5 about familiarisation, and making them aware with the
 6 language.

7 **MS SAGE:** And Mr Archer, we're going to have a break there
 8 for lunch. We'll have a 45-minute break so we'll come
 9 back at 2.10.

10 **THE WITNESS:** Thank you.

11 **THE CHAIR:** 2.10.

12 **(1.24 pm)**

13 **(The Short Adjournment)**

14 **(2.10 pm)**

15 **(Proceedings delayed)**

16 **(2.13 pm)**

17 **THE CHAIR:** Ms Sage.

18 **MS SAGE:** Mr Archer, this morning we looked at appendix 2,
 19 non-contact, physical observations, and appendix 13,
 20 assessing a critically unwell patient.

21 In the non-contact physical observations tool
 22 there's reference to a blue tinge to lips, tip of nose
 23 or fingernail beds, and a patient being pale or flushed,
 24 clammy, mottled, grey or cold. And in appendix 13 it
 25 asks, under "Circulation", whether a patient is blue,

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1 alternative methods of assessment and alternative signs
 2 for assessing deterioration in people with darker skin
 3 tones when things such as pallor and cyanosis might be
 4 less readily visible on a patient's skin?

5 **A.** That is something I would definitely consider adding for
 6 additional clarity. That is something -- questions
 7 often get asked of that in the training and the
 8 questions would be answered within the interactive but
 9 I can see absolutely no harm in putting that in. That
 10 would only create additional clarity.

11 **Q.** You stated in your oral evidence this morning that there
 12 are rapid responders identified at the start of shifts.
 13 In Ms Borton's statement at paragraph 25, she suggests
 14 that's not current practice. She says this:

15 "In addition, I believe consideration should be
 16 given to adopting a more structured team approach to
 17 emergency responses. Where practicable, staff
 18 commencing a shift could identify those with enhanced
 19 emergency response competencies, agree who would assume
 20 the team leader role in event of emergency, and clarify
 21 potential responsibilities within the response team."

22 How do you explain the discrepancy between your
 23 evidence this morning that that's happening and
 24 Ms Borton's evidence that she thinks it should be
 25 introduced in the future?

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1 pink, pale or mottled. To what extent do EPUT's current
 2 resuscitation and deteriorating patient training
 3 materials provide staff with guidance on how those signs
 4 may present differently or should be assessed
 5 differently in patients with darker skin tones?

6 **A.** That level of detail would come down to the actual --
 7 those facilitating the training. When you look, for
 8 example, at the Resus Council Immediate Life Support
 9 manual there is reference at the back of the manual as
 10 one of the appendices, specifically in relation to black
 11 and brown skin colour, as a potential limitation to
 12 pulse oximetry. There is a potential that it may
 13 overestimate. So whilst the number that is being
 14 generated by the pulse oximeter is important, you will
 15 already have had a baseline saturation and you have to
 16 take into consideration the patient's presenting
 17 conditions.

18 So it's not -- it's not prescriptive within the
 19 document, but that is something that would be captured
 20 within training and discussed.

21 **Q.** So it's not in the document; it's in the RCUK ILS
 22 training. That's correct?

23 **A.** Correct. At the back of the manual there is talk of
 24 limitations to pulse oximetry.

25 **Q.** Do you think that EPUT materials should identify

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1 **A.** I'm -- I have always been aware that there is -- there
 2 has been allocations made in relation to that rapid
 3 response. There's also the pilot that's underway
 4 currently on one of our sites in relation to leadership.
 5 So whilst leadership is not assumed, you could have a
 6 number of Immediate Life Support trained staff that
 7 could take on that role but we're going to provide --
 8 there is a pilot underway to support that, as well. So
 9 I can't -- I'm not sure, to be perfectly honest. My
 10 understanding, and having spoken to a number of our
 11 Professional Nurse Educators that are on -- working on
 12 the sites, that the allocations are in place. I would
 13 need to go back and have a further conversation if that
 14 isn't the case.

15 **Q.** So your --

16 **A.** -- (overspeaking) --

17 **Q.** -- understanding is it's happening and Ms Borton's
 18 evidence is --

19 **A.** Yes. They are termed "rapid", so there would be members
 20 of the team identified to respond to emergencies. So
 21 I'm not sure, to be perfectly honest.

22 **Q.** Can we turn to emergency simulations.

23 **A.** Yes.

24 **Q.** Your evidence in paragraph 47 of your statement is that
 25 there's significant benefit to be gained from teams

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1 engaging in the simulations and at paragraph 39 you say
2 that there are significant risks associated with not
3 practising both the technical and non-technical skills
4 required for the resuscitation of a patient and so the
5 benefits of regular practice -- and you're talking about
6 simulations here -- far outweigh any short-term
7 operational inconvenience.

8 When you're talking about significant risks in that
9 paragraph, do you mean risks to patients or risk to
10 staff or both?

11 **A.** I think the risk is in relation to the response. If
12 I can expand slightly further, we have a training
13 session that is delivered face-to-face and it's five
14 days. That is focused around restraint. Because of the
15 nature and the cohort of our patients, there are
16 regularly restraints carried out. So those skills that
17 you learn in the classroom can be put into practice,
18 unfortunately fairly regularly.

19 I've mentioned that these medical emergencies aren't
20 something our team see regularly so therefore, rather
21 than rely on memory recall of something that happened at
22 potentially nine, ten, 11 months ago, there is a risk
23 that the knowledge gained, unless you practise, will
24 dwindle. Over three months, I believe, your memory
25 recall starts to fade so you need to practise. So there

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1 another box with specific actions identified and the
2 person responsible to take those forward. They will be
3 presented as they are now, as a standing item at the
4 Quality and Safety meetings.

5 We are also going to add, there is a box there
6 already to record staff who have attended. We are also
7 going to propose that we add an additional box for staff
8 that work within that unit that have not responded, so
9 then there will be oversight and it'll make it easier
10 for the Senior Leadership teams to actually identify
11 those that haven't been part of a -- but it is not
12 prescriptive at the moment, it is something we could add
13 but it would need a wider conversation as to how many
14 times.

15 **Q.** And at the moment there's also no centralised record of
16 which staff have attended a simulation, is there? EPUT
17 doesn't have a record of that at a corporate level?

18 **A.** It's recorded on the Resus Event Forms which will now go
19 into our Quality and Safety, but there is no central,
20 you know, depository. That will be held locally.

21 **Q.** And you don't personally monitor or audit whether all
22 staff are attending simulations over a certain period,
23 do you?

24 **A.** No, that would be at local leadership level.

25 **Q.** And so if -- it's at local leadership level so there's

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1 is a risk to an -- an appropriate response if we don't
2 practise.

3 **Q.** And if there's a risk in terms of the response being
4 appropriate, if people don't practise, the result of
5 that is that there is a patient safety risk if people
6 aren't doing simulations? That's correct?

7 **A.** Potentially, yes.

8 **Q.** Mr Archer, how is it, then, that there is no minimum
9 requirement for how often individual staff members
10 should attend a simulation at EPUT?

11 **A.** So that's, again, that's something we're not necessarily
12 prescriptive about at the moment. That would definitely
13 need a wider conversation with clinical colleagues to
14 make, if we are going to prescribe how many medical
15 emergency simulations staff need to attend, we need to
16 make sure that's realistic and achievable. That would
17 be a much wider conversation. We are in the process of
18 the -- there was an amendment to be made to the existing
19 CPR Policy anyway based on some additional guidance and
20 feedback that I've received from our Executive Medical
21 Director. The current Medical Emergency Simulation
22 Report Form, we are in the process of changing the
23 layout of that. We are going to add a section that
24 focuses on actions. So whilst it's captured within the
25 free text, we want to make it very clear by adding

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1 no EPUT-wide monitoring of which staff have attended
2 simulation trainings, as far as you're aware?

3 **A.** Not at present.

4 **Q.** Do you agree that the result of that is it's possible
5 for a member of EPUT staff never to take part in
6 a medical emergency simulation and that EPUT would have
7 no means of knowing that's the case?

8 **A.** At present. And I think that's why we're making the
9 amendments to get that additional assurance. There are
10 risks with delivering simulations only at certain times,
11 that's why we actively encourage and I know that staff
12 will do -- carry out the simulations on early shifts,
13 late shifts, weekends and nights. So we're trying to
14 get as much assurance and oversight as possible and by
15 adding that additional information that we can capture
16 on the simulation practice report will help us with that
17 assurance.

18 **Q.** And that additional information will be which staff
19 haven't -- didn't attend that simulation or which staff
20 have not attended a simulation recently?

21 **A.** On the form it'll be those staff that were on shift that
22 did not attend for whatever reason. So I don't have
23 oversight of the staff names. That would need to be
24 managed at a local level.

25 **Q.** Should there be a written requirement in the CPR Policy

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1 for how often each individual staff member should take
 2 part in a simulation?
 3 A. I think I've just answered that. Apologies if I wasn't
 4 clear. That is something that we can consider but
 5 I would need -- we, as an organisation, would need to be
 6 sensible and appropriate with what we're writing in the
 7 policy because it has to be achievable, but it is
 8 something we could definitely consider in the future.
 9 Q. I understand that. Do you have a view on how often
 10 a Registered Nurse should be taking part in
 11 a simulation? You personally?
 12 A. I personally think there's -- as many times as possible
 13 would be great but mindful that isn't a number. I think
 14 realistically, with all of the other offerings that we
 15 put in place, the support that the PNEs put in place,
 16 two or three, potentially, a year, but again I would
 17 need to make sure that that's achievable, but I would
 18 encourage as much participate as often as possible but
 19 that's just a number that I've --
 20 Q. And I appreciate that's just a number you've come to
 21 today in your evidence. Would you say the same for
 22 non-registered clinical staff or a different frequency?
 23 A. It should be the same for everybody and that would be
 24 the same for doctors, as well. It's -- resuscitation
 25 attempts, medical emergency responses are a team effort.

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1 capturing of the question on the Tendable audit, to
 2 provide even more additional assurance.
 3 Q. That question has been added, as we know, in
 4 August 2026. Does that mean that since you started in
 5 post in 2022, and so for the last four years, you've
 6 been unable to identify whether this key aspect of
 7 EPUT's resuscitation strategy was being complied with?
 8 A. Not easily. So that's why I've asked for that assurance
 9 to be added.
 10 Q. Now, there's a SWARM huddle report, and I think it's one
 11 you've been referring to in your evidence, that's dated
 12 23 June 2025 and in that report it was recommended that
 13 a question on whether simulations had taken place should
 14 be added to the managers' Tendable audit. But it wasn't
 15 added to the Tendable audit until August 2026.
 16 Now, that was after this Inquiry turned its focus to
 17 resuscitation. Was that change prompted by the Inquiry,
 18 when it was finally carried out?
 19 A. No, we'd been talking about adding that for a period of
 20 time. The group that it would have been taken to for
 21 approval wasn't quorate so the meetings didn't happen.
 22 So it's been -- it's taken a while to be put in place.
 23 Q. Over a year.
 24 Does the fact that until August this year, EPUT was
 25 not monitoring whether wards were taking part in

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1 It shouldn't just be down to one individual. So we
 2 encourage everybody, students, students will be on the
 3 wards, as well, Allied Health Professionals. It's
 4 a team effort.
 5 Q. So everybody in your view -- and I appreciate this is
 6 a view you've come to today -- should be taking part in
 7 a simulation, say, two or three times in a year
 8 -- (overspeaking) --
 9 A. I think twice could potentially be reasonable. I'd need
 10 to test that with operational teams to get a view.
 11 I think that will be great. That's my personal opinion.
 12 Q. It's also right, isn't it, that until August of this
 13 year, there was no centralised system for monitoring
 14 whether emergency simulations were taking place on each
 15 ward with the result that you were not aware that there
 16 was no record of a simulation exercise taking place on
 17 Willow Ward between September 2024 and February 2026?
 18 A. Yes. So it was a process in place, and it's been within
 19 our policy since before I joined, so there was a process
 20 in place, but I wasn't necessarily assured that I was
 21 getting all of the forms that were being shared to me.
 22 It's geographic -- if it was under one roof, I could
 23 wander around onto each ward. So to provide assurance,
 24 because that's what we're striving to gain. Best
 25 practice, assurance, and that will come with the

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1 simulations and its continuing inability to say whether
 2 individual EPUT staff members take part in simulation
 3 exercises lead you to reflect on your statement that
 4 EPUT is positioned at the leading edge in terms of
 5 resuscitation and mental health?
 6 A. I think that's unfair. That's one element. We've now
 7 got that additional assurance. The support, the
 8 other -- the support we provide our staff and our teams,
 9 in my view, is proactive as opposed to reactive. So
 10 I think that assurance was important to us and we put
 11 that in place, but I do think that we are potentially --
 12 we are -- we sit on a national forum, myself and my
 13 colleague Mr Smale. We share aide memoires that other
 14 organisations don't have. So I can see that as being
 15 potentially slightly ahead of -- in the leading edge.
 16 There's always areas for improvement. I absolutely
 17 understand this is a journey for us, but we are
 18 passionate about making improvement.
 19 Q. A final point on the SWARM report before I move on.
 20 That report said that a medical emergency simulation
 21 must be carried out every four months as a minimal
 22 requirement but the requirement in the CPR Policy is
 23 every three months. Was that correct? Should it have
 24 been every three months?
 25 A. That was an error. It's as per the policy.

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1 **Q.** In terms of the medical emergency simulation practice
2 reports that you receive, do you keep a log or
3 a document that details the learning from each
4 simulation so that you can compare outcomes and assess
5 whether there are repeated problems or learning?

6 **A.** So I -- when I receive them, I will review them, I'll
7 feed back. I'm very clear on acknowledging, as I've
8 said previously, examples of good practice. What we are
9 providing with a medical emergency simulation is
10 a psychologically safe space for staff to practise the
11 technical and non-technical elements proactively before
12 we have to do that in real life.

13 So I will, if there's something I question, I will
14 feed back. That learning will also be shared. So at
15 the end of -- the simulation, the hands-on simulation,
16 is important, but for me the real benefit comes from the
17 learning conversation. So what we want is for our teams
18 to be absolutely aware of things that they did really
19 well but also some key learning that they can take away
20 that hopefully next time, when the same thing happens,
21 they'll be able to do things differently.

22 So the learning conversation and the way that the
23 team -- that feedback is shared is really, really
24 important. The learning conversation is something that
25 we utilise within our resus, our RCUK training courses.

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1 **A.** They are well known but I must go back to probably -- I
2 can't remember exactly what led the question, but
3 looking at the -- the themes that existed over time
4 aren't themes that we've seen recently within the last
5 couple of months. What we've seen is example of good
6 practice. So I would like to say that some of those
7 themes have been acted upon and the education has taken
8 place and the learning has been embedded so hopefully --
9 there is always human error. Whilst we put as much
10 teaching in place as possible, it's extremely difficult
11 to completely mitigate human error and I've already said
12 that these medical emergencies and cardiac arrests are
13 really stressful. They're emotionally draining, they're
14 physically tiring. So with -- short of removing humans
15 full stop, there is always that risk of human error.

16 But we are as proactive as we possibly can to try to
17 share the learning.

18 Since I've joined the organisation, I wouldn't like
19 to say how many pieces of learning we've shared via the
20 Lessons Team that we've done. I've probably done three
21 live briefings, put lots of key messages out there,
22 shared with the teams at local level, the Lessons Team
23 go round and they put a folder and they'll make the
24 teams aware of the latest because I'm mindful that not
25 everybody has access to, in the time-pressured

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1 It's really important. So I do have oversight. I'll
2 feed in. I'll provide some support, input, praise.

3 **Q.** But do you keep a log or a record or a document that
4 sets out which issues are repeating between medical
5 emergency simulations?

6 **A.** I keep all of those medical emergency simulations in
7 a folder that I can access. So at any time I can pull
8 any one of the number up.

9 **Q.** But again, is it that, in terms of knowing whether
10 a medical emergency simulation report has a lesson in it
11 that's in a previous report, you've got to remember that
12 and be able to pull up the previous report?

13 **A.** At present, although that's something that I can
14 absolutely consider to improve my process, I have access
15 to all of them. I don't just delete them and put them
16 in the trash can. I will look at them, I will keep hold
17 of them. I can pull them back whenever I need. But I'm
18 always happy to take recommendations on board if it
19 improves what I currently do. It's a learning process
20 for me. I'm not perfect.

21 **Q.** Is potentially one of the reasons that you don't
22 currently feel you needed to keep a record because the
23 repeating themes are so well known to you that you don't
24 need them to be written in a document because they
25 happen so often?

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1 situation, not everybody has time to sit in front of
2 a computer or a laptop so we try and do as much as we
3 possibly can.

4 **THE CHAIR:** You mentioned earlier that the themes that had
5 come through that were troublesome were staff not being
6 able to administer oxygen, calling emergency services,
7 communications once they were able to get hold of
8 emergency services. You're suggesting now that those
9 issues are no longer happening because people are being
10 trained, they're not coming through?

11 **A.** I think the -- potentially the frequency is less. I'm
12 mindful that they may crop up from time to time. It's
13 very difficult to eradicate but I think the approaches
14 we're taking is -- in embedding that learning is
15 hopefully making an impact and that's something that
16 we'll continue to monitor.

17 **THE CHAIR:** What do you think the current particular issues
18 are, and are keeping you concerned?

19 **A.** I would say leadership. I think there are challenges
20 associated with leadership. That is why we are looking
21 to put together an aide memoire, a prompt, so the team
22 leader has some clear guidance. Because again, you
23 know, it's -- the leadership, the non-technical skill of
24 leadership is taught in the Resus Council ILS training,
25 but as I say, that's a one-day course. So that is

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1 something that -- that's a skill. If you do it
2 regularly it comes naturally. But if you are not taking
3 on the role of leader there are some key -- some key
4 things, and this goes back to the themes that we can
5 help prompt to make sure that those themes in the future
6 hopefully don't happen.

7 So calling for the phone with some additional text
8 about bringing the DECT phones to the patient, for
9 example. Oxygen administration with a prompt to ensure
10 that the thumb wheel on the side is turned on. So we're
11 doing as much as we possibly can to hopefully
12 eradicate --

13 **THE CHAIR:** So leadership was one of the issues and you
14 still mention oxygen administration, you still mention
15 phones. Are those still live issues?

16 **A.** Oxygen administration, no. I haven't seen anything
17 recently.

18 **THE CHAIR:** So what is it?

19 **A.** Sorry?

20 **THE CHAIR:** What else? What else are the issues you've
21 seen?

22 **A.** Recently, I would say that the leadership is one that
23 really springs to mind. I'm sorry, I can't think of
24 others off the top of my head, to be honest.

25 **THE CHAIR:** Okay.

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1 Mental Health Unit now been resolved, do you know?

2 **A.** Yes, yes. I know that for a fact because our Medical
3 Director had contacted the doctor that was on shift on
4 the particular day to make sure that had been resolved.

5 **Q.** The result of the three simulations that took place at
6 Basildon Mental Health Unit is that the Professional
7 Nurse Educator there has decided to introduce weekly
8 simulations on alternate wards. Have you given any
9 consideration to whether the CPR Policy for EPUT should
10 require more regular simulations than every three
11 months?

12 **A.** At present, I think that is a minimum. We strongly
13 advocate teams going above and beyond. Whilst it's not
14 prescriptive in there, when it comes to review, I think
15 that is something that I could make clearer. I think
16 it's only a good thing. So before -- and apologies if
17 I've said this, but before I started, teams did not have
18 access to training equipment, the training mannequin and
19 the resus bag.

20 As I was joining, our workforce team, because they
21 deliver ligature training which touches on Basic Life
22 Support, as well, they procured one of these -- a set of
23 kit for each site. So they have access to it and we
24 strongly encourage -- our Professional Nurse Educators
25 are wonderful, they will open a bag, they will talk

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1 **MS SAGE:** Mr Archer, you read Louise Borton's second
2 statement before giving your evidence today and we heard
3 a summary of it at the start. She gives examples of
4 recurring issues that were recurring in June and August
5 of this year including the recognition and escalation of
6 medical emergencies, communication with the duty doctors
7 because there wasn't enough radio signal on the wards at
8 Basildon Mental Health Unit, access to emergency
9 equipment, leadership during emergencies, and staff
10 familiarity with local procedures.

11 Before you read her statement, were you aware that
12 those recurring issues were persisting in the last few
13 months at Basildon Mental Health Unit?

14 **A.** Before I saw the reports I wasn't. The reason we
15 facilitate the emergency simulations is to remind our
16 teams of what we are expecting them to do. So we're
17 creating that safe space. And for me, this is the
18 reason why we facilitate medical emergency simulations.
19 Things that don't quite go to plan can be discussed and
20 rectified during the simulation. If you don't do the
21 simulation, there is a risk that that will crop up in
22 real life. So that's why we are really pushing and
23 promoting the medical emergency simulation.

24 **Q.** Has the issue with radio coverage and the ability for
25 duty doctors to be called via the radio at Basildon

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1 about the equipment, they will get people to pick it up
2 and be familiar with it. So whilst currently the
3 requirement states every three months, that is
4 definitely something as an organisation that we could
5 consider, if that's something that we want to change.

6 **Q.** Ms Borton, in her statement also explains about the
7 concerns that she raised with you in September 2022 and
8 again in December 2024 and the suggestion to introduce
9 compartmentalised grab bags. Do you accept what
10 Ms Borton says in her statement about those
11 conversations between you about compartmentalised
12 grab bags?

13 **A.** Yes.

14 **Q.** And she says that you explained to her that there were
15 significant cost implications in introducing
16 compartmentalised grab bags. Who within EPUT could
17 authorise the spend on compartmentalised grab bags?

18 **A.** It's not about the cost. When I had the conversation
19 with Ms Borton, we were having a conversation about the
20 resus bags that we were using in ICU, which have a lot
21 more equipment within them. That was the reason, within
22 those particular resus bags, that there were
23 compartmentalised. Because there were drugs that were
24 added in it, it was split up into airway.

25 We have less equipment within the resus bag. We've

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1 even made attempts to make it even easier for staff to
 2 locate the equipment by putting the nasopharyngeal and
 3 the oropharyngeal airway adjuncts in the pocket and
 4 we've gone above and beyond and we've -- personally,
 5 I think it was unfamiliarity with equipment. So that
 6 could build in delay if you're having to unzip
 7 something. So for me, it's about familiarising staff
 8 with the equipment. I said to Ms Borton that I would
 9 put the film together and that is live and that's been
 10 in place for a long time.

11 **Q.** And that film, it's not part of mandatory training at
 12 EPUT at the moment, is it?

13 **A.** Correct --

14 **Q.** Should it be?

15 **A.** It's something we can consider. At the time of
 16 producing it the intention wasn't to make it mandate,
 17 because you end up mandating everything. That's the
 18 risk, you mandate absolutely everything. If, as an
 19 organisation, we feel that when it comes to us having
 20 a conversation, we could potentially mandate. There's
 21 no reason why we could not mandate, that's an easy thing
 22 to do. I'd be really interested to hear from my
 23 colleagues as to whether that's something we should
 24 explore. It's easy to do, definitely, and definitely
 25 something that -- I'm happy to take any recommendations

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1 can reach operational colleagues. We use our
 2 Professional Nurse Educators to help share messages,
 3 learning. We're trying to use as many innovative
 4 methods as possible. However, we are geographically
 5 spread. 5,500 staff across 52 inpatient wards across
 6 200 community sites. There is one of me and only
 7 a handful of the Lessons Team and so we need to be
 8 innovative and creative in how we embed the learning. I
 9 absolutely agree that it's essential, and that's why we
 10 are trying as hard as we possibly can to think of ways
 11 to make the landing -- the learning land.

12 **Q.** Do you consider that those issues that you've
 13 identified, i.e. the geographical dispersal of the
 14 Trust, the number of people that there are in the
 15 Learning Lessons Team and yourself, do you consider
 16 those need to be addressed by significant structural
 17 change within EPUT in order to improve patient safety
 18 within the Trust?

19 **A.** I think we have tried to mitigate that as best as we can
 20 by -- we have Deputy Directors of Quality and Safety.
 21 We have our Professional Nurse Educators, our Student
 22 Education Facilitators. We have myself, we have
 23 a Lessons Team, we have a Patient Safety Team. It is
 24 recognised that we're a vast Trust and that's why we are
 25 always looking at ways to try to make this learning land

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1 on board, but we have to discuss them, and we need to be
 2 realistic with what we are mandating. But open to
 3 conversations.

4 **Q.** And finally this. In your statement at paragraph 68,
 5 you explain that you don't think that at EPUT learning
 6 in respect of recurring themes is absent, but you say
 7 this:

8 "... but because sustaining and assuring the
 9 consistent implementation of that learning across
 10 a large and geographically dispersed organisation is
 11 inherently challenging and requires ongoing
 12 reinforcement through training, simulation, audit and
 13 local leadership."

14 Do you agree that sustaining and assuring the
 15 consistent implementation of learning is a critical and
 16 essential element of ensuring that lessons are fully
 17 learned from serious incidents?

18 **A.** I do, absolutely.

19 **Q.** Do you accept that if learning is not being consistently
 20 embedded into frontline practice it suggests that the
 21 changes and actions implemented following previous
 22 incidents and identified failures are still insufficient
 23 or inadequate?

24 **A.** I mean, there is a potential risk, but that's something
 25 that we are addressing, we're looking at ways that we

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1 with those that need to be aware that key learning has
 2 been identified.

3 And that is ongoing. And it will be, but it is
 4 something that we are keen to explore and we are
 5 exploring and have been. As I say, I've worked so
 6 closely with the Lessons Team. We've put so many,
 7 whether it be a safety alert, for example like the
 8 oxygen cylinder, and just to put that into perspective,
 9 in 2018, NHS England issued a national safety alert. So
 10 it wasn't just EPUT that weren't getting that right; it
 11 was a national issue, and that's why -- and there is
 12 a risk and there is still a risk. Because the devices
 13 are being manufactured with a thumb wheel that
 14 potentially is covered. We've mitigated it by making
 15 sure that the -- we've tried to eradicate human error
 16 wherever possible by putting systems in place to
 17 mitigate that, but it is a journey. We are passionate
 18 about it. We're aware of the challenges. It is
 19 something we are working through. Whether a structural
 20 restructure would fix those problems, I think what is
 21 important is we've got people in the care groups that
 22 can share the learning.

23 **MS SAGE:** Thank you, Mr Archer. Those are all the questions
 24 that I have for you. What we'll do now is we'll have
 25 a break for ten minutes to see if there are any other

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1 questions that come in.

2 **THE WITNESS:** Thank you.

3 **MS SAGE:** So we will return at 3.00 pm.

4 **THE WITNESS:** Thank you.

5 (2.48 pm)

(A short break)

7 (3.01 pm)

8 **THE CHAIR:** Ms Sage.

9 **MS SAGE:** Mr Archer, there are a handful of further
10 questions for you. Others we've received can be more
11 appropriately dealt with the witnesses from EPUT that we
12 will hear from tomorrow.

13 You stated in your evidence that in an emergency,
14 ward staff rely on calling an ambulance to gain access
15 to staff who are ALS trained. You said you can have
16 ambulance response times of seven minutes. When
17 providing examples of learning from Datix, you referred
18 to a hypothetical example of a 30 to 40-minute wait for
19 an ambulance. What is the average ambulance response
20 time? Do you know?

21 **A.** And apologies if I caused some confusion. As you're
22 probably aware, the ambulance responses are categorised
23 depending on acuity, so again, this is very dependent on
24 the information that is shared with the Ambulance
25 Service, so that's why we kind of worked and we put that

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1 adrenaline and amiodarone, as something that is covered
2 in ALS training but not ILS training. Noting the risk
3 of overdose and other events that require urgent
4 administration of resuscitation drugs on mental health
5 wards, do you agree that training in administration of
6 these drugs is important for staff attending
7 emergencies?

8 **A.** I think training is important, I think with cannulation
9 that comes with an abundance of risk. It is also
10 a skill that needs to be practised. I will give you an
11 example, when we first took on our stroke response
12 service in our acute Trust, we had a cannulation
13 competency package which resulted -- so there was
14 initial learning and then there was absolute competency
15 that we had to achieve. We physically -- we don't do
16 that in mental health. Physical health wards are
17 different because fluids are administered. On our
18 mental health wards that currently does not happen
19 because it's not a skill our staff would be expected to
20 use regularly and with that comes risk.

21 And obviously, whilst it's important to recognise,
22 it's also important to recognise that when a patient is
23 unwell they become peripherally shut down, so even an
24 expert will struggle. So that's why paramedics will
25 carry intraosseous needles because venous access can

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1 document together to get the exact information across
2 that's required.

3 I haven't seen ambulance response times of 20, 25
4 minutes, in an acute -- an acutely unwell patient. We
5 are fortunate that we often have fairly rapid response
6 times because we are fairly closely located to
7 a neighbouring A&E department. The only site or some of
8 the sites, for example, Clacton, do not have an A&E on
9 their doorstep so I think it's variable. I think if we
10 were concerned in relation to ambulance response times,
11 we have -- I have links with the Ambulance Service. We
12 co-populated that document with input from the Ambulance
13 Service. We would absolutely escalate it. We do that
14 as an external safety alert.

15 Whilst I can't give you an exact time, as far as I'm
16 aware, we haven't raised that as a concern.

17 **Q.** What is the longest delay of which you're aware of an
18 ambulance attending an emergency at EPUT? Are you able
19 to help with that?

20 **A.** I can't. I'm so sorry.

21 **Q.** When asked about the advantages of ALS training, you
22 management pacing and laryngoscopy which cannot
23 generally be performed on a mental health ward. In her
24 statement at paragraph 24, Louise Borton refers to the
25 administration of resuscitation drugs, including

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1 prove almost impossible and if you're not practising
2 that, that's a real challenge.

3 **Q.** In respect of simulations, are bank and agency staff
4 included in simulations at EPUT? And if so, is there
5 any plan for a mechanism of monitoring whether they have
6 attended simulations like you have a plan for in respect
7 of full-time staff?

8 **A.** So everybody that's in the ward is encouraged to attend
9 and expected to attend. We have greatly reduced the
10 reliance on agency staff. The bank staff are
11 predominantly working on the same wards, so there is
12 that -- that variation has been reduced as well. So
13 it's important to capture bank, if agency were there.
14 Their training is dealt with via a framework assurance
15 but simulations, if they are there on the day, their
16 framework will assure that they are ILS providers but we
17 expect them to -- it's a team effort, absolutely.

18 **Q.** In respect of the framework ensuring they're ILS
19 providers, that's in respect of agency nurses?

20 **A.** Correct.

21 **Q.** Has EPUT liaised with other NHS Trusts in respect of
22 best practice on implementing and monitoring simulations
23 and do you consider there should be national standards
24 and guidance on the frequency of simulations and staff
25 attendance, given your acknowledgement of the importance

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1 of simulations for staff on mental health inpatient
2 wards in particular?
3 **A.** So whilst it has briefly been discussed in the national
4 forum, it is one hundred per cent something that I'm
5 going to take to the national forum to work -- to try to
6 work out what other organisations do. I'm really unsure
7 of what happens in other Mental Health Trusts. I can
8 only talk for what we do. We heard evidence yesterday
9 from ELFT. It wasn't clear as part of their evidence if
10 they document medical emergency simulations. It wasn't
11 clear if learning was identified from them, based on
12 yesterday's evidence.

13 I'm keen and it's part of our learning journey,
14 that's why we link in with the national forums, it's
15 something that I'm absolutely going to be taking forward
16 and seeking best practice because it's about informing
17 change, if change is appropriate.

18 **Q.** And would you go further, do you consider there should
19 be national standards on the frequency of simulations on
20 mental health wards?

21 **A.** I personally do. So within the Resus Council guidance
22 that's out there around the educational guidance, there
23 is mention of -- kind of like the refresher sessions,
24 medical emergency simulations. It's not clear, it's not
25 specific around frequency. I personally, because it's

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1 **THOMAS SIMONS (affirmed)**
2 **DR DAWN ADAMSON (sworn)**
3 **Questioned by MR WAKERLEY**

4 **MR WAKERLEY:** Thank you.

5 It's Mr Thomas Simons; is that right?

6 **MR SIMONS:** That's correct.

7 **Q.** Yes, and Mr Simons, you are currently the Chief Human
8 Resource and Organisational Development Officer for
9 Workforce Training and Education at NHS England, is that
10 right?

11 **MR SIMONS:** That's correct.

12 **Q.** And you've had that position since 2020?

13 **MR SIMONS:** That's also correct.

14 **Q.** You've set that out in a witness statement for us dated
15 28 August of this year, didn't you?

16 **MR SIMONS:** Yes.

17 **Q.** And that's a statement that you have in front of you?

18 **MR SIMONS:** That is.

19 **Q.** And is it a statement that, at its end, you've signed
20 following the declaration of truth of its content?

21 **MR SIMONS:** That's correct.

22 **Q.** And had you a chance to read it before you came into
23 this session this afternoon?

24 **MR SIMONS:** I have.

25 **Q.** And was there anything within it that you wish to amend

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1 a passion of mine, I personally feel that it's something
2 that should be explored from a national perspective
3 because it is so important. Because our staff don't get
4 the exposure to it as often as our colleagues within the
5 acute Trust would. So I think that would only be a good
6 thing.

7 **MS SAGE:** Thank you, Mr Archer. Those are all the questions
8 I have for you.

9 What we're going to do now is rise for five minutes
10 so that the next witness -- you can go out and the next
11 witnesses can come in.

12 **THE WITNESS:** Okay, thank you very much.

13 **THE CHAIR:** And can I thank you very much indeed for your
14 evidence. We've worked you very hard today. Thank you.

15 **THE WITNESS:** Thank you.

16 **(3.08 pm)**

(A short break)

17 **(3.14 pm)**

18 **THE CHAIR:** Mr Wakerley.

19 **MR WAKERLEY:** Chair, thank you. We're ready for our final
20 two witnesses today that we're going to hear again
21 simultaneously, as yesterday. Could our witnesses
22 please be either sworn or affirmed, please.
23
24
25

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1 before we start?

2 **MR SIMONS:** There wasn't.

3 **Q.** You can confirm its contents are true and accurate?

4 **MR SIMONS:** That's correct.

5 **Q.** And to your right is Dr Dawn Adamson; is that right?

6 **DR ADAMSON:** That's correct.

7 **Q.** And again, we'll deal with your qualifications in
8 a moment but, again, just the same questions, please.

9 You've prepared one statement for the Inquiry dated
10 30 September of this year; is that right?

11 **DR ADAMSON:** That's correct.

12 **Q.** Again, it is signed by you at the end on the last page
13 following the declaration about its truth; is that
14 right?

15 **DR ADAMSON:** That's correct.

16 **Q.** You have a copy of it?

17 **DR ADAMSON:** I do.

18 **Q.** You have had the opportunity to read it before coming
19 into session?

20 **DR ADAMSON:** I have.

21 **Q.** And do you have anything that you wish to amend to its
22 content?

23 **DR ADAMSON:** No, thank you.

24 **Q.** And you, again, are content that it represents your
25 evidence. And I think, in it, you make it clear that

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1 you've also read and considered Mr Simons' statement; is
2 that right?
3 **DR ADAMSON:** That's correct.
4 **Q.** So you're also familiar with its content?
5 **DR ADAMSON:** I am.
6 **Q.** Thank you.
7 Mr Simons, we dealt with your current position.
8 I think also you were involved in the development and
9 publication of the Future of the NHS Human Resources and
10 Organisational Development Report, the 10-Year Plan; is
11 that right?
12 **MR SIMONS:** That's correct.
13 **Q.** And you've also, prior to that, held a number of senior
14 human resource and organisational development positions
15 across NHS organisations?
16 **MR SIMONS:** That's correct.
17 **Q.** Thank you.
18 Dr Adamson. Your qualifications, please, you deal
19 with in the body of your statement. And of course, I'm
20 not intending to underplay those qualifications in any
21 way; you set them out in full. But for our purposes
22 today, you are a Consultant Interventional Cardiologist
23 and Clinical Lead for Adult Congenital Heart Disease and
24 Obstetric Cardiology at University Hospitals Coventry
25 and Warwickshire NHS Trust.

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1 **MR SIMONS:** Yes, that's correct.
2 **Q.** And because of your role, Dr Adamson, I think you may be
3 able to help us more with the rationale for some of
4 those changes, but we shall see.
5 **DR ADAMSON:** That is correct.
6 **Q.** I want to start, please, firstly by looking at the
7 current position, and Mr Simons, you deal with this in
8 your witness statement and I'm just going to take you
9 straight to that, please. But you deal with what we
10 know or what the Inquiry knows as the Core Skills
11 Training Framework. That's something you're familiar
12 with?
13 **MR SIMONS:** That's correct.
14 **Q.** And you tell us this, at paragraph 15, we don't need to
15 put this up for the moment, your paragraph 15, that the
16 current position is that the Core Skills Training
17 Framework, CSTF, is the principal national framework for
18 Statutory and Mandatory training across the providers of
19 NHS services in England; is that right?
20 **MR SIMONS:** That's correct.
21 **Q.** You tell us that it applies to employees across an
22 organisation covering staff employed in both clinical
23 and non-clinical roles; is that right?
24 **MR SIMONS:** That's correct.
25 **Q.** And you also tell us that, paragraph 14, each employing

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1 **DR ADAMSON:** I am.
2 **Q.** And you have worked there for 18 years now, since 2008?
3 **DR ADAMSON:** That's correct.
4 **Q.** You're also NHS England's National Speciality Advisor
5 for Heart Disease; is that right?
6 **DR ADAMSON:** That's correct.
7 **Q.** And I think as part of that role, you were also asked to
8 consider a resuscitation element; is that right?
9 **DR ADAMSON:** That's right, I'm the topic lead for
10 resuscitation for the StatMand reform.
11 **Q.** You are the topic lead for the resuscitation part of
12 statutory and mandatory reform within NHS England?
13 **DR ADAMSON:** That's right.
14 **Q.** And you're also a member of a steering committee of the
15 Out of Hospital Cardiac Arrest Outcomes Study?
16 **DR ADAMSON:** That's correct.
17 **Q.** And I think it's also right that also sitting on that
18 steering committee is a Professor Soar, who is an expert
19 who is going to be giving some evidence to the Inquiry
20 a little later this week; is that right?
21 **DR ADAMSON:** That is correct.
22 **Q.** Now, Mr Simons, I think this is right: that you can help
23 us with the current framework and proposed changes to
24 the current regime of statutory and mandatory training
25 as set out by NHS England; is that right?

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1 organisation develops and maintains its own local
2 policy, taking account of the requirements and guidance
3 and drawing on the expertise of local statutory and
4 mandatory training leads, and other local subject matter
5 experts; is that right?
6 **MR SIMONS:** That's correct.
7 **Q.** Can you tell us, please, who in fact was responsible for
8 the Core Skills Training Framework?
9 **MR SIMONS:** So the Core Skills Training Framework was
10 developed back in 2013. At that point, it was the
11 organisation Health Education England that took
12 responsibility for essentially developing that framework
13 with providers and staff and subject matter experts.
14 **Q.** And then you, as I understand it, NHS England, took on
15 the role from Health Education England in 2023,
16 1 April 2023. Is that right?
17 **MR SIMONS:** That's correct, yes.
18 **Q.** Now, you tell us this at paragraph 17. Perhaps we can
19 just put up Mr Simons' statement page 6, paragraph 17:
20 "The CSTF establishes minimum standards by
21 identifying relevant learning outcomes, target
22 audiences, refresher requirements and training delivery
23 standards for each subject area."
24 Is that right?
25 **MR SIMONS:** That's correct.

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1 **Q.** And in paragraph 18, you make this point about
 2 resuscitation, "resuscitation training is not a specific
 3 statutory requirement," but you recognise that it is
 4 a "key patient safety issue", and its inclusion in Core
 5 Skills "reflects the longstanding recognition across the
 6 healthcare system that staff must be appropriately
 7 trained to respond to medical emergencies and cardiac
 8 arrests".

9 Again, that's right?

10 **MR SIMONS:** That's correct.

11 **Q.** Again, not a statutory requirement but is it a mandatory
 12 requirement?

13 **MR SIMONS:** So the Core Skills Framework is set out for
 14 providers to follow. It is in the contract, the NHS
 15 contract which sets out requirements that they have to
 16 undertake. It is monitored, I think in most cases, by
 17 Trust boards, and the CQC are required as part of their
 18 inspection regime to look at the outcomes for which that
 19 training is seeking to address.

20 **Q.** Insofar as the guidance that, or the Core Skills
 21 Training Framework, as set out by HSE England, does it
 22 say that resuscitation treatment is mandatory?

23 **MR SIMONS:** It sets out a set of standards which -- and to
 24 which staff it should apply which NHS Trusts and
 25 providers should follow.

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1 **MR SIMONS:** Yes.

2 **Q.** Or, you've told us again, the CQC. Those are not NHS
 3 England, are they?

4 **MR SIMONS:** That's right.

5 **Q.** So NHS England is setting a guideline but playing no
 6 part in securing that it's actually being followed.

7 **MR SIMONS:** Not directly.

8 **Q.** No. You tell us, though, in paragraph 20 of your
 9 statement, that resuscitation is one of the core subject
 10 areas of Core Skills Training Framework.

11 **MR SIMONS:** That's correct.

12 **Q.** And you also set out, if we can put up -- it's already
 13 there, please -- paragraph 21 -- the target audiences
 14 and the required frequency of refresher training, and
 15 the comments in a table, don't you? This is the current
 16 position.

17 **MR SIMONS:** That's correct.

18 **Q.** And we can see that level 1 is described as: "
 19 "Non-clinical staff, dependent upon local risk
 20 assessment or work context."

21 They require annual refresher training in
 22 resuscitation, including a variety of methods such as
 23 and including e-learning; yes?

24 **MR SIMONS:** That's correct.

25 **Q.** And then over the page, level 2:

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1 **Q.** I think you may have already answered this, but does NHS
 2 England itself play any follow in ensuring that those
 3 local policies do in fact reflect the statutory and
 4 mandatory training?

5 **MR SIMONS:** So in the main, that is the responsibility of
 6 individual employers, their Trust boards, and the CQC
 7 inspection regime.

8 **Q.** Right. So in the main. But the question I asked you
 9 was, does NHS England play a role in ensuring that its
 10 guidance is followed?

11 **MR SIMONS:** No.

12 **Q.** Do you think it should?

13 **MR SIMONS:** The current -- I think the challenges with the
 14 Core Skills Framework are more related to its focus on
 15 training as the dominant intervention to affect
 16 outcomes. So when we start -- and I'm sure we will talk
 17 in a moment about --

18 **Q.** Yes.

19 **MR SIMONS:** -- the new skills framework, there's a real
 20 shift from essentially looking at completion of training
 21 to confidence and competence in the new framework, and
 22 so the trust boards often look at completion rates, how
 23 many of people have done the particular training rather
 24 than -- (overspeaking) --

25 **Q.** Mr Simons, forgive me, that's the Trust's board?

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1 "Staff with direct clinical care responsibilities
 2 including all qualified healthcare professionals."

3 And level 3:

4 "Registered healthcare professionals with
 5 a responsibility to participate as part of the
 6 resuscitation team."

7 Again, annual refresher training, and at levels 2
 8 and 3: practical instruction, i.e. hands-on simulation
 9 training and assessment is recommended for clinical
 10 staff.

11 Do you agree that that element of practical
 12 instruction, including simulation, makes the training
 13 more effective?

14 **MR SIMONS:** So I think Dawn might be better placed to
 15 comment on that but I think the assessment has been
 16 "yes".

17 **Q.** Perhaps, then Dr Adamson, to ask you that same question,
 18 do you agree or do you think the practical instruction,
 19 hands-on, including simulation, makes training more
 20 effective?

21 **DR ADAMSON:** I think it can't be taken in isolation. So
 22 what I mean by that, it is important that people have
 23 the knowledge of what to do. I think it is paramount
 24 and we're making it mandatory that people are able to
 25 demonstrate the competency of being able to do, for

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1 example, hands-on CPR, and that, when I talk about the
2 new framework, is going to be mandatory to all
3 patient-facing staff. But what is equally important is
4 that, having identified the roles of the individuals,
5 that when they come together in a team, that those team
6 roles can be worked within the environment of which
7 they're working and that's where it is paramount that we
8 have a degree of scenario training, and so that is why
9 the new framework is going to be moving away from the
10 reliance of classroom training into a combination of
11 classroom training and then sort of in situ within your
12 environment scenario training.

13 **Q.** Before we look at the new regime, in terms of the
14 current regime, does NHS England recommend anything
15 about the recording of attendance at simulation?

16 **DR ADAMSON:** So the recording is made, the attendance is
17 definitely recorded and that's what, in effect, is
18 defined as compliance as whether you've attended the
19 training. But again, we want to shift that to an
20 outcomes dependent.

21 **Q.** I understand. We'll move on to the new framework in
22 a moment, but as things currently stand, is there
23 guidance given by -- recommendation by NHS England as to
24 the manner in which attendance at simulation ought be
25 recorded?

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1 patients with disturbed mental functioning should
2 undertake Adult Immediate Life Support training."
3 Is that right?

4 **DR ADAMSON:** (The witness nodded).

5 **Q.** And by the definition that you've given us, that is
6 restricted, is it, to registered healthcare
7 professionals? That's at the moment.

8 The Inquiry has heard evidence that the RC, the
9 Resuscitation Council UK, refers to all staff who are
10 either delivering or involved in rapid tranquilisation
11 as receiving ILS regardless of the fact of their
12 registration. Do you think there should be
13 a distinction?

14 **DR ADAMSON:** If I could answer that. I think it's important
15 that we clarify what exactly we mean by that because
16 I think if you are administering rapid tranquilisation
17 then by definition you need to be a prescriber so
18 therefore you have to be a registered healthcare
19 provider so not, for example, a healthcare assistant.
20 So I completely agree that in this situation, people
21 that are involved in this should have Immediate Life
22 Support.

23 Where -- I don't want to cross and go into the new
24 system early, but we are suggesting that all healthcare
25 providers, so from healthcare assistant upwards, do have

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1 **DR ADAMSON:** So I'm not familiar with whether the scenario
2 training is recorded because I've not been involved in
3 the previous Core Skills Training Framework. I've been
4 asked to come in as sort of a ground zero based-up
5 review so in effect with looking at things from complete
6 fresh. So apologies; I'm not aware of that information.

7 **Q.** All right, well, then, I won't press on that.

8 But again, for example, in your guidance, Mr Simons,
9 perhaps, the NHS England Guidance, do you set out within
10 it who it is that NHS England expects to receive, for
11 example, Basic Life Support, or who NHS England expects
12 to receive intermediate -- Immediate Life Support
13 training, beyond what you've set out in this table here?

14 **MR SIMONS:** Not beyond what's set out in this table. But
15 could I just, a point you asked about recording --

16 **Q.** Yes.

17 **MR SIMONS:** -- perhaps? So recording of Statutory and
18 Mandatory training is placed on a national system for HR
19 called ESR that records the completion of that training
20 whenever it takes place, and providers have
21 a responsibility to input that on to the system.

22 **Q.** At your paragraph 22, you do say that CSTF does
23 specifically provide that, in inverted commas
24 "registered healthcare professionals involved in the
25 administration of rapid tranquilisation in the care of

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1 mandatory mental health care immediate response
2 training, in other words that should they come across
3 a patient who is in difficulty due to self-harm,
4 ligature, or whatever, that they're able to recognise
5 cardiac arrest, deal with it immediately, and then
6 summon help and start Basic Life Support, but the next
7 level up of airway management, et cetera, that really
8 should be with a registered healthcare provider, not
9 with all staff.

10 **Q.** This is going to be the recommendations in the future?

11 **MR SIMONS:** (The witness nodded).

12 **DR ADAMSON:** Yes.

13 **Q.** What I want to focus on just at the moment is the
14 current position, and there, in your statement,
15 Mr Simons, you're referring to the administration of
16 rapid tranquilisation. There isn't a separate section,
17 as I understand it, where the recommendations are
18 dealing with physical restraint or with seclusion, for
19 example. Do you know of that?

20 **MR SIMONS:** No.

21 **Q.** Because the Core Skills Training Framework is not
22 specifically for mental health inpatient wards, is it?

23 **MR SIMONS:** It's not, no.

24 **Q.** It applies across all NHS organisations, does it?

25 **MR SIMONS:** That's one of its limitations, yes.

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1 Q. That is one of the ...?

2 MR SIMONS: One of its limitations.

3 Q. One of the limitations?

4 MR SIMONS: Yeah.

5 Q. As currently drafted, is there a section within the
6 current Core Skills Training Framework exclusively
7 dedicated to mental health inpatient beyond that which
8 we see referred to in your paragraph 22?

9 MR SIMONS: Not that I'm aware of.

10 Q. Certainly as we understand, that Professor Soar may
11 suggest that it is beneficial if anyone who is a first
12 responder, regardless of their registration or not,
13 a first responder, does have ILS-level training; would
14 you agree with that as a proposition?

15 DR ADAMSON: I personally wouldn't. I do think that they
16 should have a level of immediate response training, and
17 they should be able to deal with what they're faced
18 with, whether it be a ligature self-harm, they should be
19 able to recognise cardiac arrest and summon help. They
20 should be able to start Basic Life Support and where
21 appropriate, apply a defibrillator. But at that point,
22 I would expect the rest of the team, those of which are
23 qualified to come and then support with that
24 resuscitation attempt and be able to do the additional
25 competencies of airway management and managing that

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1 spontaneous circulation and improved physical and
2 neurological outcomes.

3 Q. Perhaps then moving on to the new regime, please. You
4 say, Mr Simons, in your statement, and I'm looking at
5 paragraph 28 and 29, 28. The focus is on improving
6 outcomes to develop and periodically assess workforce
7 competence.

8 And at 29:

9 "The redesign programme aims to move from a focus on
10 completion of training towards a focus on improving
11 outcomes and workforce competence ..."

12 Now, is it that NHS England had identified
13 shortcomings in an approach where compliance was
14 measured through attendance at training? Is that the
15 genesis of this?

16 MR SIMONS: So in 2022, 2023, we had a number of quite
17 significant concerns raised about the experience of
18 training and the effectiveness of it. And those
19 concerns primarily came from resident doctors in
20 training who also were concerned about the portability
21 of that training and the appropriateness of it. We
22 started to look at that in some detail, and what we
23 understood quite quickly is there were a range of
24 issues. Some were related to the Core Skills Framework
25 and its level of variance of its application in terms of

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1 cardiac arrest, and all of that should occur within
2 seven to eight minutes before the Advanced Life Support
3 team, which for a majority of mental health units which
4 are predominantly community based would be our Ambulance
5 Service and paramedics.

6 And the reason that I'm saying this is because in
7 the event of a cardiac arrest, or finding someone in
8 this very distressing and traumatic scenario, human
9 factors come into play, and to expect healthcare
10 assistants or non-qualified staff to work beyond their
11 bounds of professional responsibility to take on
12 additional roles, I think is both unnecessary, and
13 I think may lead to more harm. What we would rather see
14 is that staff are competent and confident to deal with
15 the immediate response and start high-quality Basic Life
16 Support, and then the team support then the additional
17 competencies prior to the ambulance attending.

18 I think we have to remember that these events don't
19 happen very frequently in this -- or the institutions
20 that we're discussing today, and therefore, to remain
21 confident and competent when things are happening
22 infrequently, is difficult, and so, by simplifying but
23 making sure that what you learn you can do it very well,
24 means you're much more likely to have the outcome which
25 we're all trying to get, which is to have return of

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1 frequencies and who should be included in what training,
2 but more materially, we recognised quite quickly there
3 was an overreliance on training as the primary
4 intervention to affect outcomes.

5 Q. Now, you tell us that the intention was that the
6 redesign would be a new Nationally Mandated Skills
7 Framework that, for a non-professional, would be in
8 place ideally by December of 2024, and the new
9 professional level by June 2025, and obviously those
10 dates have been missed by some distance.

11 Where are we at the moment, please, Mr Simons?

12 MR SIMONS: So we've completed the final draft of the Skills
13 Framework. We expect to release that prior to Christmas
14 this year, before the end of December this year. This
15 currently will go before ministers for final approval
16 but we expect that to be given before the end of
17 December.

18 Q. So the recommendations that you envisage are presently
19 before ministers for approval?

20 MR SIMONS: About to be given to ministers, not
21 before-- (overspeaking) --

22 Q. About to be?

23 MR SIMONS: Yes.

24 Q. But is there still feedback taking place?

25 MR SIMONS: We've completed significant feedback throughout

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1 this process, and it's in a final version to go before
2 the minister.
3 **Q.** At paragraph 38 of your witness statement says this:
4 that -- and I think this is a reference to the new
5 framework, paragraph 38:

6 "It adopts a competency-based approach under which
7 competencies are defined nationally and staff are
8 required to demonstrate them through formal assessment.
9 Assessment methods and learning modules are currently
10 being developed to support staff in acquiring and
11 demonstrating those competences."

12 And:

13 "The programme recognises that competence may be
14 developed through a range of approaches, including
15 trained, practical exercises, simulation, local learning
16 activities and other safety interventions."

17 Is that right?

18 **MR SIMONS:** That's correct, yes.

19 **Q.** And you say in 39 that:

20 "New ... competency assessments and learning
21 materials are expected to be introduced on a phased
22 basis, with implementation scheduled to be by
23 April 2027, with iterations and additions to follow."

24 So still somewhat of a work in progress.

25 **MR SIMONS:** That's correct.

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1 basic level for all staff but what we're moving away
2 from and I think this is a key to the difference between
3 the previous Core Skills Training Framework and the new
4 framework isn't just about that reliance on classroom to
5 competence and that demonstration of competence, but
6 that in the past it's been a blanket: train everybody in
7 everything.

8 And in the event of an emergency, that isn't
9 working, because people just go into panic mode and
10 forget things. So what we're trying to do is look at
11 what the role that you are undertaking clinically and
12 make sure that you have the tools, training and
13 competence within that role to be effective in
14 resuscitating the patients that you're likely to come
15 across, which is why, if you're working in a mental
16 health institution, we would ask that all patient-facing
17 staff, from healthcare assistant upwards, do get
18 mandatory mental health immediate response training.

19 Then we're going to layer or taper on the more
20 additional competencies, dependent upon your role and
21 the need for them.

22 **Q.** These are going to be recommendations?

23 **DR ADAMSON:** They are going to be recommendations, but the
24 ... yes, I mean, they are going to be recommendations.

25 The mandatory part is the basic, but we are going to

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1 **Q.** And I think Dr Adamson, you're nodding there, is that an
2 agreement, that it's still very much a work in progress?

3 **DR ADAMSON:** Yes, that's correct. We've decided what the
4 basic level for all staff is, and we've added to the
5 fact that now all non-patient-facing staff, so even ones
6 that work in offices that may never see patients, will
7 receive some degree of mandatory Basic Life Support so
8 that they can help with out-of-hospital cardiac arrests
9 in their own homes and communities, but then all
10 patient-facing staff, qualified or non-qualified, will
11 receive Basic Life Support training.

12 **Q.** And is this in some respects a restatement of principles
13 that are already there, or are these, in effect, a fresh
14 take on the subject altogether?

15 **DR ADAMSON:** I think it's a combination. I mean the Current
16 Skills Training Framework has been, you know, developed
17 alongside RCUK, the Resuscitation Council UK Guidance
18 and Principles, and what we have been done is taken
19 a combination of the information from educationalists on
20 the hierarchy of effectiveness as to what actually is
21 the most effective way to impart training, combine that
22 with clinical expertise and experience within the teams
23 that are day-to-day resuscitating patients, and then
24 supported by, and working in collaboration with, RCUK
25 and that combination has identified what we need as a

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1 sort of mandate that there is local risk assessment and
2 role recognition, and that actually the competencies
3 that we're going to ask you to be trained on isn't going
4 to be your band of -- whether you're a Band 5 or 6 or 7
5 nurse, it is what is the role that you're doing and what
6 are the competencies that you require to safely undergo
7 that role?

8 **Q.** Mr Simons, in your statement at paragraph 35 on page 15,
9 towards the top, you say there's:

10 "... an increased focus on the recognition and
11 management of deteriorating patients, the targeting of
12 Advanced Life Support training to higher-risk clinical
13 roles ..."

14 And are you seeking to define what those higher-risk
15 clinical roles are?

16 **MR SIMONS:** (The witness nodded).

17 **Q.** Mr Simons?

18 **MR SIMONS:** Yes.

19 **Q.** And those are going to be within the guidance?

20 **MR SIMONS:** That's correct.

21 **DR ADAMSON:** (The witness nodded).

22 **Q.** At 41, please, paragraph 41 on page 16:

23 "Understanding the new framework, all staff are
24 expected to demonstrate the following resuscitation
25 competencies:

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1 "(a) [the] ability to summon help in an emergency
2 (... by calling 999 or 2222 in a hospital setting);
3 "(b) [the] ability to confidently commence
4 cardiopulmonary resuscitation on an adult in any
5 environment;

6 "(c) [the] ability to place and use an Automated
7 External Defibrillator."

8 Now, all of those are effectively basic life
9 support, would you agree?

10 **MR SIMONS:** (The witness nods).

11 **DR ADAMSON:** (The witness nods).

12 **Q.** Over the page:

13 "Additional role-specific competencies ..."

14 And then you list seven there, which must, by
15 necessity, take them over the basic life support; is
16 that right? And I'm sorry, I see you nodding and that's
17 both of you nodding there. Is that right?

18 **MR SIMONS:** Yes.

19 **DR ADAMSON:** Yes, that is correct.

20 **Q.** You -- again, when asked which staff in a mental health
21 inpatient unit you would expect to be able to
22 demonstrate those listed competences, your answer, is it
23 depending on what their role is?

24 **DR ADAMSON:** It is. So, as I stated before, there is going
25 to be an expectation for all staff to have the immediate

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1 a bag valve mask oxygen system which allows the patient
2 to be oxygenated, that equipment needs to be brought and
3 needs to be used correctly, and I think we've heard and
4 looked through some of the case scenarios from the
5 Inquiry to show that that wasn't the case. And so
6 that's why we're making that a specific competency, so
7 people can be really focused on what their role is
8 within that resuscitation and make sure that they have
9 got those competent tools to be able to do it.

10 **Q.** Can I ask you, please, as part of NHS England's work,
11 has there been work on recognising physical signs of
12 deterioration in patients with perhaps darker skin tone,
13 for example, specifically?

14 **DR ADAMSON:** I mean there is some work on the deteriorating
15 patient that's done through -- that the Patient Safety
16 Team but I'm not a hundred per cent familiar with that
17 so I wouldn't like to comment completely, but we could
18 get that information for you.

19 **Q.** Mr Simons, do you know the answer to that?

20 **MR SIMONS:** I don't, no.

21 **Q.** You do tell us, though, that you've been working closely
22 with RCUK and that the NHS England, I think the
23 expression used is "committed to working closely with
24 them" as further competency assessments and learning
25 materials are developed.

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1 mental health response training as well as the Basic
2 Life Support, but that not all staff working in a mental
3 health unit will need to have the additional
4 competencies, for example, of airway or being able to
5 lead a cardiac arrest. And, actually, we want those
6 roles to be focused so that we can have individuals that
7 are able to be trained in a more focused way so that
8 they're more confident and competent, and then to take
9 each of those individuals, because resuscitation is not
10 something that you can do alone. You start it alone but
11 then it's a team approach, and then it's making sure
12 that that team works under the stress and pressures of
13 that arrest situation. And that's where the scenario
14 training is going to be coming in.

15 **Q.** And your evidence as the NHS England lead on this topic,
16 insofar as a first responder first on the scene of an
17 unresponsive patient who may have airway issues, is that
18 that person should not be trained in how to deal with
19 those airway issues?

20 **DR ADAMSON:** They will be trained in the Basic Life Support,
21 so the immediate management, which is to clear the
22 airway, to check the airway is clear and if not, to
23 remove it, if there's a foreign body, for example. But
24 the more advanced airway, which is the insertion, for
25 example, of an oropharyngeal airway and then the use of

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1 Can you tell us how you envisage the relationship
2 between NHS England and RCUK developing?

3 **DR ADAMSON:** So the relationship has already developed.
4 I work very closely with Adam Benson Clarke who we've
5 already heard from and we, right at the beginning of
6 this reform, met with Professor Gavin Perkins who is the
7 current president of RCUK, and Mr James Cant, the CEO,
8 and we all met together to really talk about -- in
9 effect to come together for a Memorandum of
10 Understanding of what it is that we wanted to do, having
11 prior met with a community of practice, so that was a
12 number of resuscitation leads from a variety of
13 environments, from acute Trusts from mental health
14 units, from paediatric Trusts, and come together to
15 start deciding what it is we wanted the new
16 resuscitation reforms to look like, to gain the outcomes
17 that we are all looking for, which is this improved
18 outcome for patients.

19 We then met with RCUK to talk about how we wanted to
20 shift the focus from just classroom training to that
21 more bespoke role-specific training with the additional
22 scenario training. We met them on a number of occasions
23 and then we did a webinar for which they came along and
24 gave their support. So they've been fully supportive.

25 We have accelerated the next level, which is the

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1 development of the different competencies and we've
2 prioritised the mental health competency in light of the
3 Lampard Inquiry, and we are working with -- so that
4 means we literally have joint meetings with RCUK -- to
5 talk about where -- what we see that competency
6 framework for the mental health response to be, so we
7 are working extremely closely.

8 **Q.** Can I, please, just look then briefly at -- I think it
9 may be some of those slides from the resuscitation SME
10 webinar?

11 **THE CHAIR:** Before you do, can I just ask, these
12 competencies under (d), which are going to be the
13 additional competencies, are you participating that
14 somebody would just, as it were, have a bespoke
15 requirement for some of these? Or is this whole suite
16 of additional competencies to be given to everybody, for
17 instance, who might be --

18 **DR ADAMSON:** So in effect it would be like a library of
19 competencies, so for example, there's an example of
20 resuscitating a child or baby, which, if you don't work
21 with children or babies, you don't require that ability,
22 that resuscitation. I think that's number 4. So -- and
23 again, dependent upon your level, so we would expect
24 only staff who are actually on the cardiac arrest team,
25 or working in environments where there are frequent

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1 are looking at a real range from community hospitals all
2 the way up to acute Trusts. So we're trying to make
3 sure that we have a framework that can be used for all
4 staff in all situations. And that's why it is quite
5 complex. But what we do know is the teams that don't
6 see resuscitation happening very frequently, that human
7 factors come into play, and they do go into panic and
8 they don't remember the basics and then, by not
9 remembering the basics, then everything starts to fall
10 apart and we don't see the outcomes we need.

11 So what we're trying to do is make sure that we're
12 only training people with the tools and competencies
13 that they require, and not giving them anything
14 additional unless it is required.

15 **Q.** Sorry, I'm being reminded that my time is short, and
16 therefore your time is short. Forgive me.

17 **DR ADAMSON:** Apologies.

18 **Q.** Another of the slides, please, just briefly. Slide 4.
19 Is it page 4? Page 4, please. We can see there at the
20 base that the headline is that this new -- at the base,
21 please -- the new programme -- could you shrink that
22 back down, please -- is effectively, or should, release
23 200,000 days of staff time; is that right?

24 **DR ADAMSON:** That's across the whole mandatory training so
25 that's not just for resuscitation.

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1 cardiac arrests, so coronary care, intensive care, A&E,
2 to have the Advanced Life Support skills, because again,
3 there is no need or point in training everybody to do
4 everything, because we know that that doesn't work to
5 give us the outcomes that we want.

6 **MR WAKERLEY:** Just looking then, please, at those slides.
7 If you have, please, NHSE028070 at page 15, I think at
8 point 8 of page 15 -- yes, it's fairly small on the
9 screen.

10 But you make the point here, in this slide pack,
11 which I think you were part of the presentation for,
12 Dr Adamson --

13 **DR ADAMSON:** I was.

14 **Q.** -- that in point 8 is this:

15 "Develop competencies for target audiences matched
16 to risk training needs, i.e. reduce the advanced and ILS
17 training and increase high-quality BLS to ensure both
18 confidence and competence."

19 That's the ambition.

20 **DR ADAMSON:** That's correct. And the -- sorry, apologies.

21 **Q.** But in terms of increasing high-quality BLS, do you
22 envisage then changes to what is encompassed by BLS?

23 **DR ADAMSON:** Not necessarily what is encompassed by it but
24 what we do know is -- and again, it's -- the
25 resuscitation reform is looking at all NHS staff, so we

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1 **Q.** Not just resuscitation. That's across --

2 **DR ADAMSON:** No.

3 **Q.** -- all NHS organisations, not just mental health and not
4 just resuscitation training?

5 **DR ADAMSON:** Absolutely not. So I think what we're
6 recognising, there's a huge amount of training that is
7 being used which is taking away staff from doing what we
8 need them to do, which is to be having -- looking after
9 patients and doing high-quality patient care and that
10 the outcomes aren't necessarily reflective of that
11 degree of training, and that's back to that hierarchy of
12 effectiveness. So that's why we want to shorten the
13 training into what is needed, but then make sure that we
14 transpose that training into the workplace and do the
15 scenario training and see, actually, can you put that
16 training into practice when you need it most?

17 **Q.** When we look at Gateway 2 pack of slides, which is the
18 other slide pack, please.

19 Slide 6, if you can find that, please. Slide 6.

20 We can see the boxes, and again, just trying to pick
21 out of this, we can see that the audience in the middle:

22 "All clinical staff who are patient facing including
23 nurses, midwives, healthcare support workers,"
24 et cetera.

25 So approximately 68% of NHS staff -- and we look at

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1 the intervention:
2 "60-minute e-learning module and 15-minute
3 situational judgement test, tested annually ... [but]
4 with a 3 yearly update training ..."
5 That's the intent, is it?

6 **DR ADAMSON:** That's the intent for the basic, okay? So
7 again, the problem is this is very much a work in
8 progress. So as part of the framework, we had to say:
9 what is the basic national offer to all staff? And this
10 is the basic national offer to all staff. This does not
11 mean that this is the only training that we are
12 recommending, and we are then developing these
13 additional competencies based upon your role, and so --

14 **Q.** Just sorry to cut across you Dr Adamson, but I'm being
15 pressed on time.

16 **DR ADAMSON:** I appreciate that.

17 **Q.** Just in terms of the three-yearly update on training,
18 why was it chosen to be three-yearly?

19 **DR ADAMSON:** So that's three-yearly really on the theory and
20 any changes that might happen, because normally, RCUK
21 changes guidance between three- and five-yearly, so it's
22 really just to update on any changes, but the actual
23 e-learning module as what you need for the Basic Life
24 Support, that will still be annual.

25 **Q.** On the face of it, that's substantially online rather
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1 We can see at the top of that page at 2.20, that
2 Professor Soar had seen Mr Simons' statement which is
3 obviously the one which sets out much of the detail
4 which you've adopted, Dr Adamson. At page -- at 2.23,
5 he says this, although training may not be the most
6 effective intervention, the higher order he refers to,
7 intervention systems must be put in place.

8 Would that include, for example, simulation?
9 Emergency simulation?

10 **DR ADAMSON:** So that's the scenario training I'm describing,
11 the simulation training, so that needs to be put in
12 place but not just that, we are guaranteeing -- so
13 currently, data for cardiac arrest within mental health
14 units is not collected and so we are mandating that all
15 cardiac arrests in an NHS institution is mandated to be
16 recorded, and that the data will have clinical oversight
17 with someone who, or clinical oversight and governance
18 by someone in the new organisation as we move from NHSE
19 to DHSC.

20 **Q.** I think the last question that I have time for is,
21 insofar as his next entry, 2.24, the Gateway 1 Guidance,
22 that was the slides, the first set of slides, it
23 describes:

24 "Mandatory training is the minimum for keeping
25 everyone safe, with anything further determined locally.
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1 than in person, though, isn't it?

2 **DR ADAMSON:** So the information and the knowledge is online,
3 but it's then tested with situational judgement tests,
4 but then on top of that is the annual assessment of
5 competency so that's where you have the face-to-face
6 demonstration that you are able to undertake the basic
7 life support that we require and then, when you add on
8 the layers of training that you require for your other
9 roles, for example, airway, then that would be added on
10 and then the scenario training added on, as well.

11 So at the moment, if you can think about this as the
12 foundations, and there are going to be additional layers
13 added on, dependent upon what you need, but I think the
14 big key is that we're moving away from training
15 everybody in everything to focus.

16 **Q.** Thank you. I'd like to end, please, just very briefly
17 looking at one or two things that Professor Soar may
18 talk about when you're not here. So just to see if you
19 can help us at all.

20 Dr Soar's report, please, part 2. At
21 paragraph 2.2.3. I don't know if we can find that.
22 2.2.3. Sorry, 2.23. 23. A little further on, please.
23 Is it page 16, maybe? A little bit further, please.
24 And the next page, please.

25 Sorry, back one page, please. Yes.
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1 My concern [that's Professor Soar] is that the basic
2 level for most staff including in mental health settings
3 is probably set lower than at present."

4 And you don't share that view?

5 **DR ADAMSON:** No, I disagree, because again the problem with
6 the Gateway slide is that was the basic for all staff
7 but we are mandating that all mental health staff
8 receive immediate mental health resuscitation response
9 training, and that there is that team allocation and
10 scenario training. So there is a lot more that we're
11 going to be putting in, but this is what we're
12 developing now alongside and with RCUK, and that we're
13 hoping to have in place by April of '27.

14 **Q.** Of next year.

15 **DR ADAMSON:** But we're already -- we've already started to
16 decide what those competencies might be along with RCUK,
17 the additional competencies for responding to self-harm.
18 So I think what Professor Soar has seen is the most
19 basic level of foundations rather than the whole
20 structure that is going to be presented once we finish
21 the reform.

22 **MR WAKERLEY:** Thank you, Dr Adamson.

23 Chair, those are my questions now, on the basis of
24 our time, and perhaps we can see if there are any other
25 questions, if you would break for a short period.
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1 **THE CHAIR:** How long do you want? Ten minutes?

2 **MR WAKERLEY:** I think historically it's been ten minutes,
3 yes, please.

4 **(4.09 pm)**

5 **(A short break)**

6 **(4.21 pm)**

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

8 Some further questions, please.

9 Dr Adamson, I think you chose, or you referred to at
10 one stage a library of competencies. The framework, the
11 new framework, appears to put the onus on the Trust to
12 determine the role-specific categories that they need to
13 apply; is that right?

14 **DR ADAMSON:** It is to a certain degree, yes. As I said, we
15 are still in this reform so we haven't finalised, but we
16 are aware that each Trust will know the teams and the
17 risks and the, essentially the clinical scenarios for
18 which their teams are working in, and are therefore in
19 the best position to be able to decide what competencies
20 are thus required.

21 **Q.** Do you envisage a risk, though, that if you delegate
22 that responsibility to the individual Trust on the
23 Competency Framework, that you can have quite divergent
24 competencies across different sites and across different
25 Trusts? You're trying to achieve a level of standard,
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1 the chest compressions, who's managing the airway, who's
2 going to get the equipment and have they checked that
3 equipment is working? So I think, as in with all teams,
4 when we have huddles at the beginning of our clinical
5 day, it's down to those teams to sort of do a sort of
6 safety risk, a safety assessment as to what is required
7 in that day and make sure that the teams know their
8 roles for that day.

9 So that's what we mean by arrest teams, so I don't
10 think we should complicate that within the acute Trusts
11 Advanced Life Support arrest teams.

12 **Q.** Understand. And you've told us that you, effectively
13 you've referred us to the fact that within seven or
14 eight minutes, a paramedic team or an acute team
15 arrives, I think was your evidence.

16 What if that doesn't happen, though? What if there
17 are issues with that team arriving? You've got the
18 staff on ground who are having to deal with it.

19 **DR ADAMSON:** So having been involved in cardiac arrest many
20 times myself, those minutes will go past very, very
21 quickly. By the time that you have got someone in to
22 a position of safety, that you've then started the basic
23 life support, the equipment has arrived, and then you've
24 started to manage that airway, that will have taken your
25 seven minutes up, no doubt very quickly. So even if the
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1 aren't you?

2 **DR ADAMSON:** We are, and we're going to be putting guidance
3 with the framework, and as I said, it is still in
4 development. So the actual ... the actual ...

5 **MR SIMONS:** Groups of staff?

6 **DR ADAMSON:** Yes, the groups of staff and who will be
7 getting what, we will be giving some guidance to that.

8 **Q.** I'm going to move to the next question. In terms of an
9 arrest team, so the team of people who are dealing with
10 an unresponsive patient who have those additional
11 competencies, do you then consider in NHS England that
12 all Mental Health Trusts should have dedicated arrest
13 teams that will respond to emergencies?

14 **DR ADAMSON:** So I don't think they should have arrest teams
15 as in the acute Trusts which are often dealing with one,
16 two, three arrests per day and have got a very dedicated
17 Advanced Life Support team. That role should still be
18 fulfilled within the Mental Health Trusts by the
19 ambulance services and paramedics following a category 1
20 cardiac arrest call of which they should be responding
21 within seven minutes.

22 But what you should do within your clinical teams is
23 be clear on the roles of who is calling the paramedics
24 and who is standing at the door to let them in,
25 particularly, who's, you know, who is going to be doing
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1 ambulance takes eight, nine, ten minutes, that basic
2 life support, if it's going on well, can keep that
3 patient's circulation going and that brain perfused so
4 that we can improve the outcomes of the patient.

5 **Q.** The higher trained staff who are dealing with that prior
6 to the arrival of the emergency response the better,
7 would it not be?

8 **DR ADAMSON:** No. The problem being that within any
9 individual mental health institution they're likely, as
10 a team, only ever to see a cardiac arrest, you know,
11 relatively infrequently, maybe one, maybe two a year.
12 If I look at my own area, we have 180 inpatient beds and
13 we get one to two cardiac arrests a year. And
14 therefore, for any team to be able to respond to that
15 emergency, to be on shift when those arrests happen, the
16 likelihood is they won't have that expertise, confidence
17 and competence, and we've got to bring in human factors
18 that, you know -- and I don't want to go through
19 describing what it's like when you first turn up to your
20 first arrest -- but that does play a significant factor.

21 But if you are doing the basics, the CPR, the
22 airway, well, you should be able to manage that patient
23 for really quite some time and the seven minutes is
24 obviously the category 1 response from the National
25 Ambulance Service, but even if that is a little bit
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1 delayed and it's for that reason that we've put in the
2 airway management, so we are factoring in the fact that
3 you're absolutely right, some mental health institutions
4 may be slightly further out, that response may be longer
5 than seven minutes, and that's why we're putting these
6 extra competencies in of being able to run that basic
7 life support really well for those institutions.

8 So that's why it needs to be tailored because where
9 you are, if you're on site in an acute Trust versus, you
10 know, in the middle of the countryside, your responses
11 are going to be different so you do need a tailored
12 approach that's different.

13 **Q.** I'd like to stop you there but just ask you this,
14 please: I hope that it's -- it is clear. I'm asked, can
15 you identify any national requirement, whether within
16 ESR -- electronic staff record guidance -- or the Core
17 Skills Training Framework or NHS England Guidance or
18 Resuscitation Council Standards, that requires
19 attendance at resuscitation simulation exercises to be
20 recorded on ESR as opposed to being recorded through
21 another local training or governance system?

22 **DR ADAMSON:** Not currently, but that's why we're developing
23 the data dashboard for resuscitation for all units and
24 that will include that training -- (overspeaking) --

25 **Q.** Thank you, and I think the message that perhaps is clear

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1 is that the proposals are still being developed; is that
2 right?

3 **DR ADAMSON:** They are still being developed, yes.

4 **MR WAKERLEY:** Thank you.

5 Chair, those are the questions, and I think that
6 brings us to the end of the evidence today. I think,
7 Chair, if you would adjourn at that point to sit again
8 tomorrow at 10.00, please.

9 **THE CHAIR:** Thank you.

10 Thank you, we've trundled you through the evidence
11 very quickly, but I've got what I need from it, thank
12 you for that. And as you say, these are reforms that
13 are not yet finalised, and the nature of the training
14 modules and that sort of thing are still being worked
15 on, so I would ask that you keep us abreast of what it
16 is that emerges as the final plans, please.

17 **MR SIMONS:** Of course.

18 **THE CHAIR:** Thank you.

19 **(4.30 pm)**

20 **(The hearing adjourned until 10.00 am the following day)**

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