

Wednesday, 7 October 2026

(10.00 am)

(Proceedings delayed)

(10.02 am)

**THE CHAIR:** Good morning.

Ms Harris.

**MS HARRIS:** Good morning, Chair.

Chair, today we will be hearing first from Dr Kallur Suresh, EPUT's Chief Medical Officer, and then from Ann Sheridan, EPUT's Executive Nurse. Later today, this afternoon we will also hear from Mr Stuart Dunn who is the Interim Director of Mental Health at the Care Quality Commission.

Today, the Inquiry will continue to focus on the topic of emergency response and resuscitation.

From Dr Suresh and Ms Sheridan we will hear about EPUT's governance structure and how it applies to emergency response and resuscitation, we will hear further evidence about training at EPUT and we will hear some evidence about induction, monitoring, audit of resuscitation training and events, and how EPUT learns from previous incidents.

Dr Suresh and Ms Sheridan submitted a joint witness statement. In the circumstances, how the Inquiry proposes to hear this evidence is by calling Dr Suresh

1 first and then I will call Ms Sheridan to deal with any  
2 matters upon which Dr Suresh hasn't answered questions,  
3 and also to deal with this specific topic of learning  
4 from previous incidents.

5 Later this afternoon, Mr Dunn will tell us about the  
6 CQC's role in regulating the mental health care sector,  
7 its development of Brief Guides for its inspectors and  
8 how they are used by inspectors and by registered  
9 providers. And we will hear detailed evidence about the  
10 CQC's Brief Guide in Immediate Life Support training for  
11 services that may use restrictive interventions.

12 Before we hear any evidence this morning, however,  
13 I'd like to point out to the fact that today's evidence  
14 may in parts be distressing and difficult to listen to,  
15 and for some, it may not be possible to sit through each  
16 session. Anyone in the hearing room is welcome to leave  
17 at any point but we would ask people not to re-enter  
18 until a scheduled break in the proceedings.

19 I would like also to remind people that emotional  
20 support is available for all those who require it, and  
21 once again, we have here today support staff from  
22 Hestia, an experienced provider of emotional support.  
23 They are wearing orange-coloured lanyards and scarves  
24 and I can see they are sitting in various points in the  
25 room and there is an emotional support room, a private

1 room available should anybody need to talk to Hestia.

2 Alternatively, speak to a member of the Inquiry team  
3 and we can put you in touch with Hestia. We are all  
4 wearing purple-coloured lanyards as normal.

5 If you are watching online, information about  
6 available emotional support can be found on the Lampard  
7 Inquiry website which is lampardinquiry.org.uk, and it's  
8 under the "support" tab which is in the top right-hand  
9 corner. We want all of those engaging with this Inquiry  
10 to feel safe and to feel supported.

11 Chair, that introduction having been given, can we  
12 please move to today's first witness, which is Dr Suresh  
13 who is already at the table, and can the witness please  
14 be sworn.

15 **DR KALLUR SURESH (affirmed)**

16 **Questioned by MS HARRIS KC**

17 **MS HARRIS:** Thank you very much. Can you state your full  
18 name for the record, please.

19 **A.** Kallur Suresh.

20 **Q.** Dr Suresh, you have provided 13 witness statements to  
21 this Inquiry so far, I think 12 of them in your own  
22 name?

23 **A.** That's correct.

24 **Q.** And the 13th was a joint statement with your colleague  
25 Ms Ann Sheridan?

1   **A.**   There is another joint statement on use of technology.

2   **Q.**   I think that's with Mr Zephan Trent?

3   **A.**   Mr Trent.

4   **Q.**   And the Inquiry will be concerned with that particular

5           topic next week when I think you're returning to give

6           evidence in relation to those matters?

7           Your first statement is dated 16 October 2025.

8   **A.**   **(The witness nodded)** .

9   **Q.**   And your 12th statement, which we're also concerned with

10          today, is dated 21 May 2026; is that right?

11   **A.**   That's correct.

12   **Q.**   And the joint statement to which we have referred is

13          dated 9 September 2026?

14   **A.**   That's correct.

15   **Q.**   That's the one with Ms Sheridan. You have, I hope, in

16          a bundle, a copy of those three statements in front of

17          you?

18   **A.**   That's right.

19   **Q.**   You have signed the final page of each statement?

20   **A.**   Correct.

21   **Q.**   And each statement bears a statement of truth?

22   **A.**   That's right.

23   **Q.**   Have you had an opportunity to read through those

24          statements recently?

25   **A.**   I have.

1 Q. Is there anything within any of those statements, the  
2 ones we're concerned with today, that you would wish to  
3 change?

4 A. No, I have already made those corrections to you before.

5 Q. Do you stand by those statements?

6 A. I do.

7 Q. They form the basis of your evidence to the Inquiry  
8 today along with any answers that you give. I will  
9 refer to paragraphs in your witness statement but I can  
10 tell you that we won't be reading them out particularly,  
11 as they are very long.

12 You have also provided a significant number of  
13 exhibits.

14 A. That's correct.

15 Q. Can I just then ask you a little bit about your  
16 background, please. In terms of your professional  
17 background, you are a Consultant Psychiatrist?

18 A. That's correct.

19 Q. You are the Chief Medical Officer at Essex Partnership  
20 University NHS Foundation Trust --

21 A. That's right.

22 Q. -- that we call EPUT for short.

23 A. **(The witness nodded)**.

24 Q. And you have been in that post since 1 December 2025.

25 A. That's correct.

1 Q. Prior to that, you were the Deputy Medical Director for  
2 the West Essex care unit and Consultant Psychiatrist and  
3 west area Medical Director for North Essex Partnership  
4 University NHS Foundation Trust?

5 A. That's correct.

6 Q. Which I think we sometimes refer to as NEP or NEPT  
7 during these proceedings.

8 You were appointed as an Associate Medical Director  
9 for West Essex and you held that role until the merger  
10 of NEPT and SEPT in 2017.

11 A. That's correct.

12 Q. The three statements with which we're going to be  
13 principally concerned today, and the evidence you give  
14 today, you are giving on behalf of EPUT, the  
15 organisation, in your capacity as Chief Medical Officer;  
16 is that right?

17 A. That's right.

18 Q. However, there are issues you can assist the Chair on in  
19 any event from your experience working as a Consultant  
20 Psychiatrist.

21 A. I'm happy to.

22 Q. Your two most recent statements set out in detail the  
23 methods by which you have provided the information in  
24 answer to the Inquiry's requests for evidence. I'm not  
25 going to go through them now, but as a corporate witness

1       you have indicated in all three of the statements that  
2       we are concerned with -- and you write as follows:

3               "Not all matters related to the Trust are within my  
4       own personal knowledge and therefore I have relied on  
5       information and documents provided by the Inquiry  
6       project team and subject matter experts."

7               Is that right?

8       **A.**   That's correct.

9       **Q.**   Because it's a corporate statement?

10      **A.**   It is.

11      **Q.**   At the conclusion of the joint statement, you have  
12       provided, at the Inquiry's request, a list of 36  
13       individuals who have all contributed to that joint  
14       statement.

15      **A.**   That's right.

16      **Q.**   And amongst the contributors was Mr Nicholas Archer from  
17       whom we heard yesterday?

18      **A.**   That's correct.

19      **Q.**   And we heard yesterday that he adopted that statement in  
20       addition and he aligned himself with it?

21      **A.**   That's correct.

22      **Q.**   Again, by way of preliminary, you have been made aware  
23       of the matters upon which the Chair would like  
24       assistance in oral evidence, and you and your colleague,  
25       Ms Sheridan, have indicated in advance to the Inquiry

1       which of you is best placed to deal with which, if that  
2       makes sense?

3   **A.**   That is correct.

4   **Q.**   And that having been said, there should therefore be no  
5       difficulty with your answering the questions that you  
6       have said you're in a position to answer.

7   **A.**   That's right.

8   **Q.**   I'd like to then move to your substantive evidence and  
9       begin by asking you some questions about the service  
10      structure, the resuscitation service structure at EPUT.  
11      We heard yesterday that the resuscitation service  
12      structure is headed up by Nicholas Archer?

13  **A.**   That's correct.

14  **Q.**   And he is the Head of Deteriorating Patient Pathways and  
15      the Resuscitation Training Officer.

16  **A.**   That's right.

17  **Q.**   His line manager is Rebecca Pulford?

18  **A.**   That is correct.

19  **Q.**   She is the Director of Nursing and Chief Nursing and AHP  
20      Information Officer.

21  **A.**   That's right.

22  **Q.**   And Nicholas Archer is also accountable to your  
23      colleague, Ann Sheridan?

24  **A.**   Yes.

25  **Q.**   The Executive Nurse.

1           Just in relation, please, to Nicholas Archer, we  
2           have heard evidence that he himself doesn't have  
3           specific knowledge or any personal experience of working  
4           in a mental health inpatient unit and/or resuscitation  
5           in a mental health context. You heard that evidence.

6   **A. (The witness nodded) .**

7   **Q.** Do you consider that a person without that experience on  
8           a mental health inpatient unit can undertake the role he  
9           undertakes effectively at a large mental health Trust?

10   **A.** I do because Mr Archer comes with a significant degree  
11           of experience in the process of resuscitation, given his  
12           previous experience and qualification, and he is often  
13           on our wards providing mental health care, not himself  
14           but through the staff, but making staff aware of  
15           resuscitation procedures as well as learning from them.

16   **Q.** We have already heard within these proceedings a lot of  
17           evidence about the RCUK, the Resuscitation Council UK  
18           Quality Standards for Mental Health Inpatient Care, and  
19           some of the terminology that appears within.

20           Now, I'm going to ask please if the Resuscitation,  
21           RCUK Quality Standards could be put up, please. That's  
22           RSCUK022529.

23           I think we might as well do it at the same time.  
24           Could we put by the side of those, please, the current  
25           EPUT policy, which is CLP14, which is EPUT023452.

1           Looking, please, at the Quality Standards first and  
2           going, I think, to the bottom of page 2, please -- thank  
3           you very much, we'll start with the top. The top of  
4           page 2, we remind ourselves --

5   **THE CHAIR:** Mine isn't working.

6   **MS HARRIS:** Ah, I'm just going to pause for a moment because  
7           the Chair's screen isn't working. Perhaps we can just  
8           wait for a moment to see if there's a quick fix and if  
9           there isn't perhaps we can break for a moment.

10           Shall we rise for a moment, sorry.

11   **(10.15 am)**

12                                   **(A short break)**

13   **(10.17 am)**

14   **THE CHAIR:** Apologies.

15   **MS HARRIS:** We were just looking, then, at page 2 of the  
16           Quality Standards and we remind ourselves, in terms of  
17           the terminology that when we're looking at these  
18           Standards -- and I'm looking at the top here -- that:

19           "The term 'MUST' is used when the consensus is that  
20           the standard promotes normal practice and is obligatory.

21           "2. The term 'SHOULD' is used when the consensus is  
22           that the standard promotes normal practice."

23           And:

24           "3. The term 'RECOMMENDS' is used when the  
25           consensus is that the standard promotes best practice."

1           Looking down the page we see part 1 is entitled  
2           "Resuscitation Committee/service structure". And reads  
3           as follows:

4           "Many organisations that provide mental health care  
5           do not have a separate Resuscitation Committee ..."

6           Moving on:

7           "... if they do not, they must have a system that  
8           incorporates the duties of resuscitation services into  
9           their governance and clinical structures. The  
10          circumstances vary across organisations and with the  
11          jurisdiction in which patients are cared for and treated  
12          in the UK."

13          And point 1, if we look at the top of page 3, states  
14          clearly that:

15          "Every healthcare organisation that admits mentally  
16          ill people must have an identified Resuscitation service  
17          structure that has clearly defined terms of reference."

18          Can you help us, please, can you describe for us --  
19          and it may help if we look at page 10 of the document on  
20          the right-hand side, which is the policy and the section  
21          on duties -- can you describe for us, please, the system  
22          and structure for resuscitation provision at EPUT?

23   **A.** We have a Resuscitation Team as Mr Archer said  
24          yesterday, headed by Mr Archer and his colleague  
25          Mr Smale. They offer training, support, continuous

1 learning, as well as reporting upwards through the  
2 Trust's own governance structures. They are also  
3 supported by Professional Nurse Educators, Resuscitation  
4 Link Practitioners who are based on the wards and in the  
5 community teams, enabling staff to keep their skills  
6 up-to-date and making sure that learning happens through  
7 various incidents.

8 In terms of the governance structure, Mr Archer and  
9 his colleague prepare a quarterly report which feeds up  
10 to the Quality of Care Meeting which is chaired by my  
11 Executive Nurse colleague and sometimes by myself and  
12 then that feeds into the Quality Committee which is  
13 chaired by a Non-Executive Director but attended by many  
14 of the execs as well as other Non-Executive Directors.

15 Then that feeds into the board, in terms of any  
16 exceptions, escalations and risks that are arising from  
17 the resuscitation practices within EPUT.

18 **Q.** Can I just ask you a couple of questions. The first is  
19 you said Mr Archer had a Resus Team which was headed up  
20 by him with the support of Mr Smale. His evidence  
21 yesterday was that in fact there wasn't a team, it was  
22 him, he had the support of Mr Smale and that there were  
23 others that he could rely on for administrative support  
24 and so on and so forth. Can you help us, what are you  
25 describing as his team?

1   **A.** Sorry, I meant the two of them supported by  
2       practitioners on the ground who help implement some of  
3       the policy requirements as well as the learning.

4   **Q.** Can we just have a look, please, in light of what you've  
5       said about the governance structure at the duties, and  
6       at the Standards. If we look at number 2 of the  
7       Standards, it says that:

8       "Every organisation must have been identified board  
9       member who is responsible for resuscitation services."

10      Who is that please, at EPUT?

11   **A.** At EPUT it would be myself. I've taken on this role  
12       since December of last year, and I normally present the  
13       resuscitation and deteriorating patient reports to the  
14       Quality Committee.

15   **Q.** Can I ask you then about some of the other people that  
16       we've heard about. First of all, we heard about  
17       Dr Mateen Jiwani. How --

18   **A.** He's the Non-Executive Director who chairs the Quality  
19       Committee. The Quality Committee has oversight of  
20       resuscitation practices within EPUT.

21   **Q.** If we look at your duties as in the duties that are set  
22       out in the current policy at EPUT on the right-hand  
23       side, it says that:

24       "The Trust board is responsible for ensuring that  
25       the principles of the policy and other associated

1 policies are implemented across the organisation ..."

2 And talks about necessary financial resources, which  
3 I'll come back to. It then makes reference to the  
4 Executive Chief Operating Officer, the Deputy CEO, and  
5 the Executive Nurse, who also have duties.

6 Now, correct me if I'm wrong, Dr Suresh, but are  
7 they all three board positions as well?

8 **A.** They are.

9 **Q.** So we have the involvement, then, of you as the, you say  
10 the nominated board member.

11 **A.** **(The witness nodded)**.

12 **Q.** And those three board members in addition, and Dr Jiwani  
13 ... is there some reason why there are so many board  
14 members that are involved?

15 **A.** Dr Jiwani has no executive responsibilities. He is the  
16 Non-Executive Director overseeing the Quality Committee  
17 which the resuscitation reports feed up to. It is  
18 historical that the Chief Operating Officer and the  
19 Deputy CEO, they are the same person, and the Executive  
20 Nurse, were responsible for it, but we take it as  
21 a joint lead on quality and safety which resuscitation  
22 comes under. So myself and Ann Sheridan, who is the  
23 Executive Nurse, we lead on quality and safety jointly,  
24 and the Chief Operating Officer is responsible for all  
25 of the operations within the organisation.

1   **Q.** Looking at the document on the right-hand side again,  
2       and looking at 3, then it says:  
3       "The resuscitation service structure must be part of  
4       each responsible authority's management structure ..."  
5       And it goes on to say that it must include local  
6       resuscitation experts.  
7       Taking on board what you have said about the roles  
8       of the various differing personnel, how is the service  
9       structure incorporated into the management structure at  
10      EPUT?  
11   **A.** For example, myself and the other board members have  
12      joint responsibility for operations as well, because  
13      I myself manage the medical staff overall and Ann  
14      Sheridan is responsible for professional management of  
15      all nursing staff and the Chief Operating Officer for  
16      all the other Allied Health Professionals and other  
17      staff.  
18   **Q.** We know from 5 that the lead person responsible for the  
19      resuscitation service structure must have an active and  
20      credible involvement in resuscitation and the authority  
21      to drive and implement change. And that's Mr Archer.  
22      We heard about that yesterday.  
23   **A.** That's correct.  
24   **Q.** And it says at number 8 that:  
25      "In the absence of other organisational

1 arrangements, the Resuscitation service structure must  
2 also be responsible for implementing operational  
3 policies that govern prevention of cardiac arrest,  
4 including recognition of patients who are deteriorating  
5 before they arrest."

6 Now, from the duties, if we look again at the  
7 document on the right-hand side, according to your  
8 policy, is that those three board members there, the  
9 Executive Chief Operating Officer the Deputy CEO, and  
10 Ann Sheridan?

11 **A.** That's correct. We get reports of how resuscitation is  
12 working across the organisation, and then we have people  
13 in the structures below who are going to implement some  
14 of the learning and policies.

15 **Q.** Who are the people in the structures below? I don't  
16 want their names, what are their titles?

17 **A.** That's right, EPUT is organised in the form of care  
18 units because the Trust covers the whole of Essex, it is  
19 divided into care units and each care unit covers the  
20 geographical area on a function. For example we have  
21 the West Essex community care unit covering West Essex,  
22 Mid and South Essex which covers the Chelmsford area,  
23 and Southend and Basildon, and the North East community  
24 care unit which covers the North East Essex which is  
25 Colchester and Tendring.

1           We also have an inpatient care unit where most of  
2           these incidents are likely to happen and we also have  
3           a specialist care unit as well. So even though EPUT is  
4           one organisation it is organised in terms of the care  
5           units which make it operationally more feasible to  
6           manage them.

7   **Q.** In terms of training, if we look at Number 10 on the  
8           document on the left-hand side, which is the Standards  
9           document, it says that:

10           "The resuscitation service structure must determine  
11           the level of resuscitation training required by [the]  
12           staff members."

13           This appears to be covered in your duties at 5.5  
14           which says that:

15           "The Trust's Workforce Development Team will ensure  
16           the provision of training and education to meet  
17           identified needs."

18           Now, we've heard about the Trust Workforce  
19           Development Team a little bit from Nicholas Archer.  
20           What, again, I don't want people's names but what is the  
21           make-up of that team? Who is on that team?

22   **A.** That team consists of trainers who provide some of the  
23           in-house training. We have a large suite of mandatory  
24           training which is -- statutory and mandatory training  
25           for all of our staff, depending on their role and the

1 different professional background that they have. So  
2 the training team is responsible for providing some of  
3 the training, making sure records are kept of who has  
4 done what training, and also make the operational  
5 leaders aware of where we are with regard to mandatory  
6 and statutory training, and one of those training is  
7 also the resuscitation training but it sits alongside  
8 a whole host of other mandatory training requirements as  
9 well.

10 **Q.** My question was, who makes up that team, who's in it?  
11 And you've told us it's trainers. Is it just the  
12 trainers who are making up the Trust Workforce  
13 Development Team?

14 **A.** We have a Workforce Development Team headed by I think  
15 the Director for Workforce Development and underneath  
16 them sits a structure of trainers as well as other  
17 people who help administer some of the functions, which  
18 includes collection of data, organising training days,  
19 particularly in-house training days. For example our  
20 resuscitation training ILS has just moved in-house as of  
21 1 October. Earlier we used to depend on an external  
22 provider. And those dates and the training is managed  
23 by that team. I'm not aware of the full composition of  
24 that team, apologies.

25 **Q.** Is that something that Ms Sheridan might be able to help

1           us with?

2   **A.** She might be able to help with that, yes.

3   **Q.** All right. In terms of the needs, we understand from

4           Mr Archer, however, that he identifies the needs, the

5           training needs, in terms of resuscitation provision; is

6           that right?

7   **A.** Yeah.

8   **Q.** And then he communicates that to the team, is that how

9           it works?

10   **A.** That's correct, yeah.

11   **Q.** And as far as you are aware, and he gave evidence that

12           he was well supported and that he was allowed to drive

13           things forward. Are the recommendations he makes well

14           received by that team?

15   **A.** Yes. Mr Archer is the expert who not only keeps

16           monitoring external drivers for any changes to training

17           which includes guidance from NHSE or other external

18           bodies, and makes sure that our policy is keeping up to

19           date with any external changes required, as well as

20           incorporating some of the learning that happens within

21           the organisation.

22   **Q.** Moving on separately and I think we need to go to the

23           next page, please, for the left-hand document,

24           number 11. We see that there is a recommendation that

25           there are at least twice yearly meetings of the

1           resuscitation service structure.

2           Now, you've already given us some evidence about the  
3           various groups that meet. How -- first of all, do EPUT  
4           follow that recommendation and if so, how?

5   **A.** I'm not personally aware of how often these meetings  
6           take place but Mr Archer and his colleague work very  
7           well together. They have close working relationship  
8           with the Resuscitation Link Practitioners that  
9           I mentioned earlier to make sure any learning is  
10          embedded and policies are followed as well as we have  
11          Physical Health Link Practitioners as well, but I'm not  
12          aware of the frequency with which they meet.

13   **THE CHAIR:** Can I ask another question, please, sorry, it's  
14          an interruption to what you're talking about, before  
15          I forget.

16   **MS HARRIS:** No, please.

17   **THE CHAIR:** The Executive Chief Operating Officer Deputy CEO  
18          who is mentioned in the policy and you have told us is  
19          part of the team that works jointly with you to oversee  
20          this policy, is that now -- is it now the case that they  
21          are the joint -- Acting Joint Chief Executive of the  
22          Trust?

23   **A.** That is correct, yeah.

24   **THE CHAIR:** Thank you.

25           Sorry.

1   **MS HARRIS:** No, thank you, Chair.

2           It may be then, that you're not in a position to

3   answer my next question which is whether any of those

4   board members that we've previously identified would be

5   involved in meetings of the regular here recommended

6   twice-yearly meetings of the service structure?

7   **A.** I will defer it to Ms Sheridan.

8   **Q.** You're certainly not going to them, by the sounds of it?

9   **A.** No, I don't.

10   **Q.** In terms of responsibilities, can we just look, please,

11   at 12 on the Standards, again at the responsibility of

12   EPUT's resuscitation service structure, and consider who

13   might be responsible for what in line with the people

14   you've told us about.

15           So the responsibilities include:

16           "ensuring implementation and adherence to national

17   resuscitation guidelines and standards."

18           Whose responsibility is that?

19   **A.** That would be Mr Archer making sure that our policies

20   align with national guidelines and standards and then

21   the -- all the operational staff, in implementing those.

22   If I can just explain the operational structure a little

23   bit that might help put that in context.

24   **Q.** Please do.

25   **A.** For example, for the inpatient wards, we have a Ward

1       Manager who oversees all the operations on the ward and  
2       are responsible for the day-to-day running of that ward.  
3       A number of wards are then managed by our Matrons. Each  
4       Matron may cover two or three wards, for instance, and  
5       then the Matron -- several units in one particular area  
6       are managed by a Service Manager and then we have an  
7       Associate Director above them. So they form the  
8       operational structure which will implement not just  
9       resuscitation-related policies but all other policies,  
10      as well.

11   **Q.** So Nicholas Archer would be responsible for the  
12       adherence to make sure you were compliant and you were  
13       up to date, and the implementation you say would be  
14       dependent on a downward movement down this structure  
15       that you've just described?

16   **A.** That is correct.

17   **Q.** All right.

18               The second responsibility is:

19               "defining the roles and composition of the  
20       resuscitation team within the organisation."

21               Whose responsibility is that, please?

22   **A.** We do not have a Resuscitation Team per se, if that is  
23       referring to the crash team. We have a rapid response  
24       process within the organisation, but resuscitation is  
25       taught to all of our staff, both registered and

1       unregistered, and those roles are defined within the  
2       policy, which is authored by Mr Archer.

3               Does that answer your question?

4   **Q.**   Insofar as you say that is the way that EPUT answers it,  
5       yes.

6               "ensuring that the resuscitation equipment for  
7       clinical use is available and ready for use."

8               Whose responsibility is that, please?

9   **A.**   That would be the local leadership of various clinical  
10       units such as wards, the Ward Manager is responsible for  
11       auditing that the equipment is available, ready for use,  
12       and is also up-to-date and hasn't expired, for example  
13       in the case of drugs, for instance.

14              These are audited weekly and Mr Archer gives  
15       specialist input, if required, in terms of procuring the  
16       right kind of equipment for replacement and repairs, and  
17       also we have a Medical Devices Group which advises on  
18       that one as well.

19   **Q.**   That, I think, deals with the second bullet point the  
20       following one at the same time.

21              We've looked at "planning adequate provision of  
22       training in resuscitation."

23              Do we understand from your evidence that would be  
24       Nicholas Archer identifying the needs and communicating  
25       them to the workforce team?

1   **A.**   That is correct, yeah.

2   **Q.**   "Determining requirements for and choice of  
3       resuscitation training equipment."  
4       Would that be the same?

5   **A.**   That would be the Medical Devices Group with the advice  
6       from Mr Archer.

7   **Q.**   And of course we know that Mr Archer heads up the  
8       medical devices as well, doesn't he?

9   **A.**   That's correct.

10  **Q.**   So that's another responsibility he has.  
11       "Preparing and implementing all policies relating to  
12       resuscitation ..."

13       Is that Nicholas Archer as well?

14  **A.**   That would be, yes. Well, when it says "implementing"  
15       it would be the responsibility of the operational staff  
16       but he certainly prepares the policies, reviews them,  
17       and makes sure they're ratified by the governance  
18       structures within EPUT.

19  **Q.**   And in fact we see, don't we, his name as the author on  
20       many of the most recent documents?

21  **A.**   That's correct

22  **Q.**   In terms of implementation, though, who oversees it?  
23       Because your "Duties" appears to suggest that that comes  
24       back to those board members?

25  **A.**   Board members supported by the structures that I have

1 underlined earlier, in terms of implementation.

2 **Q.** "Preparing and implementing a policy on resuscitation  
3 decisions ..."

4 This is, of course, of the DNACPR decisions and  
5 advanced care planning. Whose responsibility is that?

6 **A.** That would be the responsibility of the individual  
7 clinicians and clinical teams. For example the DNACPR  
8 discussions happen regularly at a board level. Again,  
9 there is a time and place to have those discussions in  
10 a sensitive way but the individual clinicians mainly  
11 headed by the Consultant Psychiatrist, they decide about  
12 DNACPR decisions.

13 **Q.** Final two:

14 "Quality improvement -- action plans based on  
15 audits."

16 And:

17 "Recording and reporting incidents in relation to  
18 resuscitation in which patients' safety may have been at  
19 risk."

20 Whose responsibility are those?

21 **A.** Again, Mr Archer touched upon it yesterday. We do  
22 record resuscitation events in a defined form and learn  
23 from them, especially in terms of any patient safety  
24 issues. Quality improvement, if there are any action  
25 plans, they would then go to the local managers to

1       implement those action plans because some of the action  
2       plans may be specific to a particular area, some of them  
3       may be Trust-wide as well.

4   **Q.** Who is overseeing that?

5   **A.** We have a Compliance Team which looks at collecting  
6       evidence, for instance to make sure actions are embedded  
7       and sustained over a period of time. We also depend on  
8       that team who report up to CQC and other regulatory  
9       bodies where action plans have to be implemented,  
10      evidenced, and that evidence provided externally.

11   **Q.** And who heads up the Compliance Team?

12   **A.** It's ... I'm just trying to recollect the title of the  
13      person. I think it's the Associate Director for  
14      Compliance. But I'm not a hundred per cent sure on the  
15      title.

16   **Q.** What we can see from your evidence is that Mr Archer has  
17      a significant amount of responsibility?

18   **A.** That's correct, yeah.

19   **Q.** In a very large Mental Health Trust. EPUT is a very  
20      large Mental Health Trust?

21   **A.** A medium-sized Trust.

22   **Q.** And as we've already touched upon, he has very little  
23      administrative support, in reality.

24            You're nodding.

25   **A.** I was at his evidence yesterday and he said he has the

1 administrative support he needs and he has the ability  
2 to ask for them if he needs more.

3 **Q.** I think we can remind you, we heard from him that he had  
4 the support of Mr Smale, that Ann Sheridan, her  
5 assistant helped him, and occasionally he was able to  
6 ask some of the Medical Devices Team to help him out.

7 **A.** That's correct.

8 **Q.** Having been thorough the requirements of the Standards  
9 and having explained to us what is quite a complicated  
10 combination of groups and personnel that are involved in  
11 overseeing the resuscitation provision, do you consider  
12 that your, as in EPUT's service structure, aligns with  
13 the expectations that are set out in these Quality  
14 Standards?

15 **A.** Our policies align, save for a couple of areas which are  
16 in our joint statement. Mr Archer has the ability to  
17 ask for more help. I would see his role more as an  
18 advisory role and keeping in touch with external, you  
19 know, external requirements for resuscitation. And he  
20 has the support of Mr Smale, again supported by people  
21 on the ground who help implement some of the policies.

22 **Q.** Do you consider that the structure, the lines of  
23 reporting, are clear for those that may need to escalate  
24 concerns upwards and for those who may want to ensure  
25 implementation downwards? Sorry, that's probably a very

1 clumsy question, but you have described a number of  
2 different groups, as I say, and a number of different  
3 personnel involved and a number of different people that  
4 oversee different aspects. So, as the Chief Medical  
5 Officer, what's your view on the efficacy, if you like,  
6 of the structure of the resuscitation service?

7 **A.** I mean, there is certainly a merit in looking at whether  
8 the lines of accountability and responsibility are more  
9 straightforward and clearer, but given that a number of  
10 staff, a lot of staff are involved in not only  
11 implementing, but also learning from policies et cetera,  
12 it has to, by definition, involve multiple teams within  
13 the organisation, each of which has responsibility for  
14 one aspect of learning.

15 **THE CHAIR:** Can I just go back on your suggestion that  
16 Mr Archer's role is principally advisory? He told us  
17 yesterday about how he convenes or takes part in SWARM  
18 huddles, debriefs, identifying issues that have arisen  
19 out of resuscitation events, and then seeks to ensure  
20 that the learning is captured, that he ascertains  
21 information out of Datix, and then makes sure that the  
22 lessons learned go into action plans, go into training.  
23 That strikes me as a bit more than just advisory.

24 **A.** Yeah, sorry, what I meant was his role is largely  
25 advisory in terms of keeping the policies up-to-date and

1       advising the organisation about any changes that are  
2       needed, but like he mentioned yesterday, he also takes  
3       part in all of these particularly in terms of learning  
4       from incidents.

5       **THE CHAIR:** Yes, and he does that all with a, I think you've  
6       conceded, a rather *ad hoc* administrative support in the  
7       sense that he has to call on other people's goodwill to  
8       let him have administrative support? Do you accept  
9       that?

10      **A.** Like I said before, he has administrative support that  
11      he needs at present, but if he requires more  
12      administrative support, that is certainly something, a  
13      discussion we can have with his line manager.

14      **THE CHAIR:** Okay, thank you.

15                 Sorry to interrupt.

16      **MS HARRIS:** No, thank you very much, Chair.

17                 Can I ask you, just before we leave this, on  
18      a slightly different topic, and it's what we see at  
19      point 13 in the Standards which is:

20                 "The healthcare organisation must ensure that there  
21      is a defined financial support for the Resuscitation  
22      Service structure."

23                 And if we look again at 5.1 we can see, and  
24      I touched upon it earlier, that "The Trust board is  
25      responsible for ensuring [and it's the second bullet

1 point] the necessary financial resources."

2 Now, can I just ask you about that and it may be  
3 that we take those down, please, and we put up instead  
4 your joint witness statement at page 58. Brilliant.  
5 Thank you very much.

6 You deal with this at paragraph 252, because you can  
7 see, can't we, we can see, that the Inquiry asked EPUT  
8 specifically about the budget available, and you say as  
9 follows at 252:

10 "The Trust does not hold a single identified budget  
11 line specifically for resuscitation training or per  
12 staff member. It cannot extrapolate the number of hours  
13 spent on resuscitation training per staff member.  
14 However, all resus activity, including BLS delivery, is  
15 funded through the central training budget."

16 If we go over, please, to page 59 and paragraph 255  
17 you say as follows:

18 "Financial support for the Resuscitation Service is  
19 provided through the Trust's wider education, training  
20 and workforce development budgets. Whilst EPUT does not  
21 maintain a separately identified budget line or  
22 dedicated resuscitation cost centre, resuscitation  
23 related expenditure is funded and managed within the  
24 Trust's established training governance and financial  
25 planning frameworks."

1           You then go on at the conclusion of that paragraph  
2           to say that:

3           "Defined financial support is provided in the  
4           Following ways ..."

5           And to summarise you say, "Funded training  
6           programmes", and at (ii) "Staffing resource", and that  
7           during 2026 you'd approved the business case for  
8           dedicated ILS training posts for resuscitation officers  
9           and at (iii), you say "Prioritised expenditure."

10          Then at paragraph 256, you summarise:

11          "The Trust meets the financial support requirement  
12          of the RCUK Quality Standards through its commitment to  
13          funding resuscitation training, staffing and  
14          infrastructure, within its broader workforce development  
15          budgets, in addition to its recent investment in  
16          dedicated resuscitation officer posts."

17          Can I just ask the question simply, please: does  
18          EPUT have a defined financial support for its  
19          resuscitation service?

20       **A.** It does. It sits within the, as I say in my statement,  
21       within the broader training and development, staff  
22       development budgets. If I can also add that we are now  
23       moving to establish a faculty of physical health, which  
24       is again referenced in our statement. This will bring  
25       a lot of training in-house and make sure that there is

1 a more supportive structure to personalise the trainings  
2 to EPUT sites, particularly with regard to resuscitation  
3 and deterioration in physical health.

4 **Q.** We understand the various initiatives that are being  
5 brought in, Dr Suresh, but the question is a simple one:  
6 does EPUT ring-fence resources for its resuscitation  
7 service structure?

8 **A.** I have not had any escalations to me, that the service  
9 resuscitation structure budget is not sufficient but we  
10 stand ready to provide any support that the  
11 resuscitation service requires in order to meet with  
12 externally set standards.

13 **Q.** All right.

14 Thank you, that can now be taken down.

15 I'm moving on to a different topic, which is in  
16 relation to documentation and policies and their  
17 availability on the SOPHIA system.

18 We've just looked, we don't need to go back again,  
19 in detail at the responsibility of the service structure  
20 and the board in relation to the provision of the  
21 service, and we did so by looking at CLP14 which is  
22 EPUT's current CPR policy, we were looking at the  
23 version from March 2026. And we noted that one of the  
24 key responsibilities of the Board was to ensure that  
25 that policy and other associated policies were

1 implemented across EPUT.

2 And that it -- what we can see from the duties, that  
3 the board delegates to others to ensure that the policy  
4 and other associated policies are, to use the phrase  
5 within the policy, "embedded within clinical practice".

6 Would you agree, then, it's absolutely essential --  
7 and this is a general concept, if you like -- that the  
8 policies are clear or EPUT policies are clear and  
9 straightforward?

10 **A.** Yes.

11 **Q.** That they are easy for staff to access?

12 **A.** Absolutely.

13 **Q.** That they are easy for staff in all roles to follow?

14 **A.** That is correct.

15 **Q.** That ideally, they're not too lengthy?

16 **A.** True.

17 **Q.** And would you agree that in an ideal world you might  
18 want to avoid too many attachments and hyperlinks and  
19 appendices and other ways you might have to navigate  
20 through a policy?

21 **A.** I agree in the principle, but sometimes policies have to  
22 reference, in order to avoid not being -- in order to  
23 avoid being lengthy, policies have to sometimes  
24 reference external sources, so that the external source  
25 is the final version of whatever guidance there is, for

1 instance. Because those websites are always kept up to  
2 date. But what we also have is something called "Policy  
3 at a Glance", every policy, even though it may be  
4 lengthy, we have a one-page summary of each policy that  
5 makes it easier for staff to access it and get the key  
6 information from each of the policies. This has been  
7 the practice for a number of years and the Policy at  
8 a Glance, even if a member of staff is unable to read  
9 the whole policy, because like you said, sometimes they  
10 are quite lengthy, the Policy at a Glance gives them the  
11 key messages that they can take from the policy, enough  
12 to be able to practise on the ward.

13 **Q.** Please feel free to look at it if you want to, but I'll  
14 summarise it, but you deal with this in part at  
15 paragraph 24 of your joint statement, where you tell the  
16 Inquiry that during 2021 to 2022, the Trust undertook  
17 a review of all the policy framework, and that -- which  
18 included seeking feedback from staff, which -- regarding  
19 the accessibility and usability of Trust policies and  
20 procedures, and that the feedback received identified  
21 several recurring themes. And the staff reported:  
22 Receiving several policy and procedures could be  
23 confusing; that there was an inconsistency of the  
24 information contained with each document; that  
25 procedural documents were often lengthy and complex,

1 sometimes incorporating multiple processes within  
2 a single document; and that in response, EPUT commenced  
3 a programme of work which was aimed at simplifying and  
4 standardising its governance documentation.

5 So that's the view review that's taken place; is  
6 that correct?

7 **A.** That's correct.

8 **Q.** And you go on to say at your paragraph 25 that following  
9 a substantive review of the Trust's policy procedure  
10 framework, a decision was taken to consolidate policies  
11 and procedures. And you give an example that the  
12 standalone ligature risk assessment had been  
13 incorporated into the Ligature Risk Assessment Policy --  
14 so, sorry, the procedure had been incorporated into the  
15 policy.

16 You're nodding. Is that right?

17 **A.** That's correct.

18 **Q.** Sorry, I have to say that because the transcript  
19 obviously doesn't pick up your nodding.

20 **A.** Sorry, that's correct.

21 **Q.** Yesterday, Mr Archer confirmed that the current version  
22 of CLP14, the one we've just been looking at, which was  
23 ratified in March 2026, is in fact a consolidated  
24 document, as well?

25 **A.** That is correct.

1 Q. So it's the policy and procedure now merged together?

2 A. **(The witness nodded)**.

3 Q. Yes?

4 A. That's correct, sorry.

5 Q. And it's 41 pages long and it has, I think, about 17

6 appendices?

7 A. Mm-hm.

8 Q. Can I just clarify something, because we have been asked

9 about this by core participants, and can I ask, please,

10 that you look at your 12th statement, at paragraph 26,

11 please. No -- yes, page 6, sorry. So 12th statement

12 page 6, paragraph 26.

13 A. Sorry I'm just getting there.

14 Q. I think we'll ask it to be put up on the screen, as

15 well, for ease. Thank you very much.

16 At paragraph 26 it says:

17 "A draft of the CPR procedure is currently going

18 through the ratification process, and is expected to be

19 in place by the end of July 2026. This version will

20 incorporate RCUK's updated 2025 guidelines."

21 Can I just confirm with you that that's not in fact

22 the case because the procedure had already been

23 incorporated into the policy; is that right?

24 A. That is correct, the policy is the current version.

25 Q. So there isn't anything that will be that -- a document

1           that we don't have, or anything of that sort?

2   **A.**   No.

3   **Q.**   And we -- sorry, thank you, that can come down.

4           We know that as part of the review programme we've

5           just been talking about that EPUT initiated the eSOP

6           Project.

7   **A.**   Yes.

8   **Q.**   And the objectives of the eSOP Project were to record,

9           digitise, optimise and monitor the use of Standard

10          Operating Procedures, which is SOP stands for?

11   **A.**   That's correct.

12   **Q.**   Should it be e-S-O-P, or is it eSOP?

13   **A.**   Because it's now digital it is called eSOP. It used to

14          be a SOP before.

15   **Q.**   All right. And at paragraph 27 of your witness

16          statement you say:

17                "One of the key outcomes of the programme was the

18                introduction of the SOPHIA platform."

19   **A.**   That's correct, yeah.

20   **Q.**   And you also go on to explain that:

21                "SOPHIA is ... central electronic repository for

22                approved policies, clinical guidelines and standard

23                operating procedures ... a single platform for accessing

24                these documents in order to reduce the risk of staff

25                relying on outdated, superseded or conflicting versions

1       ... [and it] supports interactive standard operating  
2       procedures and provides staff with access to  
3       evidence-based guidance, step by step instructions, and  
4       process flowcharts."

5               And at your paragraph 28 you say that it is  
6       a revised document structure:

7               "... the intention was for each subject area to be  
8       supported by a concise policy statement document ..."

9               Yes?

10   **A.**   That's correct, yeah.

11   **Q.**   You go on to say at paragraph 29 that it was planned in  
12       phases, that Phase I was consolidating existing policy  
13       and procedural documents and uploading them?

14   **A.**   Mm-hm.

15   **Q.**   And that Phase II, do we understand it, is still  
16       ongoing? It's the progressive review of a policy, so  
17       when a document comes up to its review date you review  
18       it and then it goes on to SOPHIA?

19   **A.**   That's correct, yeah.

20   **Q.**   And so we understand the position, then, the idea of  
21       SOPHIA or the SOPHIA platform, is that the right way to  
22       describe it, is that staff can easily access the most  
23       up-to-date and current documentation?

24   **A.**   That's correct.

25   **Q.**   And it seems from your statement that the intention was

1 to monitor the use of the SOPHIA platform?

2 **A.** That is correct.

3 **Q.** Has there been an audit to verify whether staff are

4 actually using the SOPHIA platform?

5 **A.** I'm not aware of an audit that has been carried out but

6 I will have to go back and look into that, but what

7 SOPHIA platform offers is a statement to be signed by

8 staff who access that platform to say they have read and

9 understood the content of the policy.

10 **Q.** So who monitors that then?

11 **A.** At present I'm not sure who monitors that but I can go

12 back and check that.

13 **Q.** Do you think it is being monitored?

14 **A.** I'll need to check that.

15 **Q.** So it may not be?

16 **A.** I will need to check that.

17 **Q.** All right.

18 **A.** Apologies.

19 **Q.** Do all staff -- and by that I mean, temporary, agency,

20 bank staff -- do they all have access to the SOPHIA

21 platform?

22 **A.** They do. It's available through the log-in that all

23 staff have access to and they can access it through

24 their existing log-in.

25 **Q.** And are they expected to access policies on SOPHIA as

1           and when the need arises, or is there a requirement for  
2           them to do so on a regular basis?

3   **A.** Well, it depends on whether -- something like  
4           resuscitation, staff would be expected to read it  
5           beforehand because it's an acute event.

6   **Q.** Before what?

7   **A.** Before an event happens. It's not something that can be  
8           read. But as we said before, some of the policies can  
9           be quite long, particularly medication-related policies  
10          because there is a lot of governance and statute  
11          governing the use of medications. Those, you know,  
12          staff would refer to at the point. It depends how  
13          quickly one needs access to the policy.

14   **Q.** Can I just ask something you just said about staff and  
15          the resuscitation documentation and that they've been  
16          expected to read it before an event. Now, on the  
17          basis -- I'm sorry if I've misunderstood what you've  
18          said -- that nobody knows when an emergency event is  
19          going to take place, when do you expect those staff,  
20          when would EPUT expect those staff to have consulted  
21          that documentation?

22   **A.** Well, for our substantively employed staff, they need to  
23          be aware of all the policies that is relevant to their  
24          clinical work within the clinical area. Given that we  
25          provide different services in different areas, there may

1 be policies that are not relevant to staff working in  
2 a particular clinical setting. So there is an  
3 expectation that staff do that, ideally within three  
4 months of starting their employment. But we also have  
5 bank staff who are already employed by EPUT in  
6 a substantive capacity but they may do bank shifts, for  
7 instance.

8 But at the point of induction, all staff are  
9 signposted towards the policy that is relevant for them.  
10 For example, if I can give an example for doctors, when  
11 a new resident doctor starts the rotation in February or  
12 August, the Consultant Psychiatrist who is their  
13 clinical supervisor sits down with them for an induction  
14 meeting and points to them how they can access policies  
15 that they are likely to need or encounter in their daily  
16 clinical work. This could be, for example, how to  
17 prescribe medications or how to do, say, rapid  
18 tranquilisation, et cetera. So those policies are  
19 pointed out during induction, so staff are meant to be  
20 aware of that.

21 **Q.** I'm going to come to induction in just a moment but just  
22 before I leave SOPHIA as a principle, if it's working,  
23 and tell me if this is not another intended purpose, but  
24 if SOPHIA is working, it should allow EPUT also to  
25 access and share up-to-date documentation easily with

1 others, for example with this Inquiry or with another  
2 authority inspecting or investigating the services?  
3 Would you go to SOPHIA for that purpose?

4 **A.** SOPHIA is the repository for all the current versions of  
5 the policy. I'm not aware of the functionality in that  
6 much detail as to whether it can be externally shared.  
7 It is certainly available for all staff through our  
8 intranet platform.

9 **Q.** You just referred to induction, and you just talked  
10 about induction for doctors. Can I just ask you again,  
11 in relation to the induction material that you provided  
12 for the Inquiry, so let's begin, if I may, by asking you  
13 to look at paragraph 57 of your joint statement and  
14 I wonder if we can put up, please, appendix 2 to HRP21  
15 which is EPUT026720.

16 This document is called the Local Induction for  
17 Substantive Staff. It's not for doctors; am I right?

18 **A.** It's not. It's mainly for nursing and Allied Health  
19 Professionals.

20 **Q.** Including healthcare assistants?

21 **A.** Of course, yeah.

22 **Q.** All right. If we look at your paragraph 57, or you look  
23 at your paragraph 57 you say:

24 "The Trust notes the existence of a singular  
25 overarching checkbox in Exhibit 16 and acknowledges that

1       this in itself can not provide immediate assurance that  
2       each section has been specifically addressed.  However,  
3       it is the Trust's position that the box can only be  
4       completed once all sub sections are covered."

5               Sorry to do this, but if we go down, and we might  
6       just do this slowly, this is an eight-page document, I  
7       think, and we can see that it has a description and then  
8       we have the procedure and it tells the person which  
9       boxes need to be ticked.  So that you have the starter  
10      checklist on SOPHIA, complete team department  
11      orientation and complete competency checks, so on and so  
12      forth.

13             Can we go to the next page, please.  I think we can  
14      go to the next page but we can see that there are  
15      a whole list of things that need to be dealt with,  
16      including -- and I'm looking now at page 3 -- we have  
17      job duties, et cetera, et cetera, tech support, overview  
18      of health and safety and wellbeing, and do we see  
19      right -- I think it's the third bullet point up from the  
20      bottom -- "emergency equipment"?

21   **A.**  Yes.

22   **Q.**  Can we go to page 4, please.  Again, we have various  
23      other aspects that need to be drawn to the new member of  
24      staff's attention, and at the bottom, do we see that if  
25      this is an inpatient induction, there needs to be a tour

1 of the ward, location of ligature point areas and  
2 hotspots, explain ligature risk assessment for this  
3 specific ward, and so on?

4 **A.** Yeah.

5 **Q.** Again over the page, please, to 5. Again, I'm not going  
6 to read through but we can see that we've got a whole  
7 list of things that need to be done on the induction and  
8 I'm going, I think, to about two-thirds of the way down  
9 and we see, don't we, emergency responses including  
10 clinical emergency, psychiatric emergency, resuscitation  
11 procedures, rapid nurse response and first aid kits; do  
12 you see that? And we have ligature management  
13 underneath, including use of ligature cutters, awareness  
14 of hotspot gallery and ligature wallet --

15 **A.** Yeah.

16 **Q.** -- at the bottom. I think if we go to 6, again, I won't  
17 go through but we've got other requirements, including  
18 environmental risks for health and safety, which is the  
19 second point down, and sorry, if we could go over the  
20 page again. Again, other lists, and just for  
21 completeness to page 8. You have complete competency  
22 checks and you go through the competency checks which at  
23 the bottom, for example, we see include ligature risk  
24 competency -- do you see that at the bottom?

25 And then 4, it says, "Complete process" at the very

1 bottom of page 8. Do you see that?

2 **A.** Yeah.

3 **Q.** So in your -- when you say at your paragraph 57 that you  
4 note the existence of a singular overarching check box  
5 in exhibit 16, is that the check box you were talking  
6 about, the complete process check box?

7 **A.** Yes.

8 **THE CHAIR:** Who completes this? The person on the ward  
9 doing the induction?

10 **A.** The person doing the induction, which could be the nurse  
11 in charge, Ward Manager, particularly when a new member  
12 of staff starts.

13 **THE CHAIR:** Thank you.

14 **MS HARRIS:** Following from the Chair's question and  
15 reminding you, you say it's the Trust's position that  
16 that box can only be completed once all subsections are  
17 covered.

18 **A.** That's correct.

19 **Q.** Is that a system decision or a human decision? Do you  
20 know what I mean by that? Does the system not allow  
21 you -- do you have to complete the whole thing before  
22 the system will allow you to tick that last box or is  
23 that something that you tell the staff?

24 **A.** I'm afraid I'm not so familiar with this. Ms Sheridan  
25 might be in a better position to respond to this. I can

1       see that it's an electronic checklist, but I don't know  
2       whether it does not allow somebody to tick the last box  
3       -- (overspeaking) --

4   **Q.** Do you know what the question I'm asking, though --

5   **A.** I do, I do.

6   **Q.** Right.

7   **A.** Whether it's a mandatory or an asterisked kind of a box.

8   **Q.** You say again at your paragraph 54 that:

9       "The location of emergency equipment is addressed as  
10      part of the ward induction process during which the new  
11      staff member, whether permanent, bank or agency, is  
12      orientated to the ward environment. Each staff member  
13      is required to engage fully in the induction process and  
14      to familiarise themselves with the information provided.  
15      The local induction is recorded and signed."

16       Does that relate to the entry we saw on page 3 of 8?  
17      Perhaps we could go back to page 3 out of fairness. We  
18      saw it's the third bullet point up, do you see  
19      "Emergency equipment"?

20   **A.** Yeah.

21   **Q.** So is that the assurance that it's been addressed?

22   **A.** Yes.

23   **Q.** Can we now look, please, at appendix 3 to HRP21 which  
24      is EPUT026719.

25       Now this is the induction form for locum, bank and

1 agency staff. You say at your paragraph 58:

2 "The sections relating to medical emergency and

3 psychiatric emergency are the areas where the use of

4 ligature cutters are covered within the induction

5 process."

6 So, first of all, do you agree that this is a very

7 much shorter induction document than the one that's

8 given to substantive -- the process for substantive

9 staff?

10 **A.** It is shorter.

11 **Q.** Yes. And in order to, if you like, to confirm or

12 assure, we need to go down, I think, to look at the

13 bottom third "Emergency procedures", where we've got:

14 "Fire (equipment, exits and procedure)

15 "Medical emergency ... Psychiatric emergency ...

16 "Health and safety issues."

17 Thank you for that. That's helpful.

18 Do you see that?

19 **A.** Yeah, I do.

20 **Q.** So are those the boxes that would be ticked if the

21 relevant information had been given?

22 **A.** That's correct for particularly bank and agency staff.

23 What I would also like to point out is that there is --

24 I mean, first of all, we have reduced the use of agency

25 to an absolute minimum. We hardly employ any agency

1 staff at present through concerted work on temporary  
2 staffing. That's number 1.

3 Number 2 is agency staff come with the assurance  
4 that they have all these skills, because we use  
5 framework agencies. So, for agency staff, it's more  
6 often orientation rather than training and induction, if  
7 that makes sense, and also, agency staff tend to do  
8 repeat shifts on the same ward because of where they,  
9 you know, because of lifestyle reasons.

10 So even though it might say agency staff, in  
11 practice, they are staff who have already done shifts on  
12 that ward.

13 **Q.** Just on that, what about bank staff?

14 **A.** Most of our bank is made up of substantively employed  
15 staff who are already subject to a much more rigorous  
16 induction and other procedures.

17 **Q.** Your paragraph 58 you say:

18 "The Trust confirms that these areas [that's the  
19 ...] are captured within ward orientation ..."

20 And that:

21 "Given that ward orientation is not limited by the  
22 checklist, the Trust is assured that temporary workers  
23 are apprised of business critical and safe working  
24 arrangements through existing local processes."

25 Can I just ask you some questions about that. You

1 say that these areas are captured within the ward  
2 orientation. Has that been tested or verified in any  
3 way?

4 **A.** When the orientation or induction happens for staff the  
5 Ward Manager, like we have seen, is meant to complete  
6 that check and document it. But I'm not sure if it is  
7 audited regularly.

8 **Q.** Similar question. Has the assurance that temporary  
9 workers are apprised of business critical and safe  
10 working arrangements, has that been tested or verified  
11 in any way?

12 **A.** Again, I cannot be sure whether it has been formally  
13 audited but I know that temporary workers are inducted  
14 and orientated to the ward when they start their shift.  
15 Particularly when somebody is brand new to a ward and  
16 it's their first shift.

17 **Q.** You say that the -- that it's done through existing  
18 local processes. What are the local processes that  
19 you're referring to?

20 **A.** Again, this response may be supplemented by my colleague  
21 Ann Sheridan, later. But what my understanding is that  
22 when a new member of staff starts, the Ward Manager has  
23 the responsibility to provide them with local induction.  
24 So our induction consists of two things: one is the  
25 corporate induction, which is an induction to the Trust,

1 the kind of care that we provide and at an  
2 organisational level. Then there is a local induction.  
3 I know that that happens for doctors regularly, every  
4 six months when they start new within the organisation,  
5 and rotate in from an acute Trust.

6 The local induction consists of training on the  
7 orientation to the ward for example, you know, emergency  
8 equipment for the purposes of this particular issue,  
9 then we signpost them towards the policies, and we also  
10 give them a lot of information about HR and other  
11 procedures that is required for the regular working, for  
12 example, things like how to apply for annual leave or  
13 study leave or things like that.

14 So the location induction is a whole day. Plus we  
15 also induct them in a our -- or train them to use our  
16 electronic patient records, because that requires not  
17 only training, but also provision of a username and  
18 log-in so that they're able to input information into  
19 the records as well. So all this forms part of the  
20 local induction.

21 **Q.** Again, just to cut through what you're saying there,  
22 we've obviously looked at induction documents that  
23 relate to arrival on a particular ward or unit for  
24 working, and my question for you is whether or not you  
25 consider this single-page checklist is adequate to

1 record whether there's been a safe induction of  
2 temporary staff. So can I start by asking you by asking  
3 you whether you think that form is adequate? To  
4 reassure that there has been a safe induction?

5 **A.** Yes, I can see that the form is very short. That is  
6 evident. But sometimes when temporary staff start  
7 working on a ward, it happens clearly when regular staff  
8 are not available. So the time is of the essence. So  
9 there has to be a balance struck between how long we  
10 spend inducting the staff to a new ward and the length  
11 of time it takes to induct them.

12 **Q.** Can I ask you that. It may be something I need to ask  
13 Ms Sheridan. How in practice, then, are temporary or  
14 agency staff inducted when they're booked at short  
15 notice?

16 **A.** Normally, the Human Resources Department go through  
17 a hiring process, if I can call that, where the  
18 agency -- if we're using agency staff, that is -- agency  
19 sends all the documentation in terms of compliance with  
20 mandatory training, whether they have the right to work  
21 in the UK, for instance, whether they have got the  
22 qualifications that, you know, evidence of  
23 qualifications, et cetera. So that assurance comes with  
24 the agency, and then HR gives the go-ahead to appoint  
25 those staff.

1           Then locally when they start shift on the ward, the  
2           nurse in charge meets them and gives them an orientation  
3           to the ward because we don't normally assure agency  
4           staff have the qualification that they need to work on  
5           a particular ward, because that is normally taken to be  
6           the responsibility of the agency and because we use  
7           framework agencies, they come with that assurance.

8           What we do locally is their orientation to the ward.  
9           If somebody is, for example, doing only one shift,  
10          overnight for instance, the Ward Manager has to go  
11          through a quick checklist, something like this, pointing  
12          them out -- pointing them towards the business critical  
13          or the safety critical important things that need to be  
14          covered in their orientation.

15   **Q.** Just separately but related, again, looking at that  
16          checklist, is there any reason why that checklist  
17          couldn't, for example, cover an explanation about the  
18          location of ligature cutters or a ligature risk  
19          assessment or hotspots?

20   **A.** It can do, but we use the same checklist for all of our  
21          wards, and because of the architecture of different  
22          wards, those locations might be slightly different.

23   **Q.** Just again, I'm not suggesting a detail, but even a tick  
24          box to say it would be done?

25   **A.** Yes, that is something we can certainly consider.

1   **Q.** And how are the Trust assured for example with temporary  
2       staff that they would know what was in the grab bag or  
3       where the grab bag was located or something of that  
4       nature? Anything of that nature?

5   **A.** That is meant to be part of this induction, of which  
6       this is a record, or a document recording that has taken  
7       place. Clearly this does not contain elements that I  
8       would expect would happen when the actual induction  
9       takes place. For example, there is a brief mention of  
10      medical emergency, like at the bottom, and psychiatric  
11      emergency and that includes communication bleep and  
12      pharmacy arrangements, as well, and where medications  
13      are stored and, of course, the fire, the legal required  
14      fire exits, et cetera.

15   **Q.** You say at your paragraph 59 that the induction  
16      checklist is simply a record that it has occurred and it  
17      doesn't reflect the extent of the local induction that  
18      occurs, which is in accordance with what you just said.  
19      Is there anything anywhere that does reflect the extent  
20      of the induction that occurs?

21   **A.** Not to my knowledge, but a lot more happens in practice  
22      when somebody starts new on the ward than is actually  
23      recorded on this form.

24   **Q.** So you're saying things are done but things aren't  
25      recorded?

1     **A.**   That's correct.

2     **MS HARRIS:**   Chair, would that be a convenient moment for  
3             a short break.   So shall we say 15?  
4             We'll return at 11.35.

5     **THE CHAIR:**   11.35.

6     **MS HARRIS:**   Thank you.

7     **(11.20 am)**

8                             **(A short break)**

9     **(11.38 am)**

10    **THE CHAIR:**   Ms Harris.

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

12             Dr Suresh.   During the last evidence session, you  
13             referred a couple of times to the fact that questions  
14             around staffing would be better dealt with by your  
15             colleague Ms Sheridan.

16    **A.**   That's correct.

17    **Q.**   As a result of which I'm going to move on now to  
18             a slightly different topic which is the question of  
19             monitoring and audit of resuscitation service provision  
20             at EPUT.

21             And I wonder if, please, RSCUK022529 could be put  
22             back up, please, on -- I think it is page 24, although  
23             the pages aren't actually numbered.

24             Thank you very much.

25             It's the section, section 12 of the Quality

1 Standards for Mental Health Inpatient Care which deals  
2 with audit and reporting. If we look at point 1 we see  
3 that the National Confidential Inquiry into Patient  
4 Outcome and Death recommends that every CPR attempt is  
5 reported through the healthcare organisation's patient  
6 safety incident reporting systems and that this  
7 information must be reported to the organisation's board  
8 on a regular basis.

9 We also see at number 2:

10 "All CPR attempts must be reviewed."

11 So that's one of the obligatory provisions. And it  
12 goes on to say that:

13 "A suggested guide for reviewing cardiac arrests is  
14 available in the supporting tools below."

15 And I'll come to that in a moment.

16 And if we look at number 5, we see that:

17 "Organisations must review local audit data  
18 regularly against published standards. Where audit  
19 identifies deficiencies or unexpected poor performance,  
20 a review at an appropriate level must be undertaken  
21 [and] the resuscitation service structure must receive  
22 appropriate support to achieve this."

23 If we move, please, to the following page which is  
24 25, we see there the supporting tool that's referred to,  
25 it's the suggested tool for reviewing CPR attempts.

1           We don't need to look at it in detail, but what we  
2           can see, and it goes over the page, I think it's ten  
3           suggested steps and questions, and it says at the  
4           bottom:

5           "If the answer to any of the above questions raises  
6           concern, proceed to root cause analysis and action  
7           plan."

8           Just having a look at those, sorry, if we could go  
9           back over the page to 24, please, I'm not going to read  
10          them out, but it asks questions around monitoring,  
11          around the early warning scores, and about the  
12          escalation, about signs of deterioration, about  
13          assessment, about treatment, and about any other issues,  
14          at 10, missing equipment, drugs, failures, problems with  
15          team performance or communication.

16          So that's the suggested tool from RCUK in order to  
17          review CPR attempts.

18          We've also heard in evidence yesterday quite a lot  
19          of about Datix reporting, in fact we've heard a lot of  
20          evidence through the Inquiry's proceedings about Datix  
21          reporting, and I'll come back to that in a moment.

22          Yesterday you'll recall we looked at the  
23          Resuscitation Event Form that EPUT has which is, again,  
24          a different document but another method by which CPR  
25          events are reported.

1           Now, acknowledging that this is a suggested tool, is  
2           there any document or tool in place at EPUT which aligns  
3           with this tool as suggested by the RCUK, which provides  
4           a structure?

5   **A.**   Apart from the Resuscitation Event Form, I'm not aware  
6           of any other tools. Again, my colleague may be in  
7           a better position to respond to this. But the  
8           Resuscitation Event Form is our main mechanism through  
9           which we review each event and use it to learn lessons.

10   **Q.**   Against the background of RCUK's requirement that  
11           organisations must review local audit data regularly, as  
12           part of the -- I think -- sorry, that can come down now.  
13           I'm grateful.

14           As part of its most recent evidential request, can  
15           you confirm, and you deal with this at -- and I should  
16           now get the page number -- at paragraph 31. I'll get  
17           the page number in a moment.

18           It's page 6, I'm told. So this is the joint  
19           statement which is EPUT028198. Page 7, please,  
20           paragraph 31.

21           That says as part of its most recent evidential  
22           request:

23           "The Inquiry has requested details and copies of any  
24           audits conducted between the merger of NEPT and EPUT on  
25           1 April 2017 and the current date, of documentation

1 complete following resuscitation events."

2 And the first thing you tell us in paragraph 31 is

3 that no such audit has been conducted; is that right?

4 **A.** That's correct, yeah.

5 **Q.** Despite that being a requirement of the Quality

6 Standards?

7 **A.** **(The witness nodded)** .

8 **Q.** You're nodding. Is that right?

9 **A.** Sorry, yes.

10 **Q.** You go on to say, and this is over the page, I think

11 page 8, that the documentation -- sorry -- it's 7 over

12 to 8, thank you:

13 "... the documentation produced following

14 a resuscitation event is reviewed. This includes

15 a Datix Incident Report and a Resuscitation Event Report

16 Form and the outcome of the CPR event must be clearly

17 documented in the patient record."

18 Yes?

19 **A.** That's correct, yeah.

20 **Q.** Now, we heard evidence from Mr Archer yesterday that he

21 reviews Datix reports and Resuscitation Event Forms.

22 **A.** That's correct.

23 **Q.** And we heard from him that he sits in his allocated

24 administrative space. That's where he is based?

25 **A.** Yes.

1 Q. I think that's what he described it as.

2 A. Yes.

3 Q. That's why I'm using that terminology. And he reviews  
4 them individually, he says?

5 A. That's correct, yeah.

6 Q. He doesn't keep a written record of his reviews, that's  
7 his evidence.

8 A. **(The witness nodded)**.

9 Q. Yes?

10 A. Yeah.

11 Q. And in order to put any review into context, he  
12 explained that he relies on his memory of other events?

13 A. Yes.

14 Q. And he also told us that he relied on, I think the way  
15 he organises his email inbox, he puts things into  
16 certain groups?

17 A. That's correct, yeah.

18 Q. And he said this: "If I feel, and I recall there is  
19 a theme, I can look back at information I have saved."

20 A. Yes. That's what he said.

21 Q. Right. So that's a lot of knowledge that is personal,  
22 it would appear, to Mr Archer from his evidence; yes?

23 A. Yes.

24 Q. How do others access that knowledge?

25 A. Well, although there is no formal audit, Mr Archer

1       mainly authors the quarterly deteriorating patient and  
2       medical emergencies report which, as I mentioned before,  
3       goes up to the Quality Committee, through the Quality of  
4       Care Group. That contains not a formal audit but any  
5       escalations from the learning that has happened on  
6       individual cases. It also contains the number of  
7       resuscitations, I think, that have happened in the last  
8       three months and also any lessons that need to be  
9       learnt. It also contains plans for future development  
10      of resuscitation services as part of continuous  
11      improvement.

12             One of them I have already mentioned, is the  
13      Physical Health Faculty that we're planning to set up.  
14      So his report contains a lot of the information that you  
15      have mentioned but not necessarily in the form of  
16      a formal audit.

17   **Q.** Can I just explore how that works in practice. So he's  
18      got good organisational knowledge it would appear from  
19      his evidence. He's got it in his mind, he's reviewing  
20      the Datix forms, and then he produces the quarterly  
21      reports, and that information or any drawing together of  
22      themes -- I'll come back to that in a moment -- goes  
23      into that report; have I understood that correctly?

24   **A.** That's correct, yeah.

25   **Q.** All right. What about when he's on leave or when he's

1       sick, and somebody else is reviewing the Datix reports  
2       and somebody else is spotting issues -- or how do they  
3       spot issues? And who does that?

4     **A.** I know he's often covered by Mr Smale when he is himself  
5       on leave but I agree that that's not a foolproof system  
6       to rely on someone's memory of events in order to pick  
7       up themes, but part of that can be gained from the  
8       quarterly deteriorating patient reports that report  
9       upwards through the governance structures.

10    **Q.** So of the person who would be reviewing, if it wasn't  
11       Mr Archer, anybody reviewing the Datix reports or the  
12       Resuscitation Event Forms would either have had to have  
13       read the last few quarterly reports or be au fait with  
14       that knowledge, or something of that nature?

15    **A.** That's correct. All of the Quality Committee reports  
16       are logged. They are available. And the Quality  
17       Committee runs in such a way that it asks for updates on  
18       risks identified in the previous Quality Committee, for  
19       instance, because it is a formal meeting chaired by  
20       a Non-Executive Director, and attended by many other  
21       non-execs and Executive Directors. It is minuted, there  
22       is an action log associated with that, and actions are  
23       closed off as soon as possible in the subsequent  
24       meetings, and it is formally -- sorry, it is one of the  
25       board subcommittees so it has a formal status within the

1 organisation.

2 **Q.** I'm still trying to understand, or the Inquiry needs to  
3 understand, though, how somebody in a day-to-day role,  
4 reviewing Datix reports and event forms that are coming  
5 in, and I think Mr Archer told us that he would log on  
6 and have around 40 in the morning, somebody in that  
7 role, the only access or the only information they would  
8 have to look at it in context would be from these  
9 minutes from this quarterly review, from the report, and  
10 the minutes of the meeting? Or have I misunderstood  
11 your answer?

12 **A.** No, Mr Archer authors those reports so he would have --

13 **Q.** That's if it is Mr Archer.

14 **A.** He would have knowledge of that. But it is available to  
15 all the Quality Committee members. Sorry, if I can also  
16 go back to Datix, where these incidents are reported,  
17 the Datix is the responsibility of the local managers to  
18 investigate and close the Datix. By close, I mean, you  
19 know, tick the button that the investigation has been  
20 completed, actions have been taken, lessons have been  
21 learned, and the relevant people have been informed. So  
22 we do get a number of Datixes every day, and these are  
23 reviewed by the relevant people. It won't be just  
24 Mr Archer. For example, if an incident has  
25 a resuscitation component to it, it goes to Mr Archer

1        automatically because Datix has a system where  
2        a designated number of people, predetermined number of  
3        people, get notifications about those incidents.

4            For example, a single incident may have  
5        a resuscitation element but it may have other elements,  
6        as well, for example, a patient who may be aggressive or  
7        any other type of incident that may be associated. So  
8        it goes to all the relevant managers who all are  
9        expected to look at the Datix and make sure it is  
10       closed. Mr Archer looks at Datix from a resuscitation  
11       point of view only.

12    **THE CHAIR:** He told us yesterday, though, that he has to  
13       interrogate what happens, what is sent to him, to  
14       identify the ones that are to do with resuscitation and  
15       emergency events.

16    **A.** Yeah.

17    **THE CHAIR:** And that it doesn't, in a sense, get presented  
18       to him as a resuscitation and emergency event; that he  
19       has to sort of go round looking into it himself.

20    **A.** That's right. I think -- there is a check box within  
21       Datix which says, "Was resuscitation performed?" And  
22       how Datix works is -- I mean, first of all, it's a good  
23       tool for reporting incidents but probably not a very  
24       good tool to extract reports and information from. So  
25       that is the first point to make.

1           The second one is that depending on what options you  
2           choose at a higher level, it opens up relevant parts of  
3           the form, if you like -- it's all online. If, for  
4           example, one of the outcomes is, say, a fall of  
5           a patient then it opens up questions that are relevant  
6           for a fall down the line. Because Datix is a vast  
7           system. It asks a lot of questions about each incident  
8           and not all of those questions are relevant to each  
9           incident.

10           So depending on the options chosen, it opens up.  
11           For example, if you choose death of a patient on a ward  
12           as one of the options, it opens up the box around, you  
13           know, was resuscitation performed? Was 999 called?  
14           Were any medications administered? And a few other  
15           questions as well. So that's how the system works.

16           So if anybody has to -- again, I'm not familiar with  
17           the Datix system myself, I have reported incidents but  
18           I'm not the best person to speak to in terms of getting  
19           information out of it, but if you choose the box  
20           "Resuscitation performed?" "Yes," then it will give out  
21           results of where -- in which incident that may have  
22           happened. But my understanding is that box may only  
23           have been added some time ago. I cannot be sure of the  
24           exact date. Maybe around 2021, I'm not sure.

25   **MS HARRIS:** All right, we'll come to Datix in just a moment,

1 not necessarily the ins and outs of it but the reliance  
2 placed on it in a moment. But again, what I'm asking  
3 you is this: we have -- we'll come back also later on to  
4 potential learning opportunities because, as you know,  
5 the Inquiry needs to understand how EPUT learns from  
6 practices, good or bad, in whatever topic we are  
7 investigating.

8 **A.** Yes.

9 **Q.** What I'm asking you about now, is who looks at these,  
10 other than Mr Archer, who looks at these Datixes, these  
11 events, these cases, these scenarios in the round? Who  
12 steps back and says: are these recurring issues? Are  
13 these repeated failures? Are there patterns? Who is  
14 looking at it? Who has got the overview?

15 **A.** We have several groups that operate within EPUT, for  
16 example we have a Falls Steering Group, all the falls  
17 incidents will be reviewed by the Falls Steering Group.

18 **Q.** Sorry, I don't want to interrupt you, but can we focus  
19 on resuscitation?

20 **A.** Yeah.

21 **Q.** So when we're dealing with CPR events, emergency  
22 response that has resulted in CPR or a resuscitation  
23 attempt, we've heard a lot of what Mr Archer does and  
24 I'll come back to that in a moment but who else in the  
25 organisation is looking at these things in the round to

1           see what patterns are emerging or not emerging?

2   **A.** I think that would be the Deteriorating Patient Group.

3           I don't attend that myself so I cannot speak about what

4           happens within that group. But I would expect that

5           would be the place to review incidents that have

6           resuscitation as a component, and look at what lessons

7           are being learned.

8   **Q.** And we understand from his evidence and from the

9           structure that Mr Archer feeds information into that

10          group.

11   **A.** That's correct, yeah.

12   **Q.** He sits on that group, and then that group, in turn,

13          feeds into --

14   **A.** Harm Free Care Group.

15   **Q.** Which he chairs?

16   **A.** That's correct.

17   **Q.** Which he heads up. All right.

18           Are we right in understanding that considerable

19          reliance is placed on Mr Archer's institutional

20          knowledge?

21   **A.** Yes, but I would also qualify that by saying that he has

22          access to the support he needs. For example, if he

23          needs to get an extract of incidents in a certain way,

24          the Datix team will be in a position to help him so that

25          he is able to compile those learnings.

1   **Q.** Okay, we'll come back to what the Datix team can or  
2       can't do in a moment, but the Inquiry asked for  
3       information, back to 2017. So at the point of merger.  
4       Mr Archer, of course, has only been in place until (sic)  
5       2022, and we don't need to go through it, but would you  
6       agree that the procedures in place, even back in 2017  
7       after the merger, required that:

8               "The outcome of a CPR event must be clearly  
9       documented in the patient's record, that a Datix report  
10      must be completed at the earliest opportunity along with  
11      a Resuscitation Event Form, and that the Head of  
12      Deteriorating Patient Pathways and Resuscitation  
13      Training Officer would confirm that they'd been  
14      completed following an event and review in order to  
15      identify examples of good practice, any knowledge, or  
16      technical, non-technical skills." [As read]

17             Now, I've read that very quickly. That was  
18      Section 5 of the 2017 version. I'm not asking that it  
19      be put up but do you agree that's a requirement that has  
20      come thorough all of the procedures?

21   **A.** That is correct, yeah.

22   **Q.** And it appears, as we know because we looked at it with  
23      Mr Archer yesterday, at section 8 of the current policy,  
24      that's headed "Resuscitation event reporting procedure"  
25      and there are some additional -- there's some additions

1 including SWARM huddles or debriefs, but in essence the  
2 responsibility is the same: that they are reported, they  
3 are reviewed and learning and issues are identified?

4 **A.** That's right, yeah.

5 **Q.** Now, we heard about, from Mr Archer, about Datix  
6 reporting yesterday, and about issues with the -- I'm  
7 trying -- I don't want to misrepresent his evidence, but  
8 issues with inconsistent reporting. He told us about  
9 that. It depends on how people fill out what you've  
10 already acknowledged is a complicated system. There  
11 are, he told us, a vast number of dropdowns, I think  
12 that was his phrase.

13 You're nodding, do you agree there are?

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

15 **Q.** He told us -- and you may or may not be able to confirm  
16 whether this is your experience -- that events are not  
17 always classified properly, depending --

18 **A.** That is correct, because the reporter of the incident  
19 does the initial classification.

20 **Q.** And that events are sometimes reported under the wrong  
21 headings?

22 **A.** That's correct, yeah.

23 **Q.** And in a sense, as you say, the reporting relies on the  
24 accuracy of the input and the person completing that  
25 report?

1   **A.** That's correct.

2   **Q.** And Mr Archer's evidence was, and these were his words,  
3       that he "hoped [he hoped] he was aware of every  
4       resuscitation" but that it was by varying means. And  
5       you recall his evidence: he talked about Datix  
6       reporting, Resuscitation Event Forms, sometimes he said  
7       it was because he got an email because a team was  
8       reaching out. You agree that was his evidence?

9   **A.** That is correct, yeah.

10  **Q.** Sometimes if it hadn't been captured in an event form it  
11       might be because he had an email or copied into an email  
12       from Senior Leadership who were offering support to the  
13       ward or to the staff on the ward; do you remember that?

14  **A.** That's correct, yeah.

15  **Q.** And do you agree that is a somewhat unreliable, an  
16       *ad hoc* way, of Mr Archer obtaining the information that  
17       is required to discharge his responsibilities?

18  **A.** It can be viewed that way, but these events are so  
19       infrequent, when a resuscitation event happens on  
20       a ward, you know, it is -- it's quite a big event, if  
21       I can put it that way, because it is so rare on our  
22       wards, we can expect one or two incidents, if that, in  
23       a year. So when these events happen, it does become  
24       widely known. I agree that yes, we are relying on  
25       Mr Archer's, for example, use of memory, et cetera. We

1       could have a better system of monitoring these in a more  
2       systemic way, but, like I said, these events are so  
3       rare, thankfully, that they -- you know, people come to  
4       know about it.

5   **Q.** Just while we're on event reporting and you say that "we  
6       could have a better system", could I ask you a couple of  
7       questions about that.

8               Firstly, we heard yesterday that Mr Archer has  
9       proposed a new dropdown?

10  **A.** Yes.

11  **Q.** Were you aware of that?

12  **A.** I heard his evidence, yeah.

13  **Q.** Were you aware of that before he gave evidence?

14  **A.** I wasn't, no.

15  **Q.** Because he said he'd had relevant conversations. Who  
16       would they have been with?

17  **A.** That would have been with his line manager which is in  
18       the nursing structure.

19  **Q.** And he said that it would be considered by the Health  
20       and Safety Group in a couple weeks' time?

21  **A.** That is correct.

22  **Q.** Would that be the system?

23  **A.** Yeah, that's correct.

24  **Q.** But you weren't aware that Mr Archer had proposed a new  
25       dropdown to enable better reporting of resuscitation

1 incidents?

2 **A.** I wasn't specifically aware of that fact. What I cannot  
3 recall is whether it was in his latest quarterly report.

4 **Q.** All right. When did you last read his latest quarterly  
5 report?

6 **A.** I think that would have been presented to the Quality  
7 Committee in the last couple of months.

8 **Q.** You didn't look at it again before coming to give  
9 evidence?

10 **A.** No, I did not.

11 **Q.** All right. In preparation for this hearing, the Inquiry  
12 disclosed, I think as you are aware, CQC reports  
13 following three inspections at EPUT in the last  
14 12 months. I'm not going to go into detail, and I think  
15 you were invited to read those before giving evidence.  
16 But do you agree, or is it right to say, that all three  
17 of those reports noted problems with incident reporting?

18 **A.** I do, yeah.

19 **Q.** And in the most recent report, which is the Well-Led  
20 Report that was published in August this year, that the  
21 CQC stated that:

22 "Whilst the Trust was reporting and investigating  
23 incidents, this was not always happening in a timely  
24 manner, and the learning was not being shared quickly  
25 enough across the organisation, which meant there were

1 missed opportunity to improve the safe care and  
2 treatment of people using the Trust services." [As read]

3 And that it went on to say that:

4 "Leaders did not report overdue incidents and PSIIs  
5 to the board as part of the patient safety reporting and  
6 91 incidents classified as severe or fatal were overdue  
7 for review." [As read]

8 It also went on to say that:

9 "The CQC were also informed that some Patient Safety  
10 Incident Response Framework reviews (PSIRFs) had been in  
11 the process for over two years and they remained  
12 concerned that there were not robust oversight and  
13 action being taken to address overdue backlogs which  
14 will impact the Trust identifying and implementing  
15 learning." [As read]

16 You agree this is all within this report, yes?

17 **A.** That is correct, yeah.

18 **Q.** We'll turn to it later, when we deal with learning, but  
19 in light of the evidence we have heard from Mr Archer  
20 about problems with the Datix system, and the findings  
21 in this very recent CQC report, do you consider that  
22 there is still a systemic issue at EPUT in relation to  
23 incident reporting and then going on, of course, to  
24 identify and implementing learning?

25 **A.** Incidents are being reported much more than they were

1 a few years ago. There has been a steady increase.  
2 Partly that has been made easier with electronic  
3 reporting, before which we had to fill in paper forms,  
4 which were much more cumbersome. So we are seeing  
5 a larger number of incidents being reported, which is  
6 a good thing, because we can then triangulate any  
7 learning and make sure lessons are learned. So that's  
8 number 1.

9 And number 2, in terms of -- I know there have been  
10 thematic reviews of various incidents. Again,  
11 Ms Sheridan may be in a better position to talk about  
12 those thematic reviews, particularly those incidents  
13 that involve a fatality, for instance. So we follow the  
14 national PSIRF framework which focuses on learning from  
15 incidents and we shared those reports with external  
16 bodies like the coroners or families as well.

17 **Q.** Can I just break it down, though, to this: are you  
18 confident, and we'll come on to audits and obtaining the  
19 information next, but are you confident that the Datix  
20 reporting system is working as it should for EPUT?

21 **A.** It certainly works in terms of been able to report  
22 incidents and we can generate extracts from it with the  
23 help of the Datix team, but it's not a skill all of our  
24 staff possess, perhaps, because they're better at  
25 reporting incidents than getting information out of it.

1   **Q.** Let's look, shall we, at what the Datix team can do or  
2       can't do.

3       We've already looked at what the Inquiry asked for.  
4       We asked for: audit information in relation to  
5       resuscitation events since the merger, so since the  
6       1 April 2017. The Inquiry is aware that there are  
7       problems obtaining information prior to that time, this  
8       was a specific request for information since the merger.

9       You're nodding, you agree that was the request?

10   **A.** Yes, I agree.

11   **Q.** And so as we understood it, in order to answer that  
12       request, the following took place: EPUT's Senior Datix  
13       Manager, who is listed in those 36 people who helped  
14       with the statement, conducted a search of Datix for any  
15       report where the answer to the question "Was CPR used?",  
16       was "Yes."

17   **A.** Yes.

18   **Q.** You're nodding?

19   **A.** Yes.

20   **Q.** So you've said several times that you can get this  
21       information with the help of the Datix team and this is  
22       the Senior Datix Manager, so this is somebody you were  
23       referring to; am I right?

24   **A.** That's correct, yeah.

25   **Q.** All right. So he obtained that information and it was

1           put in a spreadsheet; yes?

2   **A.**   Mm-hm.

3   **Q.**   And that spreadsheet was provided to this Inquiry?

4   **A.**   Yeah.

5   **Q.**   In order to answer our request for all information  
6           relating to resuscitation CPR events since 2017, yes?

7   **A.**   That's correct, yeah.

8   **Q.**   And that spreadsheet, which I'm not going to put up,  
9           contains details, and again, it's a big spreadsheet with  
10          a number of columns; is that right?

11   **A.**   That's correct.

12   **Q.**   And it contains details of the various events, the  
13          locations, the staff involved, what happened -- various  
14          questions are answered about whether ambulances were  
15          called, what happened afterwards and so on.

16   **A.**   That's correct.

17   **Q.**   A lot of information. Now, as I said, I'm not going to  
18          put that up because there's a lot of graphic and  
19          sensitive information within that spreadsheet,  
20          obviously, by way of the reporting -- yes?

21   **A.**   Mm-hm.

22   **Q.**   All right. But when EPUT provided that spreadsheet to  
23          the Inquiry, it purported to be a record of all  
24          resuscitation events since the merger in 2017. Is that  
25          right?

1    **A.**   That's correct.

2    **Q.**   And when you provided that first version of that  
3       spreadsheet, I think it had two 23 events on it. Does  
4       that sound about right? 23 or 24?

5    **A.**   Sounds about right.

6    **Q.**   All right. And it's right, isn't it, that the Inquiry  
7       reviewed that spreadsheet and the Inquiry noted that it  
8       was either incomplete or inaccurate in various ways?

9    **A.**   That's correct, yeah.

10   **Q.**   For example, the Inquiry noted that it didn't contain  
11       six of our illustrative cases, so six cases where we've  
12       heard evidence from bereaved families which clearly  
13       established that there was a resuscitation event?

14   **A.**   **(The witness nodded)**.

15   **Q.**   And all of those six cases had appeared in Ann  
16       Sheridan's first statement.

17   **A.**   That's correct.

18   **Q.**   So, having noted these inaccuracies, the Inquiry asked  
19       you -- EPUT, sorry -- to clarify or explain why certain  
20       patients, including patients that we knew a lot about,  
21       did not appear on that spreadsheet. Yes?

22   **A.**   Yes.

23   **Q.**   And as a result, last week, EPUT provided an updated  
24       version of the spreadsheet?

25   **A.**   Yes.

1 Q. And it now has 40 events recorded on it. So, 17 more  
2 than in the first version.

3 A. That's correct, yeah.

4 Q. And we remind ourselves, the first version was produced  
5 either by or with the assistance of the Senior Datix  
6 Manager?

7 A. That's correct.

8 Q. And what's more, tell me if I've understood this  
9 correctly, that in this revised version, not only are  
10 there a number of events added that were missed in the  
11 first version, but in fact, others from the first  
12 version have been removed, because on review, it's been  
13 noted that they weren't in scope of the Inquiry. Is  
14 that right?

15 A. That's correct, yeah.

16 Q. So putting it simply, the first version of that  
17 spreadsheet, which EPUT provided to this Inquiry as  
18 a full record of CPR resuscitation events, was  
19 completely unreliable? You're nodding. Is that right?

20 A. It appears so, yes.

21 Q. It represented significant underreporting?

22 A. **(The witness nodded)**.

23 Q. Inaccurate reporting?

24 A. Yes.

25 Q. And the Inquiry really couldn't attach any weight to it

1           whatsoever, could we?

2   **A.**   No.

3   **Q.**   And what's more, given that that version was provided to

4           the Inquiry, no checks or quality assurance had been

5           exercised by EPUT in relation to that document before it

6           was provided to the Inquiry, had they?

7   **A.**   I'm not aware of what checks were carried out on the

8           document.

9   **Q.**   You agree it was an important document?

10  **A.**   It was important document.

11  **Q.**   And EPUT would know that it's the type of document that

12           would have onward disclosure to its core participants?

13  **A.**   That's right.

14  **Q.**   Do you agree that if EPUT had proper records and

15           reliable reporting processes in place, that a request

16           for the Inquiry for information relating to

17           resuscitation events since 2017 should be a really

18           straightforward one?

19  **A.**   It should be.

20  **Q.**   Particularly as we were only asking for information

21           since the merger?

22  **A.**   That's right.

23  **Q.**   Now, I want to ask you about version 2. Can you help us

24           with why version 1, why the original spreadsheet, did

25           not capture all the relevant records?

1   **A.** I have no explanation for it at present, but that is  
2       something I will look into and come back.

3   **Q.** I think the Inquiry understands that is currently being  
4       investigated?

5   **A.** That's correct, yeah.

6   **Q.** But there is no answer to it?

7   **A.** At present, I don't have an answer to that.

8   **Q.** So you don't have any more information as to why the  
9       first version was so off the mark?

10  **A.** No.

11  **Q.** All right. We've already heard concerns raised in  
12       respect of Datix reporting at EPUT; we've heard concerns  
13       raised by staff. Are you aware of that?

14  **A.** I am, yes.

15  **Q.** We've heard of concerns raised by families, including,  
16       for example, the family of Bethany Lilley who were  
17       concerned that two previous -- two previous events in  
18       the month that she'd died had not been reported. Are  
19       you aware of that evidence?

20  **A.** Yes, I have read the case summary.

21  **Q.** And in fact, are you aware that Bethany's death was one  
22       of the events that was missing on the first version of  
23       this spreadsheet?

24  **A.** I was not aware of that.

25  **Q.** Is this spreadsheet yet another example of systemic

1 problems with EPUT's use of Datix?

2 **A.** I mean, like I said, we will look into why this  
3 happened, why it did not pick up some of the cases and  
4 the second one was different to the first one. I don't  
5 want to speculate on the reasons why it could have been,  
6 but we'll certainly look into that.

7 **Q.** Right. And what does the fact that EPUT cannot put  
8 together an accurate spreadsheet tell us about the  
9 reliability of either Datix reporting and/or event  
10 reporting at EPUT?

11 **A.** I mean, Datix is our main tool through which incidents  
12 are reported. We will need to look into what reports it  
13 can reliably produce. I think we will need to speak  
14 to -- I will speak to the Datix team to be able to  
15 understand the reliability.

16 **Q.** My next question is this: how can this Inquiry be  
17 assured, then, that it can rely on this sort of  
18 information going forward?

19 **A.** I mean, we have conducted comprehensive searches of the  
20 available documents and information in response to, for  
21 example, in our requests for Rule 9 information, but  
22 I am not sure about the Datix at present.

23 **Q.** All right. In terms of other monitoring requirements,  
24 we can see from paragraph 18 of your joint statement,  
25 could this be put up, please, it's EPUT023 -- no, it's

1 not, is it? It's the joint statement at page 5. And  
2 could we put alongside it, please, sorry, EPUT023452.  
3 Apologies. Thank you very much.

4 Could we go, and I should know the page, to  
5 section 13 of the document on the right-hand side. It's  
6 at page 18, please. And I think, actually, could we go  
7 to page 19, it's the top of page 19.

8 You were asked about this, you were asked about the  
9 requirements set out in the policy, the current policy,  
10 for a three-yearly audit. Now, can I ask you to look at  
11 what is the second 13.3. Do we in fact see there are  
12 two paragraphs 13.3s? Anyway, yes, can we look at  
13 second one, please, and it says:

14 "An audit of the processes outlined in this Policy,  
15 will be undertaken at 3-yearly intervals (minimum) to  
16 ensure compliance. Reports will be submitted to the  
17 Resuscitation and Deteriorating Patient Group for  
18 review."

19 And you deal with this in your paragraph 20 where  
20 you write as follows:

21 "EPUT acknowledges that the use of the word 'audit'  
22 in paragraph 13.3 may have created an expectation that  
23 discrete, standalone audit reports in the conventional  
24 sense would exist as identifiable documents. However,  
25 as explained above, this is not the case."

1           We've heard -- sorry. So just in terms of that  
2           provision, there are no audits and no audits taking  
3           place. Have we understood that correctly?

4   **A.** That's correct. I think what is slightly confusing is  
5           the review of the policy itself because most of our  
6           policies have a shelf life of about three years and  
7           they're reviewed either at the three-year period or  
8           earlier, if there is any new guidance that might  
9           materially affect the content of the policy. So that is  
10          what it is referring to.

11   **Q.** So the policy is fairly misleading as to that  
12          requirement? It's suggesting something else.

13   **A.** That's correct, yeah. The policy is saying the  
14          content -- sorry, an audit of process is outlined in the  
15          policy.

16   **Q.** All right. Looking down to 13.5, we've heard from  
17          Mr Archer that the annual reports have not materialised.

18   **A.** Yeah, the quarterly reports have, but annual report  
19          I have not seen one.

20   **Q.** So the quarterly reports you say, are in place of,  
21          instead of, or doing the same thing but more often than  
22          the yearly reports?

23   **A.** That's correct.

24   **Q.** But you haven't provided any of those to the Inquiry --

25   **A.** Um --

1 Q. -- when asked for the audits?

2 A. I'm not sure of that.

3 Q. All right. Separately, but just while we're on the  
4 question of audits, at your paragraph 21 we see that you  
5 were asked to provide audits of the arrangement that  
6 EPUT had in place for a period of time with Basildon and  
7 Thurrock University Hospital Trust to provide  
8 resuscitation services. But you also were not able to  
9 provide those.

10 A. That's correct.

11 Q. But I think you asked us to go and ask them for them  
12 instead. Or suggested that we did; yes?

13 A. Yes.

14 Q. All right. Those can be taken down, please. I'm going  
15 to move to a different topic altogether. And this is in  
16 relation to Professor Soar's views, please.

17 Can I just see if we agree on some general  
18 principles, please.

19 Let's just see if we can agree on the principles.  
20 The larger majority of cardiac arrests -- we're now  
21 moving to the clinical position -- in mental health  
22 inpatient settings, are secondary cardiac arrests.

23 A. That's correct, yeah.

24 Q. And those are secondary to trigger events such as  
25 self-harm or injury or overdose, for example?

1   **A.** That's correct.

2   **Q.** And that the patient goes into cardiac arrest at the end  
3       of the process which starts with the trigger event?

4   **A.** That's correct, yes.

5   **Q.** That the best chance of saving a patient's life is to  
6       prevent the cardiac arrest?

7   **A.** That's right.

8   **Q.** And in an ideal world it's to prevent the trigger event  
9       in the first place, but if there is an emergency to try  
10      to prevent the patient going into cardiac arrest?

11  **A.** That's correct, yeah.

12  **Q.** So if the trigger event takes place by discovering the  
13      patient quickly?

14  **A.** Yes.

15  **Q.** By recognising the signs of deterioration?

16  **A.** That's correct.

17  **Q.** By undertaking the necessary interventions to prevent  
18      the patient going into cardiac arrest?

19  **A.** Yes.

20  **Q.** And that those interventions are time critical; would  
21      you agree with that?

22  **A.** That's correct, yeah.

23  **Q.** Do you agree that the RCUK Quality Standards state that  
24      the staff who respond immediately must have the  
25      following minimal skills, which is competent delivery of

1 CPR?

2 A. Yeah.

3 Q. Defibrillation?

4 A. Yeah.

5 Q. Basic airway interventions?

6 A. Yes.

7 Q. Including bag mask intervention and/or supraglottic

8 airway?

9 A. Yeah.

10 Q. And, in fact, they also say skills required for

11 immediate post-resuscitation care. And at EPUT, those

12 skills would now require the attendance of an

13 ILS-trained staff member?

14 A. That's correct.

15 Q. All right. In part one of his report, which you've had

16 an opportunity to read, Professor Soar's report; is that

17 right?

18 A. Yeah.

19 Q. Professor Soar provides clinical information as to

20 timings within these clinical events.

21 A. **(The witness nodded)**.

22 Q. I'm not going to go through them in details because

23 there are some very individual scenarios, but do you

24 agree that in certain events, certain ligature events,

25 for example, time from event to cardiac arrest could be

1 as quickly or as soon as about five minutes?

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

3 **Q.** And do you accept that in the context of a ligature or

4 a choking incident, for an example, that an immediate

5 response is required?

6 **A.** It is.

7 **Q.** And within seconds or certainly within at least

8 a minute?

9 **A.** That's correct.

10 **Q.** You have seen that Professor Soar expresses the opinion

11 that an individual trained in Immediate Life Support

12 should be available 24/7 within about the first minute

13 after the emergency is identified. That's his opinion.

14 Do you agree with that?

15 **A.** I agree. We do have ILS-trained staff available on all

16 shifts, although I understand our policy does not

17 necessarily mandate that.

18 **Q.** I will come back to that in a moment, but given the

19 additional skills that the person -- obtains on ILS

20 training, it needs to be an ILS-trained member of staff?

21 **A.** That is correct, in order to take the lead in the

22 resuscitation as well.

23 **Q.** To take the lead and particular certain airway

24 techniques, for example, skills are required?

25 **A.** That's correct.

1   **Q.** All right. Do you agree that the word "immediate" in  
2       Immediate Life Support should just be given its ordinary  
3       meaning, just straight away? "Immediate" means straight  
4       away?

5   **A.** That's correct.

6   **Q.** All right. And as I say, because the skills taught in  
7       the Immediate Life Support course are those required by  
8       first responders, at EPUT, the only members of staff  
9       with those skills are your ILS-trained nursing staff?

10  **A.** That is correct, inpatient staff, yeah.

11  **Q.** Do you agree in principle that those working in mental  
12       health inpatient units should receive training  
13       appropriate to the work they undertake rather than their  
14       job titles?

15  **A.** I agree.

16  **Q.** The Inquiry has heard evidence that mental health  
17       inpatient settings are increasingly staffed by  
18       unregistered healthcare staff such as healthcare  
19       assistants, and that this is equally the case at EPUT;  
20       is that right?

21  **A.** I think we have a roughly 50/50 split.

22  **Q.** We heard that from Mr Archer, and we'll come perhaps and  
23       deal with that with Ms Sheridan, but that healthcare  
24       assistants have increasing responsibilities, including  
25       observations, monitoring vital signs, and so on?

1   **A.** That is correct. They do that.

2   **Q.** The Inquiry has also heard evidence from a variety of  
3       sources that in mental health inpatient settings, it is  
4       unregistered staff, healthcare assistants, that are  
5       often first on the scene of an emergency; do you agree?

6   **A.** Not necessarily, it depends --

7   **Q.** Sorry, can I just ask, first, do you agree that the  
8       Inquiry has heard that evidence?

9   **A.** Yes.

10   **Q.** We've heard it from staff?

11   **A.** Yeah.

12   **Q.** We've heard it from families?

13   **A.** Yeah.

14   **Q.** Yes? And we know from our investigations, from some of  
15       the illustrative cases, that that was the case?

16   **A.** That is correct.

17   **Q.** So don't worry, I will let you go back to qualify your  
18       answer, but do you agree that unqualified or  
19       unregistered staff may be the first responders?

20   **A.** Maybe, yes.

21   **Q.** All right. You go ahead and qualify what you wanted to  
22       say.

23   **A.** Well, again, like we heard in one of the previous  
24       witness statements, it depends on when the incident  
25       happens. When it happens during the day, we have many

1 ILS-trained staff available, including doctors on the  
2 ward. You know, for example on a ward review day, you  
3 could have four doctors available on the ward, if an  
4 incident were to happen that time. But I know that  
5 incidents can happen any time, they're unpredictable and  
6 we need to cater to the lowest common denominator, as it  
7 were. So if an incident happens out of hours, we have  
8 ILS-trained staff available and we have provided some  
9 numbers in terms of -- on some of the wards, how many  
10 ILS-trained staff we have on those wards. We can  
11 provide more numbers if the Inquiry requires it.

12 But healthcare assistants are part of the team that  
13 attempts resuscitation. Like we heard yesterday from  
14 NHS England, I would be in favour of allocating specific  
15 tasks to them. I think a lot depends on somebody who is  
16 leading the team. When human factors come into play,  
17 you know, when somebody collapses or has a cardiac  
18 arrest, it can be quite a traumatic event for staff,  
19 during, as well as after, and they often are unable to  
20 make decisions.

21 So if there is a leader directing the resuscitation,  
22 following the orders of somebody in that situation is  
23 probably far easier than to lead the situation  
24 themselves. And -- sorry, can I just --

25 Q. No, of course, finish.

1   **A.** If we are expecting unregistered staff, nursing staff  
2       particularly, who may be quite new to healthcare, to  
3       take on that leading role, that will be quite a big ask  
4       of them, in my view.

5   **Q.** Sorry, I don't want to --

6   **A.** Sorry, I'll stop there.

7   **Q.** No. Can we just focus on this question though:  
8       I appreciate that you are giving evidence about your  
9       view as to the suitability or otherwise for ILS training  
10      or for non-registered, non-qualified staff, but I'm  
11      asking you about something quite specific here, which is  
12      about the fact that we've heard evidence, and we know  
13      that HCAs, unqualified staff, unregistered staff,  
14      non-registered staff, are often the first responders.  
15      So whether or not there might be other people there,  
16      they are often the first there; do you agree?

17   **A.** I agree.

18   **Q.** And that -- whilst you say at paragraph, I think 236 of  
19      your joint statement, you say:  
20            "EPUT cannot accept the position ... that it is  
21            common for HCAs to be left alone with patients during  
22            resuscitation ..."

23            You acknowledge that there have been instances in  
24            which HCAs have been present with a patient during parts  
25            of a resuscitation event without an ILS-trained

1 Registered Nurse or doctors remaining alongside them.

2 So it does happen?

3 **A.** It has happened in this particular instance, but

4 following that, we have made sure staff understand that

5 an ILS-trained person has to be either leading or by the

6 side of the patient, and HCAs could have gone to make

7 that call.

8 **Q.** What if -- sorry.

9 **A.** Sorry, if the call was to the emergency services asking

10 for help, shouting for help.

11 **THE CHAIR:** Can I just ask there, you have been quite clear

12 that responding immediately, and we've defined that now

13 as within a minute, practically, is very important.

14 Would you accept that it takes sometimes a minute for

15 somebody to go and fetch somebody who might be

16 ILS-trained, that every second counts, and that an HCA

17 by themselves may well have to take the first steps in

18 resuscitation?

19 **A.** Yes, they do, with their BLS training because it

20 provides them with the immediate skills, like we have

21 heard yesterday, with the ability to stabilise the

22 situation. But they don't often go, leave the patient,

23 or the expectation is that they don't leave the patient

24 to go and fetch help. They shout or they have got

25 communication systems which can contact other staff.

1     **THE CHAIR:** But they are left with the patient in those  
2           critical first minutes?

3     **A.** Yes, that's right. Help should arrive within seconds  
4           because there are other staff on the ward who should be  
5           available to come and help.

6     **MS HARRIS:** You talked about an incident. Were you  
7           referring to the position on 6 June 2025, which is  
8           a death that the Inquiry has been made aware of where an  
9           HCA was present without ILS-trained staff support? Was  
10          that the incident you were referring to?

11    **A.** That is correct, yeah.

12    **Q.** At paragraph 237 of your joint statement you provide the  
13          following, I think, by way of attempt to reassure. You  
14          say, and you've just picked up on this, that:

15                "EPUT's primary mitigation for this risk is the  
16          requirement that every registered nurse ... within an  
17          inpatient setting receives ILS training. The intention  
18          of this requirement is to ensure that on any shift there  
19          will be [and these are your words] at least one  
20          ILS-trained Registered Nurse present on the ward who is  
21          able to attend and lead the resuscitation attempt."

22                So is it EPUT's position that the primary mitigation  
23          is at least one nurse?

24    **A.** That is correct, but often we have more.

25    **Q.** But your position is there needs to be at least one. So

1           it could be just one?

2   **A.**   That's right, yeah.

3   **Q.**   Yes.   What if that nurse is on their lunch break?

4   **A.**   During the day we have more than one ILS-trained nurse  
5           on the ward.

6   **Q.**   What if that nurse has gone to the loo in the middle of  
7           the night?

8   **A.**   Again, I would defer it to my colleague Ann to talk  
9           about the nursing staff skill mix on the ward both  
10          within and outside of hours, but it says "at least one",  
11          so I would expect there to be more than that.

12  **Q.**   All right.   Because I was going to ask you this, and you  
13          may say I need to ask Ms Sheridan about this: do you  
14          consider that the presence on wards of an ILS-trained  
15          nurse is sufficient to meet a recommendation that we  
16          need -- that there needs to be an ILS-trained individual  
17          there within a minute?

18  **A.**   Yes.   The staff are on the wards and they can reach any  
19          bedroom for instance or any corner of the ward within  
20          a minute.

21  **Q.**   And I think you've agreed with the general principle  
22          that clinical staff most likely to respond immediately  
23          require higher level training than that in BLS?

24  **A.**   If, for example, healthcare assistant is doing the  
25          observations on a patient, for instance, they will be

1 the first one to see an event happening or witness an  
2 untoward event happening, but how it works on our wards  
3 is a lot of the time, particularly during the day,  
4 patients are in the lounge area. They are either  
5 sitting, taking part in activities, or doing something  
6 on their own. So they are being observed by more than  
7 one nurse. Our nursing officers are situated in such  
8 a way that they have a clear line of sight to both sides  
9 of the ward. So only if the patient is in their  
10 bedrooms and they're not on a level of observation, that  
11 that is a situation where they're not being watched or  
12 overseen, if you like. But in most other situations,  
13 particularly during the day, patients are in the lounge  
14 area. We have a male and a female lounge where patients  
15 may be doing activities with OT assistants and other  
16 people, taking part in therapy sessions with psychology  
17 or being seen by a doctor, et cetera.

18 So I would qualify the statement that the healthcare  
19 assistant is always or very often the only person that  
20 has an oversight of the patient.

21 **Q.** Sorry, I don't again want to interrupt you, but when  
22 patients go to self-harm or when the events that we're  
23 concerned with, the trigger events that lead to cardiac  
24 arrest take place, does the patient not normally take  
25 themselves to their rooms for those?

1   **A.** They might do, but we do have a requirement that  
2       patients do not isolate themselves in their room unless  
3       there is a specific reason to do so, and taking part in  
4       the ward activities is part of the treatment in addition  
5       to, you know, taking medications or taking part in  
6       sessions, et cetera, because that is all part of the  
7       treatment plan and care plan and it's individualised to  
8       each patient and that's what helps them to, kind of,  
9       towards recovery.

10   **Q.** Again, I don't want to interrupt you but we are now  
11       talking about observations and therapeutic engagement, a  
12       different provision that EPUT, as you say, needs to  
13       provide in order keep that patient within a central  
14       place. And I would like to just go back, if I may, to  
15       the question of whether or not HCAs or unregistered,  
16       non-registered staff, require a certain level of  
17       training. It would appear from your evidence, you tell  
18       me, do you accept or do you consider there's any need  
19       for EPUT to reconsider the level of life support  
20       training given to HCAs?

21   **A.** Again, I would have concerns about the responsibilities  
22       placed on HCAs who may not have the necessarily clinical  
23       background to understand the context of training, and we  
24       may be putting them in the position of, you know, some  
25       of the least qualified staff to perform some of the most

1 complex tasks that can happen on a mental health ward.  
2 So that is one aspect, whether it is appropriate or  
3 suitable for them or not.

4 The other aspect is, obviously, if that is what we  
5 choose to do, then it's the question of the logistics  
6 and training them and keeping them up to date,  
7 et cetera, but that's an implementation issue rather  
8 than the principle we are talking about.

9 **Q.** Let's go back to the principle, if I may. So, first of  
10 all, you have said that you wouldn't want to put them in  
11 that position, that you wouldn't want to give them the  
12 responsibility. It seems that, from your evidence, that  
13 you're suggesting it's better that they don't have those  
14 skills at all than have those skills in case they need  
15 them?

16 **A.** They have BLS skills. They do get BLS training at  
17 present, and that is kind of the recommended standard.  
18 And as we heard yesterday, these situations are quite  
19 rare, infrequent, and they are quite anxiety-provoking  
20 for even the best trained professionals, because of the  
21 rarity with which these things happen. So, in those  
22 moments I think the human factors come into play, and  
23 although experience and confidence matters, it's not  
24 necessarily acquired through training. Training is just  
25 one aspect of it. And, you know, so I would say that it

1 would be something that has to be thought through very  
2 carefully before expecting healthcare assistants to be  
3 able to provide that level of support for patients when  
4 the resuscitation effort -- apologies, I'm  
5 interrupting -- when the resuscitation effort is a team  
6 effort.

7 **THE CHAIR:** You've just said that they are anxiety-provoking  
8 for even the best trained staff, largely due to the  
9 infrequency and the distress of the situation. Is that  
10 not an argument for ensuring that everybody has the  
11 skills and the confidence, and is given the resilience,  
12 as far as is possible, to meet those very distressing  
13 circumstances? Is there not a duty to the staff in  
14 question to give them the best tools available to them,  
15 even if in some cases it may be quite a stretch?

16 **A.** If we look at it from that perspective, yes, but it --  
17 I mean, I go back to how resuscitation works. It  
18 happens in a crisis. Staff are expected to perform  
19 a series of complex, skilled tasks in a perfect  
20 sequence. That's is when the outcomes are best, in  
21 terms of the patient, you know, surviving, et cetera.

22 When you're under a lot of stress, seeing somebody  
23 who you have developed a relationship with collapse, you  
24 know, some of our patients may be on the wards for  
25 several months so staff do develop a relationship with

1       them, it is like a family member, and in that moment,  
2       the way people react, staff react, it's difficult to  
3       predict. So we cannot assume, in my view, that giving  
4       them additional skills always raises their confidence.  
5       But I would rather they are trained in specific skills  
6       that the leader tells them what to do, whether it's  
7       intubation or attaching the AED or whatever aspect of  
8       resuscitation, because, like I said, it's a series of  
9       complex skills that need to be executed almost perfectly  
10      for it to work well, and all under time pressure in  
11      a situation which may not be ideal because this could  
12      happen at night, for instance, or where, you know, the  
13      patient will have to be moved from their bed on to the  
14      floor, in order to attempt resuscitation, et cetera.

15   **MS HARRIS:** Dr Suresh, your evidence pre-supposes that  
16      there's a person who can exercise leadership present or  
17      nearby, or there is an ILS-trained member of staff  
18      nearby. Can I say this, I don't think anybody is  
19      suggesting that HCAs would necessarily step up in place  
20      of a doctor or nurse if they were present; what I'm  
21      trying to understand, what the Inquiry needs to  
22      understand, is the position where the HCA is the first  
23      on the scene or the ILS-trained member of staff is not  
24      nearby, or available within that crucial minute. Are  
25      you suggesting it is better for that HCA not to have

1       those skills and not to be trained in case it's  
2       stressful, rather than at least have the necessary  
3       skills and be trained so that they could do something to  
4       assist a person that they may have been engaging with  
5       for six months? Is that your position?

6   **A.** The BLS training equips them to do what they need to do  
7       within the first minute. Right? So, you know, that  
8       provides them the skills to stabilise the situation  
9       until help arrives. And as I said, it's not something  
10      they can do it on their own; it is a team effort,  
11      because different members of the team have to perform  
12      different tasks, including a leader and a scribe and  
13      somebody who is trying to let the emergency services in,  
14      et cetera, et cetera. So it is a team effort. Yeah.  
15      That's what I would say.

16   **Q.** Professor Soar is very clear, as you know, that first of  
17      all, in his opinion, HCAs already involved in patient  
18      care would be able to successfully complete an ILS  
19      course, and that also, in his opinion, that those who  
20      are acting or may act as first responders should  
21      complete an ILS course. Do you disagree with that?

22   **A.** I mean, like I said, in a mental health setting where  
23      these events are quite rare -- apologies -- it is best  
24      to allocate roles to staff and to identify a leader who  
25      can actually allocate those roles and to decide those

1 roles at the start of every shift. That would enable  
2 a team to come together or form very quickly and make  
3 sure that each person is able to perform their specific  
4 allocated task to a high standard. I think what happens  
5 in these situations is that there is a lot of  
6 expectation to do a lot of things within a very short  
7 period of time. That is what adds to the stress of the  
8 situation, in addition to the emotional responses of the  
9 staff towards a situation that happens quite rarely.

10 **Q.** Can I just ask this: do you agree that there's no  
11 reason, from a knowledge, an anatomical knowledge or  
12 physiological knowledge perspective, that they couldn't  
13 do the course?

14 **A.** Again, each HCA has a different level of background in  
15 terms of their clinical knowledge. There is no reason  
16 why we cannot supplement the required knowledge of an  
17 anatomy and physiology by doing a pre-module, for  
18 instance. That will enable them to be more comfortable  
19 with what they are doing. Because these are invasive  
20 procedures and to expect someone with no clinical  
21 background to be able to do that would be quite a big  
22 ask.

23 **Q.** Mr Archer maintained his position yesterday, as you will  
24 have heard, that it wasn't suitable, the training wasn't  
25 suitable for HCAs. But he did, however, say that it may

1           be suitable should they be provided with a separate  
2           module on anatomy or something?

3   **A.**   That's correct.

4   **Q.**   Would you agree with that?

5   **A.**   I agree with that.   That's what I just said.

6   **Q.**   That's what -- sorry.   I know, but I mean by doing a  
7           separate module at EPUT and he said it would be a matter  
8           for those in governance.

9   **A.**   That is correct.   We have to carefully consider what  
10          that means and we will have to take some expert advice  
11          as well on that one, on not only the content but how it  
12          is delivered, et cetera.

13   **Q.**   But it's a proposition you would consider?

14   **A.**   Definitely.

15   **Q.**   All right.

16                Thank you, Dr Suresh, that is all the questions I'm  
17                going to ask you at the moment because you have already  
18                indicated that other questions may be best addressed to  
19                your colleague, Ms Sheridan.

20                So Chair, can I invite you, I'm just going to  
21                rise --

22   **THE CHAIR:**   We just need to change over.

23   **MS HARRIS:**   Change over, yes, please.   That's right.

24   **THE CHAIR:**   Before you go, can I thank you very much indeed  
25                for giving evidence.

1     **THE WITNESS:**   Thank you.

2     **THE CHAIR:**   Very helpful.

3     **(12.45 pm)**

4                                 **(A short break)**

5     **(12.50 pm)**

6     **THE CHAIR:**   Ms Harris.

7     **MS HARRIS:**   Thank you, Chair, good afternoon.

8                 And good afternoon, Ms Archer (sic), could the

9         witness be sworn, please.

10                               **MS ANN SHERIDAN (sworn)**

11                               **Questioned by MS HARRIS KC**

12    **MS HARRIS:**   Ms Sheridan, could you state your full name for

13         the record, please.

14    **A.**   Ann Sheridan.

15    **Q.**   Ms Sheridan, you have provided, I think, a total of

16         seven witness statements to the Inquiry and we are

17         concerned today with two of them.  We are concerned with

18         your sixth statement which is dated 1 June 2026; is that

19         right?

20    **A.**   That's correct.

21    **Q.**   Thank you, and the joint statement that you submitted

22         with your colleague, Dr Suresh, which is dated

23         9 September 2026.

24    **A.**   That's correct.

25    **Q.**   There should be, I hope, a copy of those statements in

1 front of you in that bundle, should you need to refer to  
2 them.

3 **A.** Yes.

4 **Q.** Thank you. Good. But can you confirm that you signed  
5 the final page of each statement?

6 **A.** Yes.

7 **Q.** And that you've had an opportunity to read those  
8 statements recently?

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

10 **Q.** Is there anything you want to change within those  
11 statements?

12 **A.** No.

13 **Q.** Do you stand by those statements?

14 **A.** I do.

15 **Q.** They will form the basis of your evidence to the Inquiry  
16 today along with the answers that you give.

17 **A.** Thank you.

18 **Q.** And we won't need to read them out, or anything of that  
19 nature.

20 You too have also provided a number of exhibits to  
21 the Inquiry.

22 **A.** That's correct.

23 **Q.** Just by way of your background, and we've heard already  
24 about your position, but can you confirm yourself that  
25 you're currently the Executive Nurse at EPUT?

1   **A.**   That's correct.

2   **Q.**   You've held this position, I think, since February 2024,  
3       which is when you started your employment with EPUT?

4   **A.**   That's correct.

5   **Q.**   Are you also a Registered General Nurse, a Registered  
6       Mental Health Nurse, and a qualified social worker?

7   **A.**   That's correct.

8   **Q.**   You have provided the statements and indeed the two  
9       statements with which we're concerned today, on behalf  
10      of EPUT, as the organisation, in your capacity as the  
11      Executive Nurse?

12  **A.**   That's correct.

13  **Q.**   But you are also able to assist the Inquiry from your  
14      own clinical experience if need be.

15  **A.**   I am, yes.

16  **Q.**   Like your colleague, Dr Suresh, you too have indicated  
17      that not all the matters within the statements are your  
18      own personal knowledge.

19  **A.**   That's correct.

20  **Q.**   And you too have relied on information provided by the  
21      Inquiry project team and subject matter experts --

22  **A.**   That's correct.

23  **Q.**   -- that you too were part of the discussion with  
24      Dr Suresh as to which areas you might be able to best  
25      assist the Chair.

1   **A.**   That's correct.

2   **Q.**   And, in fact, you have been sitting in today and you  
3       have heard when Dr Suresh has said, "Perhaps you would  
4       take that up with my colleague"?

5   **A.**   Yes.

6   **Q.**   All right so I'm going to jump in straight away --  
7       sorry.

8   **A.**   Is it just okay if I can offer my condolences?

9   **Q.**   Of course, yes, you wanted to say a few words.

10  **A.**   Yes, I just wanted to offer my personal and professional  
11       condolences to all those families who have been affected  
12       by loved ones who received care from Mental Health  
13       Services in Essex, thank you.

14  **Q.**   Thank you, Ms Sheridan.

15       I'm going to then jump in, if I may, straight away  
16       to one of the topics that your colleague suggested  
17       I raise with you, and this is the question of staffing  
18       more generally --

19  **A.**   Yes.

20  **Q.**   -- as it pertains to this topic. Now, we have already,  
21       and you were sitting in here, looked at duties within  
22       the relevant policy, CLP14, and we will have noted from  
23       that policy that service and unit managers are  
24       responsible for ensuring that all staff, including new  
25       employees, whether temporary or substantive, are made

1           aware of that CPR Policy?

2   **A.**   Yes.

3   **Q.**   That CLP14, and that of course is the consolidated  
4           policy that was updated in March this year.

5   **A.**   **(The witness nodded)**.

6   **Q.**   You're nodding. You may need to say, "Yes," for the  
7           transcriber.

8   **A.**   Sorry. Yes.

9   **Q.**   Thank you. And you go on to say at your paragraph 103  
10          of the joint statement -- I'm not to going to ask that  
11          it's put up, but if you want to turn to it, it is 103,  
12          but I will read it, that that responsibility means  
13          ensuring that the policy is operationalised within the  
14          ward environment, that staff are familiar with its  
15          requirements, and that any local arrangements necessary  
16          to give effect to its provisions are put in place and  
17          maintained.

18                 And you go on to say at paragraph 104, for example,  
19          that the location of resuscitation bags within each ward  
20          or clinical area is determined at ward level in  
21          collaboration with relevant subject matter experts.

22                 Sorry, I should give you an opportunity ...

23   **A.**   Yes, that's fine. Thank you.

24   **Q.**   Just picking up, as I said, I'm picking up on, if you  
25          like, somewhat random matters because your colleague

1 suggested I did. So in terms of resuscitation bags on  
2 the wards in EPUT, do we understand that they could  
3 be -- I don't mean anywhere, but the location could  
4 differ depending on the ward you're on?

5 **A.** Yes, it could differ depending on the layout of the  
6 ward, yes, but it would normally be in the clinic room  
7 but the clinic room may be different in every ward, how  
8 it's located.

9 **Q.** You say normally in the clinic room?

10 **A.** Yes.

11 **Q.** I was going to ask you about that because on Monday we  
12 heard evidence from a comparator trust, I don't know if  
13 you're aware of this --

14 **A.** Yes.

15 **Q.** -- ELFT, that in that organisation, bar one ward,  
16 I think, resuscitation bags were always kept in the same  
17 place.

18 **A.** Yes.

19 **Q.** And do you consider that there is merit to  
20 a -- (overspeaking) -- consistency?

21 **A.** Absolutely, yes.

22 **Q.** In fact, dealing with just again, taking isolated  
23 matters, dealing with ligature cutters or the question  
24 of ligature cutters in your joint statement --

25 **A.** Yes.

1   **Q.**   -- you say this:

2           "Prescribing the same designated locations across

3           all wards provides consistency for staff and reduces

4           ambiguity, which is of particular importance in

5           a time-critical situation when knowing exactly where the

6           equipment is held is essential."

7           I mean, that's all emergency equipment, isn't it?

8   **A.**   Yes, exactly.

9   **Q.**   As well as ligature cutters?

10  **A.**   Yes.

11  **Q.**   "This is not a matter of convenience but considered

12           safety measure designed to ensure that ligature cutters

13           are both accessible and immediately identifiable at the

14           point of need."

15  **A.**   That is correct.

16  **Q.**   You also say within your statement later on that EPUT

17           provides support to individuals who carry the

18           responsibility of the matters referred to, that is where

19           equipment is kept, for example, and local arrangements,

20           through access to a range of subject matter experts who

21           are available to contribute to local decision making.

22           And the subject matter experts include the Resuscitation

23           Training Officer, the Health and Safety Compliance Team,

24           and the Estates and Facilities function?

25  **A.**   That's correct, yes.

1 Q. And so they deal, I think, with also environmental  
2 issues such as --

3 A. They do.

4 Q. -- ligature points and risks around ligature points?

5 A. That's correct, and they will work in partnership with  
6 the Ward Manager in carrying out those assessments.

7 Q. All right.

8 Reference is made there to the Resuscitation  
9 Training Officer. Is this another responsibility that  
10 falls under Nicholas Archer?

11 A. Yes, but I'd also say that that in support of that we  
12 have Resuscitation Link workers and Physical Health Link  
13 workers of which there's over 100 of those colleagues  
14 across our inpatient services. So these are staff who  
15 have a real interest, and they will support in that work  
16 as well. They'll also be complemented by the  
17 Professional Nurse Educators. This is a relatively new  
18 role in EPUT, and these posts have been introduced about  
19 two years ago following the Time to Care investment, and  
20 also, they align with the national -- what was  
21 nationally being decided at that time around those  
22 Professional Nurse Educators supporting frontline nurses  
23 in sort of translating learning into practice.

24 Q. All right. So they are all feeding into decisions --

25 A. Exactly.

1 Q. -- about how the ward should be run.

2 Do they feed into the induction process or improving

3 the induction process that we looked at this morning?

4 A. Yes, absolutely. I mean, the induction process will

5 always be dynamic and there will always be that

6 opportunity for people to actually improve and think

7 what difference needs to be done.

8 Q. Okay. What is not Mr Archer's responsibility, because

9 we've heard he's got quite a lot of responsibilities, is

10 staffing?

11 A. No, he's not responsible for staffing.

12 Q. That lies, we know from paragraph 112 of your witness

13 statement, with team managers and roster managers?

14 A. That's correct. And the team manager will be the roster

15 manager.

16 Q. Of course. Because you say:

17 "For ensuring the safe staffing of the ward and team

18 and that there are sufficient staff in the right place

19 at the right time, the roster must reflect minimum

20 staffing levels covering both the number of staff

21 required and the skill mix required including the

22 experience, competencies, and gender of staff, by shift

23 and by day."

24 A. That is correct.

25 Q. That includes night shift?

1   **A.** Yes. Would you like me to elaborate a bit on that?

2   **Q.** Well, can I just ask you this first.

3   **A.** Yes, sure.

4   **Q.** At paragraph 114 you also point out that HR61 provides

5       that the use of bank and agency staff for nights and

6       weekends should be avoided where possible.

7   **A.** That is correct.

8   **Q.** Why is that in particular?

9   **A.** Well, I think obviously the use of agency and bank --

10       first of all, I'd say that our bank staff are very much

11       part of the substantive staff within EPUT so I'd want to

12       make that distinction, but we know with agency staff

13       that that lack of continuity of care increases patient

14       safety risks and so we really want to ensure that we

15       have that continuity. And I would just add to that that

16       there are daily staffing calls that are supported by

17       senior nurses, and on a Thursday, myself and the Chief

18       People Officer join those calls where we actually look

19       at the previous seven days and the following seven days,

20       just to check, is there any issues, what's happening,

21       et cetera? And certainly any agency staff, I and that

22       person will be made aware of.

23       And we have -- we have an agreement that actually

24       where we might be thinking, oh, we can't find

25       a non-registered member of staff because that's been

1 challenged, you know, whatever -- and these are very  
2 rare situations now -- I insist that it has to be  
3 a registrant agency member of staff to give that extra  
4 assurance around that sort of patient safety and support  
5 for ward staff.

6 **Q.** All right. I stopped you earlier when you wanted to  
7 give more explanation. I don't know if you wanted to  
8 give more explanation or whether I ask questions,  
9 because you go on to say in your paragraph 115 that when  
10 the gap in the skill mix is identified, first of all you  
11 make enquiries with ward and department staff about  
12 whether people want to take bank duties because, as you  
13 say, they are part of your substantive staff?

14 **A.** Yes.

15 **Q.** But if not, if that's not possible, then clinical  
16 judgement must be exercised. Can you tell us about  
17 that? And that probably feeds into the additional  
18 information you wanted to give us about how you staff  
19 the wards?

20 **A.** Yes, I just wanted to explain a little bit about the  
21 safer staffing mechanisms. So obviously the Trust  
22 adheres to the national safer staffing requirements in  
23 mental health, it's called the MHOST, the Mental Health  
24 Oversight Safer Staffing Tool, and that really sort of  
25 sets out how mental health wards are staffed, and it's

1 an evidence-based tool looking at acuity versus  
2 dependency but also on clinical judgement alongside some  
3 quality indicators, and that process, which happens  
4 twice a year, then facilitates the staffing of mental  
5 health wards, so really determining the level and type  
6 of staff that is aligned with the acuity of that ward,  
7 so that you have -- the idea is that you have the right  
8 skill for the right level of care for every patient on  
9 the ward, and the clinical judgement is around those  
10 clinicians, including unregistered staff, being able to  
11 say: well, actually, this ward is a little bit busy or  
12 this ward, we have a garden where we have to support and  
13 access. So it gives that personal approach to how we  
14 deal with safer staffing.

15 **THE CHAIR:** Sorry, how immediate is that?

16 **A.** How immediate is the ...?

17 **THE CHAIR:** The assessment of the acuity, the need --

18 **A.** Yes, well, obviously, we do the safer staffing twice  
19 a year but we would constantly be doing it, if people  
20 think: oh, this isn't actually working, those daily  
21 calls are actually around getting that acuity right, and  
22 there will be times that we will have to look at  
23 additional staff, to ensure that we actually are  
24 supporting patients with the right level of support. So  
25 I'd want to emphasise it's not a once-off and can't be

1       revisited.

2       **THE CHAIR:** Thank you.

3       **MS HARRIS:** In terms of, again, of that clinical judgement,  
4       I think we've heard about differing staffing levels and  
5       I'm going to ask you a little bit more about it in just  
6       a moment, but my understanding from your statement is  
7       that you may have occasions whereby you are struggling  
8       to staff a particular shift or to staff a particular  
9       ward for a particular shift. And you need to make  
10      decisions then about the make-up. So we've heard, for  
11      example, about whether there would be one ILS-trained  
12      member or whether there would be three nurses available,  
13      and so on and so forth. Are those decisions having to  
14      be made on a regular basis? You know, how many  
15      ILS-trained individuals do we have available? Can we  
16      have a shift here which has got four and two? Or --  
17      sorry, does that question make sense?

18     **A.** Yes, absolutely, that makes sense. We will always be  
19      looking at, sort of, the number of our registrant staff  
20      available and the skills they have. Now, through our  
21      training compliance, we're at about 90%, so the majority  
22      of our registrant staff, if we were like redeploying  
23      staff from another area, would be ILS-trained. And very  
24      much at that ward level, the role of the Ward Manager or  
25      the nurse in charge -- and I know this because this is

1 a role that I have done -- you're very much thinking  
2 about what, you know, how can I ensure that my ward is  
3 safe? And in fact, one of the Tendable audits around  
4 Cleared to Care, which is done on every shift, looks at  
5 that: have I got the right complement of staff? So, you  
6 would be asking that question.

7 Q. We heard from Mr Archer yesterday about registered to  
8 non-registered being 50/50?

9 A. Yes.

10 Q. And 3 to 3 he said --

11 A. Yes.

12 Q. -- but obviously flexes with acuity, as you have just  
13 described.

14 A. Yes.

15 Q. And he said, and these were his words, it was  
16 "absolutely the operational model".

17 A. That's correct.

18 Q. We know that Registered Nurse are all ILS-trained at  
19 EPUT or should be, registered nurses supported by at  
20 least one if not two or three doctors, he said,  
21 potentially supported by a site coordinator who might  
22 also be supported by nursing staff from additional ward.  
23 That was his evidence, and you heard that.

24 A. Yes.

25 Q. Would you agree, however, that that is probably not the

1 reality at night or at the weekends?

2 **A.** It is true, I think at night, you would see less staff,  
3 but actually, every unit base does have an additional  
4 site coordinator, a Band 7, Band 6 or Band 7, which is  
5 in addition to the ward to be available to support those  
6 arrangements where you were speaking a little while ago  
7 about where maybe on those rare occasions wards where we  
8 might see one member of staff, one trained member of  
9 staff with a number of unregistered members of staff,  
10 that member of staff can then join that ward to provide  
11 that additional staffing.

12 **Q.** You say rare but those occasions do happen?

13 **A.** They do happen yes, but those wards where you would see  
14 lower staff is usually as a reflection that they will  
15 have a lower number of beds, but that isn't to say that  
16 actually we don't need to have the right level of staff  
17 so that's why that extra nurse who will be supporting  
18 the site is also available to support that ward.

19 **THE CHAIR:** How rare is rare? How often does it happen that  
20 you have just one registered?

21 **A.** Well, it's actually very rare. Now, obviously on some  
22 of the wards, like Rainbow, the mother and baby unit, at  
23 night there is one member of staff but supported by the  
24 site nurse in charge, but if there is any other ward  
25 that's meant to have more, that will be picked up on the

1       daily call that my colleagues are involved in or I am  
2       involved in and I will ensure that we have the right  
3       numbers of staff because that's really important to me.

4       **THE CHAIR:** That's the ideal situation, you're able to plug  
5       the gap.

6       **A.** Yes.

7       **THE CHAIR:** But it does happen, does it, that sometimes you  
8       just can't find a member of staff or a member of staff  
9       calls in sick very late or ...

10      **A.** In those occasions, because this is so important to get  
11      this right and obviously from previous incidents, there  
12      will be a coming together at that local care unit level  
13      to decide where additional staff can be found, and we  
14      might be ringing up people to see if they could change  
15      their shift, I know it's not ideal, but thinking of  
16      alternatives to try to ensure that actually, a unit is  
17      covered. And if something should happen after 5 o'clock  
18      when people are -- there are less managers around, the  
19      on-call director is available to have those  
20      conversations, and there are also at weekends review of  
21      staffing on the weekend calls where there will be  
22      a senior manager and a director on call.

23      **THE CHAIR:** Thank you.

24      **MS HARRIS:** Ms Sheridan, I am being asked if we can slow  
25      down a little bit.

1   **A.** Apologies.

2   **Q.** Because there is a transcript being taken, it's my fault

3       too.

4   **A.** Thank you.

5   **Q.** That's all right, you have a lot of information to give

6       us, so we will just pause.

7               But just picking up on your answer, then, to the

8       Chair, do you agree there are occasions when the ward

9       may only have access to one ILS Registered Nurse and one

10       doctor, and that doctor may be responsible for another

11       ward at the same time?

12   **A.** Yes, but that would be rare.

13   **Q.** Can I ask this: does ensuring the correct skills mix of

14       staff, you just talked about compliance of training

15       being at 90%, does ensuring the correct skill mix of

16       staff on each shift include considering whether the

17       staff are up to date on their training requirements?

18   **A.** Absolutely yes. And that's something that the Ward

19       Manager, when he or she is doing the roster, will,

20       actually, be looking at. They will have that

21       opportunity to say, "Oh, actually, is this person

22       up-to-date with this training? That training?" And

23       that is visible on the electronic sort of register that

24       the person will have. And in fact, I was speaking

25       recently to one of the witnesses who you spoke about

1       yesterday's statement and we're going to even improve  
2       that further around rostering because within the  
3       rostering system you will have your staff team and  
4       alongside that you can see their training needs.

5               So at the moment obviously the Ward Manager can go  
6       in to the electronic sort of people system and see their  
7       compliance, but they'd also know their compliance from  
8       their supervision and management of staff on the ward,  
9       because that's a conversation I will be having in  
10      supervision with the people I would be managing.  
11      Because I will be playing a part in deciding how that --  
12      you know, making sure that person gets their training,  
13      when that might be rostered in, et cetera.

14   **THE CHAIR:** We've heard evidence, and it relates perhaps to  
15      a time previously, but we have heard evidence that  
16      supervision is something that gets sacrificed on a busy  
17      ward really very often.

18   **A.** Yes.

19   **THE CHAIR:** What assurance can you give us that actually  
20      those conversations do take place and that staff really  
21      are being encouraged to, and required to, have the  
22      training they need?

23   **A.** Yeah, and I'm not going to dispute that. From working  
24      on wards myself I know when it gets very busy it is  
25      those things, like supervision and training, that get

1       sacrificed and yet they are so important. However, as  
2       EPUT has moved to a much more permanent staffing model  
3       and more permanent sort of leadership model, that  
4       opportunity for people to have supervision and appraisal  
5       is obviously more available now and it is also tracked  
6       as part of the compliance around training and  
7       supervision. So it is one of the areas that's reviewed  
8       and tracked.

9               However, I think having something and actually the  
10       quality of supervision, are two slightly different  
11       things. So certainly what I and my nursing colleagues  
12       have been looking at is how do we ensure that actually  
13       people get good quality supervision and get that  
14       opportunity to actually develop and learn.

15       **MS HARRIS:** Just two questions arising and then we will stop  
16       for lunch. Firstly, it's right that there's no bar to  
17       permanent staff working on the ward if they're not up to  
18       date with their training, is there?

19       **A.** How I'd like to answer that is, that I would -- for me,  
20       it's around that risk assessment. So, if there are  
21       people who are no longer compliant, then as a Ward  
22       Manager I would be looking from a risk perspective about  
23       how many other staff I have on that ward who have got  
24       the right level of skills, and I'd be putting in, I'd be  
25       putting in a plan to manage that.

1   **Q.** So that's what you would do?

2   **A.** And that's what I'd expect other colleagues to do as  
3       well, and that's what I tell other colleagues to do as  
4       well.

5   **Q.** All right. Because you -- the Trust don't stop, for  
6       operational reasons, the Trust don't stop people working  
7       when they're non-compliant?

8   **A.** They don't stop people working but they do expect people  
9       to get access to that training as soon as possible and  
10      my role as the Chief Nurse, because I spend quite a lot  
11      of time out in operational services, is to make sure, if  
12      those barriers exist -- and sometimes they do exist --  
13      to look at how we can address those. So people do get  
14      access to the right level of training and support.

15   **Q.** But it does follow that staff can be patient-facing on  
16      wards if they haven't, for example, completed their  
17      resuscitation training?

18   **A.** That can be but the expectation would be that a date  
19      would be in place for when that person is going to do  
20      the training, and they will be on that shift on  
21      a risk-managed basis. Has that ward got enough staff to  
22      adequately support an emergency situation should it  
23      arise? And of course, when we think of emergency  
24      situations, as Mr Archer was describing yesterday, there  
25      is that wider access to other staff and other wards who

1       would come to support as well.

2   **Q.** Finally this: you talk in your joint statement about the  
3       nurse in charge allocating relevant emergency response  
4       roles to staff on a shift at the start of a shift --

5   **A.** Yes.

6   **Q.** -- should a medical emergency arise. In practice, is  
7       that done at the beginning of the shift and he or she  
8       allocates in a group, or?

9   **A.** Yes, that will be done at the beginning of a shift and  
10       I was recently out on a clinical visit to one of the  
11       Basildon sites to Grangewater and I could see that that  
12       had actually happened, the colleagues were able to show  
13       me that they were able to identify that and had made  
14       a record of it. So yes, it would be at the beginning of  
15       the shift. When that shift coordinator comes in and  
16       takes the handover, that question he or she will be  
17       asking: have I got the right, you know, have I got the  
18       right team? And who is going to do what?

19   **Q.** And that person would know of the varying skills amongst  
20       the team in order to make that allocation?

21   **A.** Yes.

22   **Q.** It's Louise Borton who touches on that --

23   **A.** Yes, it is -- (overspeaking) --

24   **Q.** And is that the colleague -- (overspeaking) --

25   **A.** That's the colleague I was discussing, yes.

1   **Q.** And are these conversations you've had with her since  
2       seeing her witness statement?

3   **A.** No, I've had conversations with her and other people  
4       throughout my time when I go around visiting wards,  
5       et cetera, but we did have conversations around how we  
6       could make rosters more effective in being able to  
7       identify not just StatMand training requirements for  
8       medical emergencies but other training requirements as  
9       well, because it makes it much easier. You know, I'm  
10      really keen to make the processes and governance as easy  
11      as possible for people, busy people, working on the  
12      front line.

13   **Q.** Because she said:

14            "I believe consideration should be given to adopting  
15            a more structured team approach to emergency responses.  
16            Where practicable, staff commencing a shift could  
17            identify those with enhanced emergency response  
18            competencies, agree who would assume the team leader  
19            role in the event of a medical emergency and clarify  
20            potential responsibilities within the response team. In  
21            my view, this could help improve communication,  
22            leadership, role clarity and overall effectiveness  
23            during emergency incidents." [As read]

24   **A.** That is correct.

25   **Q.** Does that suggest to you that it's not being done?

1   **A.**   What I would say is that obviously we have got, as  
2       I said, we've got the Cleared to Care, which actually is  
3       what a coordinator does on each shift and there's that  
4       opportunity to obviously suggest who is going to do what  
5       and that's what I would expect if I was the nurse in  
6       charge because that is how you would run your shift.  
7       But obviously to make it as prescriptive or more  
8       prescriptive, we did talk about actually seeing that  
9       within the roster but as I say, I did see that in  
10      Basildon already happening.

11   **MS HARRIS:**   Chair, sorry, that was a little bit longer than  
12       I think I was supposed to be, but could we stop now  
13       I think until two o'clock, please.

14   **THE CHAIR:**   Two o'clock.

15   **(1.18 pm)**

16                                   **(The Short Adjournment)**

17   **(2.00 pm)**

18                                   **(Proceedings delayed)**

19   **(2.02 pm)**

20   **THE CHAIR:**   Ms Harris.

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

22       Ms Sheridan, good afternoon. I'd like to turn to an  
23       entirely different topic now, which is the processes  
24       that are in place at EPUT to identify issues or  
25       recurring issues, and to draft actions and to

1 disseminate learning from those particular issues, and  
2 I'd like to begin, if I may, with your sixth statement  
3 to the Inquiry, which is -- in fact, could we put this  
4 up, please -- it's EPUT024387 and it's page 4.

5 Hopefully that will save you having to look through  
6 the bundle, Ms Sheridan.

7 **A.** Thank you.

8 **Q.** It is paragraph 13. You say:

9 "The Trust currently undertakes a comprehensive and  
10 structured approach to identifying, addressing, and  
11 disseminating learning ... from internal investigations,  
12 Prevention of Future Deaths reports, and relating to  
13 resuscitation practices and procedures."

14 You then go on to say that:

15 "The Trust have in place a process for actions to be  
16 taken following an incident ..."

17 And at paragraph 15, you also identify that:

18 "During the period in which a number of these  
19 incidents occurred ..."

20 And I'm going to pause for a moment because you were  
21 asked about events after 2017 and in particular the  
22 illustrative cases -- you say that:

23 "... the Trust was operating within a highly  
24 pressured context including reliance on temporary  
25 staffing and the impact of the Covid-19 pandemic

1       restrictions."

2             And you list there the various challenges.

3             Now, you are aware that this Inquiry is particularly  
4       concerned to understand how, when things go wrong, EPUT  
5       learns from incidents, takes proper steps to ensure that  
6       staff learn from incidents, and make sure that the same  
7       mistakes or similar mistakes are not made again. That's  
8       one of the matters this Inquiry is particularly  
9       concerned with, and in fact you have dealt in your sixth  
10      statement and in your joint statement with that  
11      particular issue.

12            And in your sixth statement, in the original  
13      evidential request from your sixth statement, the  
14      Inquiry provided you, I think, with eight patient  
15      incidents to review and we asked you to provide an  
16      overview of what the Trust had learnt from those  
17      incidents and how you disseminated that learning. You  
18      actually included three more incidents within your  
19      review, and they were cases from which the Inquiry has  
20      heard from the families of those who died.

21            And to summarise what happened, you reviewed  
22      relevant action plans produced by the Trusts, you  
23      reviewed Prevention of Future Death Reports and  
24      responses and you provided a table with each incident  
25      learning and action.

1           If we look at your statement, I think at paragraph  
2       20 and 21, you say at 20:

3           "When a resuscitation happens, immediate learning  
4       and necessary actions are identified."

5           We've heard lots of evidence about how that might  
6       take place now, we've heard about hot debriefs for which  
7       there is no record because they're immediate, we've  
8       heard about SWARM huddle, we've heard about Datix  
9       reporting, we have heard about Resuscitation Event Forms  
10      and we've heard about various meetings where cases and  
11      reviews are presented.

12          And you go on to say at your paragraph 20:

13          "There is further learning gained through the  
14      patient safety incident review process, involving an  
15      investigation, agreeing if further changes are required  
16      and implementation of those changes."

17          And this cumulative learning, you say will occur  
18      over a period of time.

19          Do we understand from that, then, that that is not  
20      a quick process? That is a lengthy process?

21   **A.** Shall I give some context to what I've been doing since  
22      I've come into the Trust, which I think will answer  
23      that?

24   **Q.** Well, can you answer the question first, which is, does  
25      that tend to be a lengthy process?

1   **A.** In terms of the investigation?

2   **Q.** Yes, and agreeing if further changes are required and  
3       implementation of those changes?

4   **A.** It will depend on what comes up in the investigation,  
5       but we endeavour to get our investigation, if it is a  
6       patient safety incident report, we endeavour to get  
7       those done between three and six months. Of course  
8       there will be the initial SWARM which will identify  
9       immediate actions that will be taken, and obviously they  
10      won't just look at that one area because when an  
11      incident happens, the question we ask is: could this  
12      happen somewhere else? What does this mean for other  
13      areas in the Trust?

14           So obviously that SWARM will happen, there will be  
15      immediate actions put into place and then, if required,  
16      a further investigation will take place.

17   **Q.** Sorry, does that include the context or was there  
18      further context you wanted to add to that?

19   **A.** No, I was just going to say that when I came in to the  
20      Trust, one of the things I did was set up a Datix  
21      dashboard for each of the care units so that people were  
22      really clear, they could understand their patient safety  
23      incidents and in addition to that, we got additional  
24      support patient safety workers to work between Patient  
25      Safety Team and the care units to support that sort of

1 initial investigations. We also ensured that we had  
2 good, clinical oversight at a care unit level, and what  
3 I mean is that sort of medical oversight and the  
4 oversight of the Deputy Director of Quality and Safety  
5 to support that review.

6 We also looked at training of people to do  
7 investigations, and people who are Family Liaison  
8 Officers and then that we could ensure that  
9 investigations were being investigated and investigators  
10 were being supported. I just wanted to add that extra  
11 context.

12 **Q.** Thank you. Because at your paragraph 20, sorry, in your  
13 sixth statement, you say, having reviewed the 11  
14 incidents that you review, you accepted that "some of  
15 the incidents identified occurred while learning and  
16 actions from earlier incidents were still being worked  
17 through."

18 **A.** That is correct. Yes.

19 **Q.** So the time the process was taking meant that there were  
20 other people -- other people died?

21 **A.** I think also, when implementing actions, it's more than  
22 just the action; it's actually understanding what that  
23 learning is and how that learning brings about change.  
24 And I think there has -- you know, there can be times  
25 when we can think very much from a transactional

1 perspective, "Let's do this training course" or "Let's  
2 put this in", but it's actually checking out has that  
3 actually made a difference and testing that to see if  
4 that's made a difference?

5 Q. Because at your paragraph 21 you say, just in terms of,  
6 as you say, you've said it's about learning and how it  
7 makes -- how you bring about change -- you say at your  
8 paragraph 21 that learning had been identified, so  
9 that's the first part, but sustained implementation and  
10 embedding of improvements were not fully achieved.

11 And you accept in that statement that this  
12 contributed to what you described to a recurrence of  
13 themes. So the learning you say had been identified but  
14 the change hadn't been brought about. You then  
15 summarise some of those themes. I am not going to read  
16 all of them out but they include, if we look at your  
17 bullet points: Variable uptake and consistency of  
18 training which had impacted confidence and adherence to  
19 resuscitation and escalation protocols.

20 So there was a training deficiency.

21 Gaps in oversight and assurance mechanisms. So  
22 early audit and monitoring process did not always  
23 provide sufficient realtime visibility so problems with  
24 oversight and monitoring.

25 Challenges in embedding standardised processes

1 including equipment checks and escalation pathways.

2 Inconsistent dissemination -- I think this is over  
3 the page, apologies. Inconsistent dissemination  
4 standardising -- sorry, my fault:

5 "Inconsistent dissemination and local ownership of  
6 learning, meaning that improvements were not always  
7 translated into sustained changes in frontline  
8 practices."

9 You then go on to set out within your sixth  
10 statement -- it's my fault, I'm now being asked to slow  
11 down, just so you know. Apologies.

12 You go on then to set out some of the steps you've  
13 taken in your paragraphs 22 to 29 and I won't go through  
14 them, but in paragraph 26 of that statement, you say  
15 that the Trust additionally appointed experienced  
16 resuscitation and deteriorating patient leads, with  
17 acute healthcare and Immediate Life Support expertise.

18 We know about Nicholas Archer, who were the others?

19 **A.** The other person was the colleague who works with  
20 Mr Archer.

21 **Q.** Mr Smale?

22 **A.** Yes.

23 **Q.** Then at 27 you say that the Trust has strengthened its  
24 approach to implementation, oversight, and assurance  
25 including enhanced governance processes, improved

1 training, compliance monitoring, targeted support to  
2 inpatient areas and a stronger focus on embedding  
3 learning into everyday clinical practice with reference  
4 to resuscitation and management of the deteriorating  
5 patient.

6 Then at paragraph 28 again, I'm not going to go  
7 through this in detail, but you say:

8 "Learning is now disseminated across all services  
9 through the weekly Emerging Incident Review Groups  
10 (EIRG) and learning forums."

11 What is the EIRG, please, and who is it made up of?

12 **A.** So back in 2025 I was looking for a mechanism where  
13 I could bring clinical and operational colleagues  
14 together so I could have an oversight of patient safety  
15 incidents and also ensure that I had some grip of making  
16 sure progress was happening on investigations, incident  
17 reporting, et cetera. And so I looked to see what  
18 I could find across the NHS and I found another acute  
19 Trust had a similar meeting. So, basically, it's  
20 a coming together where I have a set format, so I meet  
21 with each of the care unit leads, the Deputy Directors  
22 of Quality and Safety. There is a medical colleague  
23 there, as well. And I go through, you know, "What's  
24 your Datix been in the last week? What are the key  
25 issues? You know, where are you with your

1 investigations? And also where are you with your  
2 actions? And is there anything that you want to  
3 escalate or that you want -- that we think would be of  
4 beneficial to everybody else in this group?" So that  
5 sort of immediate learning. So that's where it's come  
6 about.

7 And, you know, it just doesn't look at patient  
8 safety incidents; it looks at safeguarding, complaints,  
9 so there are colleagues from those areas, as well. So  
10 it just allows that triangulation to think. And also  
11 for people to get access and support.

12 **Q.** Does Mr Archer attend those meetings?

13 **A.** Yes, Mr Archer is invited and he has attended.

14 **Q.** There's reference at the second bullet point to actions  
15 being "clearly monitored and tracked through the  
16 governance frameworks."

17 Is there related documentation?

18 **A.** Yes, so each care unit will have their action plans and,  
19 in fact, we've progressed from obviously when I was  
20 writing this statement, each care unit now has an  
21 improvement plan which has amalgamated all their  
22 actions, so you have those key themes, so if I think  
23 about the inpatient and urgent care, which is mainly  
24 what we're focusing in this conversation, they have an  
25 improvement plan that now sits with the Medical Director

1 and Deputy Director of Quality and Safety to sort of  
2 review and think about those themes and what more they  
3 can do to ensure learning. So, for example, the  
4 deteriorating patient and resuscitation is one of the  
5 themes in that improvement plan.

6 **Q.** In paragraph 31 you say the Trust -- I'll check if I've  
7 got the right ... sorry, your paragraph 30, apologies.  
8 You say:

9 "... the Trust can demonstrate tangible improvements  
10 in practice ..."

11 How does the Trust demonstrate tangible improvements  
12 in practice?

13 **A.** Well, there's a number of ways we do that. We obviously  
14 look at different datasets, so if I just think about the  
15 deteriorating patient, in 2024 we enhanced Tendable  
16 audits so Tendable is a care point assurance framework,  
17 which has a business intelligence component, so we  
18 enhanced that to look at deterioration but to obviously  
19 ensure that that information was available not only at  
20 a ward level, but at a sort of -- at a sort of base, so  
21 say if we take Basildon at a sort of like inpatient base  
22 and then up into that care unit leadership, and we have  
23 seen --

24 **THE CHAIR:** Slow down a bit. You are going very fast.

25 **A.** We have seen improvements in the compliance of NEWS2 and

1       also in how people have been able to escalate NEWS2 for  
2       sort of clinical interventions or medical interventions.  
3       So that's one example.

4       **MS HARRIS:** Can I just ask you a slightly discrete question  
5       about the Tendable audits which you have said have been  
6       enhanced. One of the things we've heard evidence about  
7       is a SWARM huddle that took place in June 2025 following  
8       which an action was raised to add a question to the  
9       Tendable audit around whether simulations had taken  
10      place on wards within, I think, the previous three  
11      months, and we heard that that action having been raised  
12      in June 2025, that question was only added to the  
13      Tendable audit very recently indeed within the last few  
14      weeks, and we also heard evidence from Mr Archer about  
15      why that took so long and he told us that it needed to  
16      go via various groups and the group wasn't quorate, and  
17      so on and so forth.

18             Can you help us: do you accept that's a very long  
19      and unacceptable delay between important action being  
20      raised and it being put into place?

21      **A.** I do acknowledge it took some time but, I would add is  
22      that, actually, obviously, the process for doing  
23      simulations is -- was part of a local management  
24      structure which obviously wasn't -- didn't work in this  
25      case and we wanted to obviously firm up the governance.

1       That was identified as a solution to give more, much  
2       more grip to the governance. I spent -- I took a little  
3       bit of time to see what else was happening elsewhere  
4       across the NHS, were there any other solutions? Because  
5       I was quite interested in finding something that  
6       actually we could, when we had done our reports, our  
7       simulation reports, that they could be populated into  
8       a digital solution, and then, you know, that we'd have  
9       a central place where we'd have them. I couldn't find  
10      that anybody had any solutions, including ELFT, so  
11      I think everybody does it quite similar that it's held  
12      at a local management, it's held at local management  
13      level, and as a result, we then progressed with putting  
14      on Tendable.

15             Now we were -- Mr Archer is right, there were  
16      various sort of committees we had to go thorough,  
17      et cetera, but yes, that was one of the reasons. I was  
18      looking to see if I could get something that I could  
19      also collect the information.

20      **Q.** How was it, then, that it suddenly became approved and  
21      a group was available suddenly to approve that question  
22      being added to the Tendable audit so recently?

23      **A.** Well, we had been continuing to look at it, we just  
24      didn't sort of like give up on it, we continued to look  
25      at it and Mr Archer is right: there was some lack of

1        quoracy in some of the groups, but yes, so we didn't  
2        just do it, because obviously we identified, back in  
3        June 2025 that we thought this would be a solution and  
4        we've now made it happen.

5        **THE CHAIR:** So there was a lack of agreement about whether  
6        it should be introduced?

7        **A.** Well, I think we were thinking could we find something  
8        else? Could we find another way of doing it that  
9        actually might -- because one of the difficulties is  
10       that we have -- it's keeping those simulation forms, and  
11       I was, you know, we were looking to see, could we have  
12       something where we could connect the simulation form  
13       into like a BI programme, but there wasn't anything.

14       So the simulation forms will be kept at a care unit  
15       level.

16       **MS HARRIS:** Did the Inquiry's turning its focus to this  
17       particular topic of emergency response and resuscitation  
18       bring about any urgency in the resolution of auditing  
19       simulations?

20       **A.** Absolutely not.

21       **Q.** Can I move, then, to your joint statement where, again,  
22       you were asked to deal with some of these learning  
23       points and I think we need to pick up at page 60 and  
24       paragraph 258. You write as follows:

25       "EPUT notes that the Inquiry's categorisation of the

1 incidents identified in Question 68 ..."

2 I'll come back to that, that was on the evidential  
3 request, I'll come back to that in a moment:

4 "EPUT does not consider that the categorisation  
5 adopted in question 68 fully reflects the circumstances  
6 of, or distinctions between, the individual cases relied  
7 upon by the Inquiry."

8 Just to put question 68 into context, question 68  
9 was phrased as follows with reference to the table that  
10 you've provided that we've just touched on in your sixth  
11 statement and it read as follows:

12 "The Inquiry seeks to understand why the following  
13 specific repetitious failings identified in cases being  
14 investigated by the Inquiry where the patients died  
15 between April 2017 and December 2023 persisted over  
16 time. EPUT is requested to give a specific explanation  
17 for the persistence of each failing." [As read]

18 And the request then listed the categories that you  
19 have rehearsed within this joint statement, and you've  
20 dealt with them. And listed, the request listed the  
21 illustrative cases that the Inquiry had identified as  
22 potentially falling within those categories. Can you  
23 confirm that's how this came about?

24 **A.** Yes.

25 **Q.** Right. And those categories were as follows: (a)

1 failures to call an ambulance or 999 urgently or at all,  
2 and apparent repeated absence of the calling (9)999 in  
3 an medical emergency poster from the wards.

4 That was category (a).

5 Category (b) was the lack of availability of  
6 cordless or mobile phones on EPUT wards.

7 Category (c) was persistent failures in the ability  
8 of staff to deliver oxygen.

9 Category (d), problems with the use of other  
10 emergency equipment and/or the need for further training  
11 on such equipment.

12 Category (e) was the need to audit -- check and  
13 audit emergency equipment.

14 Category (f) was problems with identifying  
15 deteriorating patients and escalation processes.

16 Category (g) was problems with post-incident audits  
17 and use of Cardiac Arrest Event Audit Forms and  
18 Resuscitation Event Forms.

19 Category (h) was problems with calling the on-call  
20 doctor.

21 And category (i) was problems with communicating  
22 with the emergency services during incidents, including  
23 provision of the correct addresses, facilitating access  
24 towards an adequate handover.

25 So those were the categories.

1           And in relation to each you can confirm that the  
2           Inquiry has listed cases that they had identifying as  
3           potentially giving rise to those issues in those  
4           categories.

5           Put shortly, the Inquiry had grouped the cases, the  
6           issues, into themes.

7           And you go on to say at your paragraph 259 that:

8           "While there are common themes arising from some of  
9           the incidents identified, there are also material  
10          differences in the ascertainable circumstances of the  
11          individual cases, the findings reached by the relevant  
12          investigations, the contributory factors identified, and  
13          the learning arising from these events. Accordingly,  
14          EPUT does not accept all aspects of the categorisation  
15          or underlying premise of Question 68."

16          And at paragraph 260 you say:

17          "A fuller response, addressing both the similarities  
18          and the distinctions between the cases relied upon by  
19          the Inquiry, will be of greater assistance to the  
20          Inquiry in understanding the extent to which particular  
21          themes can properly be said to have persisted over  
22          time."

23          And then you've provided that fuller response.

24          You are aware that this Inquiry is not tasked with  
25          determining all of the facts of individual cases but

1 with examining systemic issues, and themes, and so I'm  
2 not going to ask you questions about EPUT's defence of  
3 those apparent repeated failures which are set out in  
4 the statement. The Chair has that evidence. But I'd  
5 like to ask you about two examples, if I may.

6 So if we look at the first category that the Inquiry  
7 asked you about, that's the failures to call an  
8 ambulance, 999 urgently or at all, or repeated absence  
9 of the poster, and the cases the Inquiry drew your  
10 attention to.

11 Now, looking then ahead to your paragraph 286 -- no,  
12 I think it's 268, possibly. Yes, it's 268. We notice,  
13 for example, that EPUT accepts in Bethany Lilley's case  
14 that there was a delay in calling the ambulance.

15 But in the statement, EPUT sets out the various  
16 other features in the case and the investigation, and  
17 concludes with the inquest finding. But EPUT accepts  
18 there was a delay in calling the ambulance, and there  
19 shouldn't be a delay in calling an ambulance. Is that  
20 right?

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

22 **Q.** And EPUT should take action to ensure that there are not  
23 delays in calling ambulances; would you accept that?

24 **A.** Yes.

25 **Q.** So can we agree, Ms Sheridan, that Bethany Lilley's case

1 reflects an issue with staff summoning help urgently?

2 **A.** Well, this obviously relates to the calling of the  
3 ambulance.

4 **Q.** Yes.

5 **A.** Yes.

6 **Q.** Right.

7 **A.** In this particular case, yes.

8 **Q.** Moving on, then, to 271, EPUT accepts that in the case  
9 of Elise Sebastian, the first member of staff who  
10 attempted to call the emergency services did not know  
11 that it was necessary to put the 9 before calling 999  
12 and the initial call did not connect. But you then  
13 go -- I say you -- EPUT set out other various features  
14 in the case and the investigation and you conclude again  
15 with the inquest finding. But you accept that a member  
16 of staff didn't know how to get an outside line to call  
17 an ambulance; yes? Do you accept that?

18 **A.** Well, I think in this case, and I was involved in giving  
19 evidence in the coroners, that there was quite a high  
20 number of temporary staff --

21 **Q.** Sorry, I don't want to interrupt you, do you accept that  
22 a member of staff didn't know how to get an outside line  
23 to call an ambulance?

24 **A.** Yes.

25 **Q.** Right. And all members of staff should know that they

1           need to call 9 for an outside line so they can call an  
2           ambulance; would you agree?

3   **A.**   Yes, I would -- yes.

4   **Q.**   And that EPUT should take action to make sure that staff  
5           know they need to put the prefix 9 on to call an  
6           ambulance?

7   **A.**   I think while EPUT can obviously take action, in that  
8           point when people are under a lot of distress and in  
9           a very difficult situation, it can be easy to not  
10          remember to put the 9, because I think those human  
11          factors do come into play.

12   **Q.**   All right. I'm not asking about the human factors; I'm  
13          asking about whether EPUT accept that was the position  
14          in that case?

15   **A.**   There was a position to actually dial a 9 before the  
16          999, I agree with that.

17   **Q.**   And can we agree that this reflects an issue with staff  
18          being able to summon help urgently?

19   **A.**   I think every situation is different, and it's quite  
20          difficult to say that actually one case represents every  
21          case, in terms of calling for emergency help.

22   **Q.**   I'm not asking you to tell me if this case or to  
23          indicate whether this case reflects every case; I'm just  
24          asking: do you accept that this case reflects an issue  
25          with staff being able to summon help urgently?

1   **A.** I agree that in this case the staff member didn't know  
2       to actually dial the 9 in front of the 999.

3   **Q.** At paragraph 282 you state that caution is required  
4       by -- before inferring -- before the Inquiry infers --  
5       that the learning arising from Michael Nolan's  
6       investigation had not been implemented or had proved  
7       ineffective.

8               However, we've just seen and you've just agreed that  
9       issues with calling or summoning help urgently had  
10       already been identified in the case of Bethany Lilley  
11       and in the case of Elise Sebastian. So what do you  
12       consider, what did EPUT consider explained the  
13       recurrence of those problems, even though they'd already  
14       been identified?

15   **A.** I think it's not always easy to identify one particular  
16       factor, and there's lots of different issues that can  
17       come into play. As I said, in the Ms Sebastian case  
18       I know that the unit had quite a high number of  
19       temporary staff, and having been into that inquest  
20       I know that that did play a role in the care that that  
21       young woman received.

22   **Q.** All right. In Sophie Alderman's case, which is your  
23       paragraph 273, you accept that her case is relevant here  
24       because the PSII identified the timing of the ambulance  
25       call as one aspect of the emergency response that varied

1 in its timeliness and adherence to guidance, but you go  
2 on to say that it did not establish a failure to  
3 recognise that an ambulance was required or a failure to  
4 call one at all.

5 But notwithstanding the observations, you assert, as  
6 I say, that the available material doesn't establish  
7 that calling 999 in a medical emergency poster was  
8 absent or that absence had contributed to the interval  
9 before the call, but you accept that there were problems  
10 in the calling of the ambulance.

11 **A.** Yes.

12 **Q.** Yes. In the case of Carol Taylor which is 276, you  
13 acknowledge that the emergency call took three minutes  
14 to connect and this Inquiry has heard evidence, and  
15 we'll hear more evidence tomorrow, as to the  
16 time-critical nature of emergencies on mental health  
17 wards. And you accept that the action plan identified  
18 learning concerning the use of ward cordless phone and,  
19 again, the requirement to dial the additional prefix of  
20 9 for an external call; you accept that in that case.  
21 Yes?

22 **A.** Yes.

23 **Q.** So do you accept that all of those that I've just  
24 outlined relate to issues around staff calling or  
25 knowing how to call an ambulance or being in a position

1           to call an ambulance as a matter of urgency? Do you  
2           accept that they all fall within that category?

3   **A.** They may all fall within that category, but in terms of  
4           the circumstances of how staff reacted, I feel can be  
5           different.

6   **Q.** Nicholas Archer gave evidence yesterday that he was  
7           aware of repeated themes, and one of the themes he said  
8           he -- and "themes" was a word, his word, that he used  
9           repeatedly -- and one of the themes he was aware of, he  
10          said, were these issues around telephone calls and  
11          calling urgent health (sic).

12                I'm just asking if EPUT is seeking still to assert  
13          that these are not recurrent failures along the same  
14          themes.

15   **A.** I think for me, it's important that we actually identify  
16          what were the factors that led to these themes. Because  
17          I think when you know the factors, or when I know what  
18          led to those, it actually helps in identifying the  
19          training for that particular area.

20   **THE CHAIR:** It might identify the training, possibly even  
21          down to individual staff members, but that doesn't mean  
22          it isn't pertinent, is it, to consider what the actual  
23          issue was at heart, which was an inability to correctly  
24          connect with emergency services. There is still  
25          relevance in that --

1   **A.**   Yes.

2   **THE CHAIR:**   -- point, is there, not?

3   **A.**   I'd absolutely agree but I think sometimes actually  
4       recognising that somebody didn't know how to put the 9  
5       in front of the 999 and that will have happened again,  
6       or whether somebody, actually, you know, the ambulance  
7       was delayed or -- I think understanding this  
8       circumstance is really important, as well, in supporting  
9       the right learning.  So I'm not disagreeing.

10  **MS HARRIS:**  Can I ask you about a second example, which is  
11       the category that the Inquiry had identified, which was  
12       your observations in relation to the Inquiry's questions  
13       about persistent failures to deliver oxygen, and you say  
14       as follows, and this is paragraph 284, you say:

15               "The Trust accepts all three illustrative cases  
16       generated learning concerning oxygen administration  
17       during the emergency responses.  The nature and context  
18       of the issues, however, differed ..."

19               And we remind ourselves that the cases you referred  
20       to were Jason Standing, who sadly died on 5  
21       January 2022, Michael Nolan, who sadly died on  
22       10 July 2022, and Carol Taylor, who sadly lost her life  
23       on 21 November 2023.  And in your statement would you  
24       agree that EPUT once again attempts to identify the  
25       distinguishing features of each case?  Yes?

1   **A.**   Yes.

2   **Q.**   I'm not going to rehearse them with you in detail, but

3       you point out, for example, where there has been

4       a finding that the oxygen issue was not considered to

5       have materially contributed to the death.   Yes?

6   **A.**   Well, that's from the Patient Safety Investigation

7       report, yes.

8   **Q.**   Right, but you point that out.   But it's right to say,

9       isn't it, that issues with the delivery of oxygen or

10      delay in delivering of oxygen can materially affect the

11      outcome for a patient?

12  **A.**   Yes, I would agree.

13  **Q.**   Right.   And so in terms of learning and disseminating

14      learning and making sure that mistakes aren't repeated,

15      the fact that it wasn't the material cause for one

16      particular death or for one particular patient does not

17      make the need to remediate it any less important or

18      urgent, does it?

19  **A.**   No, it doesn't.

20  **Q.**   But you say, and this is in your paragraph 290, that:

21           "The Trust considers that caution is required before

22      concluding that these cases demonstrate the persistence

23      of a single unchanged failing."

24           Because you point out that Michael Nolan and Carol

25      Taylor both died before the Jason Standing PSII was

1 completed and its final recommendations approved.

2 "The cases demonstrate that oxygen delivery remained  
3 an area requiring improvement, but the chronology and  
4 differing circumstances do not support a straightforward  
5 conclusion that the same failing continued ..."

6 So can I ask you this, Jason Standing lost his life  
7 in January 2022. Carol Taylor died 22 months later.  
8 And you point out that the investigation following  
9 Jason's death had not been completed and the final  
10 recommendations had not been approved; is that right?

11 **A.** Yes, that's what -- yes.

12 **Q.** Twenty-two months. Does that sort of delay to review  
13 and identify learning and implement change, is that  
14 standard?

15 **A.** Absolutely not. And certainly since I've come into  
16 post, this is one of the areas that we've worked to  
17 really address, and I can tell the Inquiry today that we  
18 have got a very small number of cases that are just over  
19 six months but definitely not over a year and quite a  
20 lot of my time in EPUT has been making that happen.

21 **Q.** Because no doubt you would agree with me that a period  
22 of 22 months to identify and disseminate learning when  
23 other patients appear to have died in similar  
24 circumstances, is indefensible?

25 **A.** It is too long, yes, I would agree.

1   **Q.** The Inquiry is aware of a more recent case -- I think  
2       you'll have heard your colleague touch on it, I'm  
3       certainly not going to ask for the identity or the  
4       details, from 6 June 2025, and for completeness this is  
5       a case you deal with at paragraphs 382 onwards of the  
6       joint -- of your joint statement and I'm not going to  
7       ask you to go to it. But despite EPUT's position that  
8       the Inquiry should exercise caution before classifying  
9       repeated failures, would you agree that that case from  
10      June 2025 appears to give rise to issues around the  
11      following: failures to use cordless phone and  
12      unfamiliarity with the system to transfer calls?

13   **A.** Well, because this is a case that I am very familiar  
14      with, I obviously have read the others cases as well,  
15      but I've been in EPUT for this case, I mean the cordless  
16      phone was available. The phone was, it was present.  
17      The member of staff, for whatever reason, chose not to  
18      use it.

19   **Q.** But it gave rise to an issue around calling for help?

20   **A.** It gave rise to an issue, but more down from that  
21      individual who didn't use the cordless phone.

22   **Q.** Did it also give rise to issues around the confusion  
23      regarding the type of oxygen mask to be used?

24   **A.** Yes, it did.

25   **Q.** Was it also a case in which ILS-trained staff were

1           unavailable because they'd left the patient to go and  
2           call the emergency services?

3   **A.** Yes, and, again, I think very much with this case there  
4           were issues around the member of staff and their  
5           immediate reaction when this incident happened, and  
6           their lack of confidence, and the anxiety that the  
7           incident caused them. And I would just like, I think,  
8           to take that into consideration as well.

9   **Q.** Did it also give rise to questions around staff  
10          induction?

11   **A.** Well, this was a permanent bank member of staff.

12   **Q.** Did it give issues, has it raised questions as to staff  
13          induction?

14   **A.** Well, certainly that was something we looked at when we  
15          did the initial SWARM around was the staff member  
16          properly inducted.

17   **Q.** I'm not going to take you to any more specific examples  
18          but it's right to say that this joint witness statement  
19          in relation to each of the categories the Inquiry asked  
20          you address undertakes the same analysis, including  
21          inviting the Inquiry to distinguish it between various  
22          cases within a theme; yes?

23   **A.** Yes, but I think within themes, it's really important to  
24          recognise those factors that contribute to that theme,  
25          and I would just like to acknowledge two of the other

1 cases from the '25 period. One was a patient with  
2 additional needs, and one was regarding the ambulance  
3 services accessing the unit in a prompt manner, and when  
4 I looked at the issues around the Ambulance Service, the  
5 first crew came, the administrator was bringing them to  
6 the ward and then a second crew came that they were  
7 unaware of.

8         So I think there are these subtle differences that  
9 are really important to take into account, because for  
10 me, that really does reflect on what that local learning  
11 needs to be and how we do things differently, and I  
12 suppose that a one size doesn't fit all, it's really  
13 important to recognise, you know, what's happened in  
14 that area. And, of course, we would ask the question,  
15 could it happen somewhere else? And certainly listening  
16 to Dr Adamson's statement or her evidence yesterday  
17 evening around how challenging sometimes it is to get  
18 the oxygen right, I mean what it comes down, to me, is  
19 making sure people are competent and confident in  
20 delivering emergency care.

21 **Q.** Can I ask you off the back of that, at paragraph 298 of  
22 the joint statement you once again reflect on Sophie  
23 Alderman's death and you state there that as part of the  
24 investigation it was revealed that all staff involved  
25 were up to date with their Basic Life Support training.

1 Do you accept -- sorry, it's 298 -- just you having  
2 talked about training staff to be competent and  
3 confident --

4 **A.** Thank you, I've got it. Thank you.

5 **Q.** Do you accept, then, that when staff have received some  
6 basic-level training, but the same or similar problems  
7 continue to recur, do you consider that the training,  
8 whether the training may be inadequate and whether  
9 training alone may not address the underlying causes?

10 **A.** I certainly feel personally that you just can't rely  
11 that somebody is trained, that they're actually  
12 competent to do something. It's obviously about testing  
13 can that person put the training into practice.

14 **Q.** Can I just ask about, as you say, you say it was  
15 important to distinguish the features and to look at  
16 some of the underlying factors, and you chose this joint  
17 witness statement in order to do that in some detail.  
18 As I say, you understand that this Inquiry is looking at  
19 whether there may be systemic issues within the  
20 provision of mental health inpatient care and they may  
21 well, do you accept the evidence, by persistent failures  
22 in the same sort of areas?

23 Do you agree as a principle?

24 **A.** Yes, I guess, I would want to say from a clinical  
25 perspective as a Mental Health Nurse that mental health

1 is often very complex and I think it's really important  
2 to acknowledge that, and bring that into the  
3 consideration, that will be something from my own  
4 experience.

5 **Q.** As we've said, you understand the reason we ask these  
6 questions --

7 **A.** Yes.

8 **Q.** -- is because we're seeking to understand whether there  
9 are in place at EPUT --

10 **A.** Yes.

11 **Q.** -- effective, robust processes for reviewing cases,  
12 identifying action required, and disseminating learning.  
13 We've just talked about the 22 months and I've just  
14 asked you about other time frames and I think you said  
15 six months, three to six months?

16 **A.** Yes.

17 **Q.** Do you not consider six months also is too long?

18 **A.** Well, sometimes a case will require that additional  
19 involvement to get the right answers, families may have  
20 questions that they will want to ask, but we are  
21 striving to get our PSSIs done within three months.  
22 That is what our target is. And we've made a lot of  
23 progress in making that happen but I'd want to not just  
24 see it as chasing a target. I'd want to make sure that  
25 the investigation report is robust.

1   **Q.** You also understand, I say you, EPUT also understands  
2       that the Inquiry is looking at not only the Trust's and  
3       provider's approach to review and learning but their  
4       approach to the Inquiry and our questions of the  
5       Inquiry.

6   **A.** Yes.

7   **Q.** Do you agree or do you consider, should I put it that  
8       way, that in contrast to the approach you took in your  
9       sixth statement, the one we looked at first, the  
10      approach that is taken in this joint witness statement  
11      can properly be described as defensive?

12   **A.** I certainly don't think that -- I mean, from a personal  
13      perspective I don't want in any way to be defensive.

14   **Q.** But do you agree that this joint statement mounts  
15      arguments, if you like, in relation to the individual  
16      cases rather than reflecting on the issues in the round?

17   **A.** I'd like to think that actually it does both. It does  
18      reflect, and that it is trying to get to the sort of key  
19      issue, recognising that there are different things that  
20      can contribute to issues.

21   **Q.** Do you acknowledge that approaching the questions the  
22      Inquiry asked about recurring themes in this way and by  
23      seeking to distinguish and say that factors weren't  
24      quite the same, or however you want to put it, is likely  
25      to compound the distress of the bereaved relatives that

1 read EPUT's approach in this way?

2 **A.** I would not want that to be the outcome at all. And  
3 I speak very much from a clinical perspective in really  
4 wanting to get to the nub of it and recognising that  
5 actually, each clinical situation and circumstances will  
6 be very different, and how staff react to it will be  
7 very different, and just wanting to reflect that,  
8 because I want to make sure that we actually do put the  
9 right learning in place. That's really important to me  
10 from a professional and personal perspective.

11 **Q.** Can I just ask about the entry in relation to persistent  
12 failure and the ability to deliver oxygen, because  
13 your -- at page 78 of the joint statement, perhaps we  
14 could pop that back up again -- you set out in  
15 a brief -- a table, do you remember the table that you  
16 did, which acknowledged -- appeared to acknowledge,  
17 albeit in a briefer detail, areas of repeated and  
18 persistent concern and set out EPUT's current position  
19 about that?

20 If we look at the bottom of page 78, do you see we  
21 have the "Persistent failures in ability to deliver  
22 oxygen" and you set out what was identified, if you  
23 like, as the repeated issues. And you then in the third  
24 column do the Trust's response.

25 And the current position you have there is:

1           "Continuous skills, maintenance and simulation-based  
2           learning implemented."

3           Can I just ask you about that.  Firstly, you will  
4           have seen in her second witness statement, Louise Borton  
5           who we referred to this morning, refers to current  
6           incidents of ward staff having trouble locating  
7           high-concentration oxygen masks and equipment for oxygen  
8           administration.

9           Do you accept, therefore, that the current position  
10          seems to suggest that that is very much a work in  
11          progress still?

12   **A.**  Well, I think that is what is so fantastic about having  
13          simulations because it gives that opportunity to  
14          identify, you know, issues that will come up at a time  
15          and actually think how people will approach them before  
16          they're in that real situation.

17   **Q.**  And that's all very well, of course, if we've got  
18          someone like Louise Borton who can tell us, because  
19          she's given us a witness statement, but given those  
20          simulations aren't being audited at the moment or about  
21          to be audited or they've only just -- how does that help  
22          you?  As you say, they're a brilliant tool, the  
23          simulations, if they flesh these issues out, but how is  
24          EPUT going to learn about them?

25   **A.**  Well, from my perspective how we'll be learning is

1 obviously, just like Louise Borton has written up her  
2 simulation, and other people have written up simulations  
3 as well, it just not been Louise, but we want to have  
4 that consistency, and obviously that's what we have now,  
5 going into each -- going into that care unit Leadership  
6 Team to review, to identify those issues that are coming  
7 up in simulation so that they can be addressed and taken  
8 forward across the inpatient services.

9 **Q.** Do you accept you'll be in a better position to reflect  
10 on whether that's working once you've got several  
11 months --

12 **A.** Yes.

13 **Q.** -- of audits under your belt, so to speak?

14 **A.** It's happening that -- we're looking at them now.  
15 Absolutely.

16 **Q.** What consideration has EPUT given to whether the  
17 repeated difficulties that we've identified against  
18 these incidents reflect wider systemic issues such as  
19 staffing or resources or equipment or infrastructure or  
20 implementation of previous recommendations or governance  
21 and assurance, that those kind of wider institutional  
22 issues, in addition to the deficits in, for example,  
23 staff training?

24 **A.** And I guess one of the things that I think has been very  
25 beneficial to EPUT has been it's Time to Care programme,

1       which has, you know, in many ways, has come on the back  
2       of some of these incidents, recognising that importance  
3       of having permanent staffing and has really looked at  
4       having permanent, registered and unregistered staff, but  
5       in addition to that, has looked at a wider skill mix.  
6       So on our inpatient wards now we see people with  
7       obviously lived experience, carer ambassadors, we also  
8       have more therapy staff and that's something I feel  
9       really strongly about because I think it's really  
10      important that people, actually, can be involved in  
11      meaningful things when you're admitted to hospital, it  
12      can be quite a boring place at times, and I think that,  
13      you know, that sort of staffing model and that  
14      investment has been something that is really welcomed,  
15      and, you know, there's been positive feedback both from  
16      staff and from patients.

17             The Trust is also obviously looking at its culture  
18      and it's just done a culture review, and that will be  
19      a further piece of work that obviously the Trust will be  
20      taking forward. So they're sort of two examples.

21   **Q.** You set out, I think, your position more fully -- and  
22      I'm not going to read it all out -- in paragraphs 367 to  
23      371, where you talk about the EIRG again and talk about  
24      EPUT's approach to learning, and you say in 370:

25             "The Trust's expectation is that learning identified

1 from incidents, investigations, complaints, patient  
2 feedbacks, audits and national inquiries, is not only  
3 disseminated but actively embedded in day-to-day  
4 practice through the EPUT Culture of Learning [the ECOL]  
5 framework. ECOL is founded on the principle that of  
6 personal accountability and that the active  
7 identification, sharing and application of lessons forms  
8 part of normal business activity across all levels of  
9 the organisation."

10 And you say at 371 that:

11 "The Trust is reviewing the effectiveness of  
12 existing ECOL processes ..."

13 Can you provide any update on that review?

14 **A.** Yes, and I think what has been really important is  
15 actually thinking about how we bring learning much  
16 closer to people who are delivering services and that's  
17 been something I've been really keen to invest in  
18 further so that actually we can see those staff on the  
19 front line getting those opportunities to learn, whether  
20 it's through the Professional Nurse Educators I spoke  
21 about earlier, whether it's through making time for  
22 people to have supervision and having that much more on  
23 learning on site rather than taking people away. So  
24 that's how we are approaching, I think moving from  
25 a more transactional to a much more transformative way

1 of learning is what we're looking at to do.

2 **Q.** Now, you're relatively new in post, I say, you've come  
3 2024?

4 **A.** Yes.

5 **Q.** That's right. What's your experience? Do you consider  
6 that the culture within EPUT is resistant to change?  
7 Have you found it resistant to change? Are there  
8 operational pressures that are preventing change?  
9 What's your considered experience as to whether this  
10 organisation is receptive to looking and moving forward?

11 **A.** So my personal view, having now been in the Trust for  
12 about two-and-a-half years, it is an organisation that  
13 wants to learn and improve. There's no doubt about  
14 that. I think, you know, we're working really hard to  
15 make sure that we listen to feedback from our staff,  
16 from our patients, from our families, and that we, you  
17 know, have to listen to those quite difficult messages.  
18 I mean, I've met a number of families since I've come to  
19 the Trust and it is really important that we hear what  
20 they have to say.

21 I think the Trust is open to feedback from CQC,  
22 feedback from other partners. I mean, I'm very keen in  
23 my role that we bring as much outside observation into  
24 the Trust as we possibly can through sort of quality  
25 visits. In fact recently we had a visit from one of our

1 NHS England colleagues around the Culture of Care, came  
2 to our wards in North East Essex, which I think was  
3 referred in the CQC and was able to give really positive  
4 feedback, and I think there's also something around, you  
5 know, for me, being open and honest when things go  
6 wrong, and I see that from other people, as well,  
7 apologising, and telling people what we're going to do  
8 about it and then going back.

9 So at the moment I'm working with a family who, you  
10 know, had -- who were clear that the care was not good  
11 enough that their loved one received who is part of this  
12 Inquiry, and they have been working with me and other  
13 colleagues to support us with delivering some of that  
14 change and they came to one of our recent nursing  
15 conference to talk through their experience.

16 So I think it's really important that people hear  
17 that and are open, and are willing to listen to those  
18 hard messages.

19 **Q.** I mean, one of the reasons for asking that is because at  
20 paragraph 409 of the joint statement where you're  
21 setting out the issues in relation to the recent death  
22 that we've touched on, you reference issues concerning  
23 the translation of organisational learning into  
24 consistently effective practice at ward level.

25 You don't think that's because of a resistance for

1 others, or, or a reluctance?

2 **A.** I think people are often very, very busy, and there's a  
3 lot of operational pressures around and for me, it's  
4 really important to sort of spend time out in services  
5 and understand what those are and to work with people to  
6 try to ensure that we can see what those barriers are  
7 and to make those opportunities for people to learn.  
8 I find that people are -- really want to learn, but it's  
9 making sure that people have the time to learn and are  
10 given the time to learn, and that's what's really  
11 important to me: that frontline staff are given the time  
12 to learn and the support and the supervision which we  
13 mentioned earlier.

14 I see -- sorry, I was just going to say, I see  
15 really good examples, you know, in our last month's  
16 Quality Committee we had a really good presentation from  
17 our children and young people services about the  
18 fantastic work that they have done to improve their  
19 partnership in working with young people, and obviously  
20 they have recently received a good rating from the CQC.  
21 We've also had other teams, an inpatient coming and  
22 talking about the fantastic work that they've been doing  
23 to reduce observation, to actually reduce restrictive  
24 practices.

25 So, for me, it's about actually making sure every

1           team has that opportunity to shine and grow.

2   **THE CHAIR:**   You have said that people are very, very busy.

3   **A.**   Yes.

4   **THE CHAIR:**   Are they too busy?

5   **A.**   I think sometimes people are very busy but sometimes

6           when you actually spend time and ask people what they're

7           busy about, that can actually have a change in attitude.

8           Sometimes we can all think we're very busy and then when

9           you sit down and say, you know, what is this busyness

10          about? It can actually make people reflect on what's

11          important.

12                I mean one of the things we've been doing at EPUT

13          before I came is introducing the fundamentals of care,

14          which has been really key about actually knowing your

15          patient. So, you know, spending time, knowing your

16          patient, doing a good assessment, and thinking about

17          that wider context in which we give care. So I think

18          people are busy but it's actually asking people, let's

19          just, let's just step back for a minute and consider

20          what that busyness is about and I see that as part of my

21          role as the Chief Nurse in helping make people have that

22          opportunity to reflect, and have some protected time, if

23          you like, and I'll just, you know, the Deputy Director

24          of Quality and Safety for Inpatients, she has been

25          working with the inpatient Ward Managers and Matrons to

1       get them to have a day a week when they can actually  
2       sort of reflect and look at learning and look at their  
3       Datixes, et cetera, and I think that's really important.

4       **THE CHAIR:** Thank you.

5       **A.** Thank you.

6       **MS HARRIS:** On that note and one last thing then, if I may,  
7       and the question of busyness, if you like, one of the  
8       things that we have been looking at over the last two  
9       days, and I'm not going to ask you more about it now, is  
10      some of the EPUT documentation, the policies, the  
11      procedures, and what they do contain, what they don't  
12      contain and you, of course, have seen Professor Soar's  
13      report which has identified some of what he considers  
14      are key omissions, say, from the documents, and we have  
15      learnt about documents that don't align with some of the  
16      national guidance.

17               So we've heard all about that.

18              And we're aware from the policy, from CLP14, that  
19      ultimately, you are one of the three people that are  
20      tasked with, certainly in relation to resuscitation,  
21      ensuring that policies are embedded within clinical  
22      practice and that they are reviewed and updated  
23      regularly in accordance with recommended best practice  
24      and national guidance.

25              We have identified -- "error" is my word -- but some

1 issues with the documentation. Is it any part of the  
2 plans going forward -- perhaps you yourself are too  
3 busy, I don't know -- to review these policies, to make  
4 the necessary corrections and to bring them in line?  
5 For example, we've heard about the NICE Guidance NG10  
6 which I'm now not going to take you to for time reasons.  
7 Will you be looking at ensuring these are brought  
8 up-to-date and brought in line just even on the issues  
9 that we've identified as part of the Inquiry?

10 **A.** I mean, I will certainly want to always review policies  
11 to make sure that they are relevant, and up to date.  
12 And I think just to come back to one of the questions  
13 that was asked of my colleague earlier, I mean one of  
14 the things that EPUT has done is obviously have SOPs,  
15 Standard Operating Procedures, which really help to  
16 translate those policies into practice. And I think  
17 that's been really, really helpful, because, yes,  
18 policies can be quite long, they can take time, and  
19 there's something about that Standard Operating  
20 Procedure which then sort of supports that person in  
21 actually understanding the policy. But of course, I'll  
22 always be open to any feedback around policies.

23 **MS HARRIS:** All right.

24 Chair, those are all the questions I am going to ask  
25 at the moment but we'll have a ten-minute break if we

1        may in the usual way to see if there are any further  
2        questions and what is being proposed is that Dr Suresh  
3        and Ms Sheridan go back together to answer any questions  
4        that arise so that they are in a position to deal with  
5        whichever is more appropriate.

6                So if we say ten minutes, which I think is just  
7        after ten past, about quarter past, probably.

8        **THE WITNESS:** Thank you.

9        **THE CHAIR:** Thank you, ten minutes.

10       **(3.03 pm)**

11                                **(A short break)**

12       **(3.17 pm)**

13                                **DR SURESH and MS SHERIDAN**

14                                **Questioned by MS HARRIS KC**

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

16                Dr Suresh, Ms Sheridan, there are just one or two  
17        extra questions, not many, I can reassure you, but  
18        perhaps if you can identify between you which of you is  
19        better placed to answer them.

20                The first follows from something you said this  
21        morning, Dr Suresh, although it may be, Ms Sheridan, you  
22        that is able to help us with this. It's the evidence  
23        around it being better or it's best practice to identify  
24        a leader or identified roles for an emergency situation  
25        at the beginning of a shift. And the question is: is

1           there a Trust-wide policy or procedure in place that  
2           requires that to be done?

3   **MS SHERIDAN:** I'll pick that up. Not at present, but as  
4           said in my evidence, the whole role of the coordinator  
5           at the beginning of the shift is actually to identify  
6           roles, but does it specify for ILS? No, not at present  
7           but that will be something we will be addressing, thank  
8           you.

9   **Q.** I was going to say because do you agree that a clear  
10          policy -- (overspeaking) --

11   **MS SHERIDAN:** Yes.

12   **Q.** -- and then compliance of course can be audited?

13   **MS SHERIDAN:** Absolutely, yes.

14   **Q.** Thank you.

15           Again, Dr Suresh, this was your evidence, but  
16          Ms Sheridan may be the one to pick it up, you've told us  
17          that you'd reduced the use of agency staff to a bare  
18          minimum, I think both of you referenced that, through  
19          concerted work on temporary staffing and advised about  
20          the reduction.

21           Can you help us with how that's been achieved?

22   **MS SHERIDAN:** I'll take that as well.

23   **Q.** Yes.

24   **MS SHERIDAN:** The Trust has put a lot of work into  
25          recruiting permanent staff, and obviously ensuring that

1 the conditions have been supportive to retain that  
2 recruitment and has been very successful. I certainly  
3 think the Time to Care programme the Trust introduced  
4 a couple of years ago, which really built on the number  
5 of staffing, has ensured that obviously now we've got  
6 better levels of staffing both for registered and  
7 unregistered staff, which means that therefore, the need  
8 for agency is very rare indeed.

9 **Q.** Do you consider this can be sustained going forward?

10 **MS SHERIDAN:** It -- we have been successful so far, but it's  
11 always something that is important to bear in mind and,  
12 you know, that, you know, key to that is building  
13 a really good team, and supporting a team.

14 So I see the work I've mentioned already in my  
15 evidence in supporting that continuation.

16 **Q.** On the topic of supporting the team and those that work  
17 for you, and we've talked a little bit about the roles  
18 and responsibilities of the staff that are first on the  
19 scene of an emergency and on location, use and  
20 equipment, there are two questions, I think, here.  
21 Firstly, how should staff support patients after an  
22 incident, and how do staff themselves receive support  
23 after an incident?

24 **MS SHERIDAN:** Okay.

25 **DR SURESH:** Shall I take that?

1     **MS SHERIDAN:**   Okay.

2     **DR SURESH:**   I'll start off, maybe Ms Sheridan can join.

3             Staff should support not only the patient, who is part

4             of the incident but also the other patients because

5             sometimes it can happen on a very busy ward. So to keep

6             other patients away from the incident would be the first

7             thing to do, and to cordon off the area and all that,

8             and it may be that they need to summon help from an

9             adjoining ward, not to help with the resuscitation

10            itself, but to manage the other staff for a temporary

11            period of time until the situation is cleared, if you

12            like.

13            In terms of staff support following an incident,

14            I think Mr Archer talked about the hot and cold

15            debriefs, the psychologists on the ward normally provide

16            debrief to the staff, usually the day after the incident

17            when the staff have had time to process what has

18            happened but the offer also stands a couple of weeks or

19            so after the incident so that staff can, when they have

20            had more time to reflect on it, about learning and what

21            their emotional reactions were, they are able to access

22            that support. That is within the ward locally. But

23            more widely, we have something called a Here For You

24            service, which is a staff support and counselling

25            service, which is confidential, open to all staff and

1       available to all staff for anything, including what  
2       happens at work.

3   **MS SHERIDAN:** Can I just add one point if that's all right.

4   **Q.** Yes, please do.

5   **MS SHERIDAN:** It's also very important to talk to the  
6       patients and to obviously have that conversation with  
7       them and ensure they have support as well and, you know,  
8       when I've been involved in incidents, that's a really  
9       key part of that work around supporting patients as well  
10      as supporting staff.

11   **Q.** Finally this, and again it's an area you dealt with  
12      Dr Suresh, but it may be one, Ms Sheridan, you pick up.  
13      We looked at the checklists and induction forms for  
14      staff on the ward, the SOPHIA checklist, which is long  
15      and comprehensive, for the substantive staff, and then  
16      we had that single-page tick box for bank and temporary  
17      staff. How do you, Ms Sheridan, satisfy yourself, or  
18      does EPUT satisfy themselves, that staff are undergoing  
19      a, if you like, a re-induction or reminder, if need be,  
20      of those particular elements? Because it's for new  
21      staff only, isn't it?

22   **MS SHERIDAN:** Yes, it is for new staff only although I think  
23      it does also say if you've been off for a period of time  
24      you have that opportunity to have a re-induction.  
25      I think that's really picked up in supervision between

1 both the supervisor and the supervisee if there are  
2 things that someone perhaps is not overly clear about or  
3 wants a little bit extra support. So I know when I was  
4 on a ward recently somebody was saying to me actually  
5 something about support for something and how they'd get  
6 that supervision. So I think it's that checking in with  
7 the manager and your supervisor on the ward.

8     **MS HARRIS:** Thank you. Those are all the questions I have,  
9           unless Chair you have any further questions.

10     **THE CHAIR:** I have no questions, thank you.

11 **MS HARRIS:** So that completes your evidence.

12     **THE CHAIR:** So can I thank you both very much indeed again  
13           for coming to give evidence, it's much appreciated.

14 I think we now have two minutes.

15     **MS HARRIS:** Yes, we have a very short turnaround. If you  
16           could perhaps rise for two minutes and we'll do  
17           a witness and advocates ...

18 (3.24 pm)

19 (A short break)

20 (3.29 pm)

21     **THE CHAIR:**    Ms Sage.

22 **MS SAGE:** Chair, we're ready to hear from our next witness,  
23 Mr Stuart Dunn. Could the witness please be affirmed.

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**STUART DUNN (affirmed)**  
**Questioned by MS SAGE**

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

**A.** Yeah, it's Stuart Dunn.

**Q.** Mr Dunn, you've provided two witness statements to the  
Inquiry but today we're going to focus just on your  
second statement which is dated 18 August 2026. You  
have a copy of that statement in front of you, and have  
signed the final page of it, which bears a statement of  
truth.

**A.** Yes.

**Q.** Have you had an opportunity to read that statement  
recently?

**A.** I have, yes.

**Q.** Do you have any corrections to make to it?

**A.** No, not at all.

**Q.** Can you confirm that the contents are true and accurate  
to the best of your knowledge and belief?

**A.** Yes, I can.

**Q.** That, and your answers to my questions this afternoon,  
will stand as your evidence to this Inquiry.

I want to start by asking you some questions about  
your background. You are not a Registered Nurse or a  
doctor.

1   **A.**   That's correct.

2   **Q.**   But you have worked in leadership roles in  
3       patient-facing roles in hospitals and residential  
4       settings?

5   **A.**   In residential settings, in the hospital I was  
6       a healthcare assistant, not a leadership role.

7   **Q.**   Before you joined the CQC in October 2014, had you  
8       worked on a mental health inpatient ward or in mental  
9       health inpatient care directly?

10  **A.**   I'd worked in a setting for people with autism and  
11       learning disability, in various different settings, the  
12       first of which was a hospital where people had mental  
13       health illness as well as a diagnosis of autism or  
14       learning disability.

15  **Q.**   And you joined the CQC in October 2014 as an Adult  
16       Social Care inspector?

17  **A.**   Correct.

18  **Q.**   You became Head of Inspection for Midlands and the East  
19       in 2020 and you were in that role until December 2021;  
20       is that correct?

21  **A.**   That's right, yes.

22  **Q.**   And in that role you were just Head of Inspection in  
23       respect of mental health?

24  **A.**   Yes.

25  **Q.**   And EPUT was within the geographic remit of that role?

1   **A.** That's right.

2   **Q.** And so that was the first time that EPUT fell within  
3       your operational inspection remit?

4   **A.** Yes.

5   **Q.** You then became Deputy Director of Operations in London  
6       and the East of England on 1 April -- sorry, on  
7       1 December 2021, and you held that role until  
8       1 April 2024?

9   **A.** So I became the Deputy Director of the London and East  
10       on the 1 April 2024.

11   **Q.** Then in November 2025 you were made Deputy Director of  
12       Operations for Mental Health in the Central Region?

13   **A.** Yes.

14   **Q.** And again, that role was a role that was just in respect  
15       of mental health as opposed to a role crossing across  
16       all of CQC's jurisdictions?

17   **A.** Yes, so the role from 1 April 2024 up until 1 November  
18       or 3 November '25 covered four main sectors that we  
19       regulate and there were two of us working in Deputy  
20       Director roles in the east part of London at least at  
21       that time.

22   **Q.** And since May 2026 you've been Interim Director for  
23       Mental Health in the Care Quality Commission?

24   **A.** Yes, that's right.

25   **Q.** That means you currently have operational responsibility

1 in respect of mental health for the whole of England?

2 **A.** Yes.

3 **Q.** The Inquiry has seen disclosure provided in relation to  
4 three inspections the CQC has carried out of EPUT in the  
5 last 12 months and the documentation disclosed, is this  
6 correct, shows you've personally been involved in  
7 inspections and regulatory activity relating to EPUT in  
8 the past 12 months?

9 **A.** That's right, yeah.

10 **Q.** And on the Well-Led inspection, which we will come to,  
11 where the site visit was in March, you were on that site  
12 visit.

13 **A.** That's correct.

14 **Q.** Now, this is the first time that this Inquiry has heard  
15 evidence from the CQC. I want to briefly ask you some  
16 questions about the CQC's regulatory and inspection  
17 powers.

18 The CQC is the principal regulator responsible for  
19 regulating mental health inpatient care provision both  
20 by the NHS and by private providers; that's correct?

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

22 **Q.** In summary, the CQC regulates the sector by monitoring  
23 and collating information on providers, inspecting them,  
24 and taking follow-up action after inspections, which  
25 might include use of its civil or criminal enforcement

1 powers?

2 **A.** That's correct.

3 **Q.** In terms of enforcement, as we've heard, the CQC has

4 both civil enforcement powers and criminal enforcement

5 powers?

6 **A.** Yes.

7 **Q.** And your civil enforcement powers that can be used where

8 a provider breaches a regulation but it doesn't

9 constitute a criminal offence, include being able to

10 cancel or suspend registration, or imposing varying or

11 removing conditions of registration, or serving

12 a warning notice; that's correct?

13 **A.** That's correct.

14 **Q.** In summary?

15 **A.** Yes.

16 **Q.** And your criminal enforcement powers, those of the CQC,

17 include the ability to issue cautions, fixed penalty

18 notices, and criminal prosecutions, which you can use

19 when a breach of legislation is serious or there are

20 multiple or persistent breaches by a provider; that's

21 correct?

22 **A.** A provider or a registered person.

23 **Q.** Or a registered person. And as with all prosecuting

24 authorities, before the CQC prosecutes a registered

25 provider or registered person, the CQC must be satisfied

1       there is a realistic prospect of conviction and assess  
2       that the prosecution is in the public interest?

3     **A.**   That's correct.

4     **Q.**   Can I ask you about the relevance of Prevention of  
5       Future Deaths reports to CQC inspections and  
6       enforcement. If the CQC receives a PFD report relating  
7       to a provider, to what extent would the CQC inspectors  
8       pay particular regard to that in their work inspecting  
9       and regulating that provider?

10    **A.**   So if we receive a PFD it would be allocated to the  
11       local inspection team would oversee it, I'd expect the  
12       inspectors to review that, and use it as -- in the same  
13       way they'd use any information or evidence we have about  
14       a service or a provider. So they'd consider what the  
15       PFD is relating to, they'd look at, is that evidence of  
16       potential provider failure? If so, they should go  
17       through our specific incident process to consider  
18       whether a prosecution should be brought. And even if  
19       it's not considered that we should bring a prosecution,  
20       they should consider that information as part of our  
21       ongoing monitoring and wider oversight of a service or  
22       provider. We also have Memorandum of Understanding with  
23       the coroners so we should --

24    **THE CHAIR:** I'm going to ask you to slow down.

25    **MS SAGE:** Slowly.

1     **THE WITNESS:**   Sorry.

2     **THE CHAIR:**   Thank you.

3     **A.**   Yeah, so we would also have Memorandum of Understanding  
4           with coroners. So there may be actions that we need to  
5           do as a named responder to the coroner's PFD. Therefore  
6           we would review that internally, we'd seek legal advice,  
7           and then we'd respond to the coroner in line with their  
8           PFD.

9     **MS SAGE:**   Mr Dunn, I want to move now to your witness  
10           statement and the topic of Brief Guides. Can your  
11           witness statement be put up and can we look at page 3  
12           and your paragraph 8, please.

13           Now, in respect of your evidence this afternoon, we  
14           will be focusing on the CQC's Brief Guide that relates  
15           to Immediate Life Support, but can we start, please,  
16           with what the status of Brief Guides is? And you say,  
17           in your paragraph 8, that:

18           "Brief Guides are a learning resource for CQC  
19           inspectors and inspection teams."

20           You go on to explain that:

21           "They provide information, references and links to  
22           professional guidance ..."

23           You say:

24           "They do not provide guidance to registered persons  
25           about complying with any of the regulations made

1       pursuant to Section 20 of the Health and Social Care  
2       Act, nor are they further indicators of assessment  
3       pursuant to Section 46 of the 2008 Act."

4             If we could put up the Brief Guide on Immediate Life  
5       Support training, which is CQC027789, we can also see  
6       that that paragraph I've just read out from your  
7       statement is at the bottom of the Brief Guide, the first  
8       page. That's correct?

9       **A.** That's correct, yeah.

10      **Q.** So am I right that the CQC's position is that these are  
11       guides produced only for inspectors?

12      **A.** They're -- yeah, they're aide memoires for our  
13       inspectors to support the gathering of evidence and  
14       ensuring we're consistent in our approach, but we  
15       publish them on our website as well.

16      **Q.** Yeah, so they're publicly available on your website.  
17       Are they ever provided to Trusts or providers at the  
18       start of an inspection, do you know?

19      **A.** I wouldn't expect them to be, but as they are publicly  
20       available, providers could access them.

21      **Q.** I'm sorry, it's been brought down but can we just have  
22       the last document back on screen.

23             So just in terms of what they do, the Brief Guides,  
24       they provide a summary of what the CQC understands the  
25       national standards are in respect, in this guide, of

1 settings that use restrictive interventions.

2 **A. (The witness nodded) .**

3 **Q.** So that's one element?

4 **A.** Correct.

5 **Q.** And the other element of them, and you'll see that from

6 "Evidence required" on that page and if we turn over to

7 the next page, is that they tell inspectors and anybody

8 else who's reading them that evidence that the CQC is

9 going to be looking for when it is inspecting providers

10 and registered persons.

11 **A.** Correct.

12 **Q.** And we can see in fact that the guide lists -- and is

13 this right -- this is listing the questions that the CQC

14 inspectors should ask during an inspection?

15 **A.** Not verbatim, but these areas that our inspectors would

16 cover.

17 **Q.** Now, given these guides are publicly available and given

18 inspector's guidance on how to assess topics, do you

19 agree that it's likely that registered Trusts and

20 providers will look at the Brief Guides to understand

21 how inspectors are going to approach assessing them on

22 certain topics?

23 **A.** I agree they definitely could.

24 **Q.** And that having done that, and having made sure that it

25 can answer all of those questions, it may consider it

1       had a system in place that met the regulator's  
2       requirements, as in a Trust or provider may consider  
3       that they've got a system in place that meets the  
4       requirements.

5   **A.** If they're able to demonstrate evidence to satisfy all  
6       of those points then our inspectors would have access to  
7       that evidence when making their judgements.

8   **Q.** And the Inquiry knows from evidence that it has received  
9       from EPUT, for example, that regulated providers do rely  
10      on these documents and in fact cite them in their own  
11      policies and procedures. Are you aware of that?

12   **A.** Yes.

13   **Q.** The Inquiry's expert, Professor Soar, who is  
14      a consultant anaesthetist and has been a consultant in  
15      an NHS Trust since 1999 says this, and I won't put his  
16      report up at the moment but I will read it to you. He  
17      says:

18           "Importantly [of the Brief Guides] CQC registration  
19      is a legal requirement for any health and social care  
20      provider in England including mental health providers.  
21      Services are rated based on CQC inspections and ongoing  
22      monitoring. This means that the CQC Brief Guide should  
23      carry significant weight in local decision making." [As  
24      read]

25           Do you agree with him?

1   **A.** I agree that the Brief Guide can support our teams to  
2       know what evidence to look for, and therefore help  
3       providers know what evidence they should have available.  
4       The guidance itself is derived from the Best Practice  
5       Standards that are linked within the Brief Guide and we  
6       make very clear that these are the sources of evidence  
7       that providers should be reviewing and addressing in  
8       their policies and their procedures. So I would expect  
9       the adherence to national guidance by other bodies like  
10      the Resus Council UK to be the ones that providers would  
11      follow. Our Brief Guides are helping our teams make  
12      sure they're knowing what to look for when they go on  
13      site.

14   **Q.** And if your Brief Guide is going to differ in any way  
15      from national guidance or national standards, do you  
16      agree that you ought to make it crystal clear to the  
17      profession the status of these guides before you publish  
18      them on your website?

19   **A.** I'm sorry, I don't --

20   **Q.** If there's -- and I'll come on to it, but if there's  
21      going to be any distinction, any difference, between the  
22      national standards and the information set out in your  
23      guides, do you agree that you should make it crystal  
24      clear to registered trusts and providers the status of  
25      these guides before you publish them on the website,

1 i.e. you must follow the national standards in  
2 preference to our Brief Guides?

3 **A.** I believe the statement we've made on the Brief Guides  
4 covers that, where we clearly state that these are  
5 learning resources for CQC inspectors and links to  
6 professional guidance, legal requirements and best  
7 practice should be followed.

8 **Q.** So your evidence is that the paragraph at the bottom of  
9 the front page of the Brief Guide tells trusts and  
10 providers: You need to comply with national guidance,  
11 not with these Brief Guides, which are simply a learning  
12 resource?

13 **A.** Yeah, the guide says they do not provide guidance to  
14 registered providers about complying with regulations.  
15 I think that's quite a clear statement.

16 **Q.** Can we then move to the topic of how many Brief Guides  
17 there are in mental health care. Can we turn to, back  
18 to your statement at page 2, paragraph 7. And you  
19 explain there about the CQC inspecting mental health  
20 services, and that before the introduction of the Single  
21 Assessment Framework the CQC inspected and rated against  
22 core services, and you list the mental health core  
23 services --

24 **A.** Yes.

25 **Q.** -- on that page, and there are ten of them.

1           And before the Single Assessment Framework was in  
2           place, you were inspecting and rating on five key  
3           questions: safe, effective, caring, responsive, and  
4           well-led.

5   **A.   (The witness nodded) .**

6   **Q.** Is it right that since the single assessment has been in  
7           place, for the core services, you are still rating them  
8           against safe, effective, caring, responsive and well-led  
9           but what has changed is that the overall Trust or  
10          provider rating is based on a well-led inspection only?

11   **A.** Yes, at Trust level. The core services, or as we  
12          currently refer to them, assessment service groups, have  
13          the five key questions and an overall rating for that  
14          Assessment Service Group. The Trust itself will have  
15          a single rating from it's well-led assessment. If it  
16          hasn't yet had a well-led assessment under the Single  
17          Assessment Framework, the previous set of ratings will  
18          be displayed on our website.

19   **Q.** And we see there the ten core services. Is it the same  
20          inspectors that are covering all core services for  
21          mental health?

22   **A.** It's -- they are covered by the same inspection teams,  
23          yes.

24   **Q.** Yes. So those inspectors have to be as familiar with  
25          the requirements, for example, for a forensic inpatient

1 and secure ward, as they do for community-based  
2 services?

3 **A.** Yes, though we do have some national projects. We have  
4 a national team looking at adult community mental health  
5 services and so they will either lead or support those  
6 inspections and our inspectors also have access to  
7 specialist resource in the form of access by experience  
8 and specialist advisers who will have more specific  
9 specialisms in those different ASGs or assessment  
10 service groups.

11 **Q.** And another way you help your inspectors with the volume  
12 of core services they need to inspect is by production  
13 of the Brief Guides and they're available to your mental  
14 health inspection teams. And if we can move on to the  
15 next page, just to get a flavour of how many there are,  
16 there's 12 listed on that page and if we turn over to  
17 the next page, there's another page, and then the next  
18 page, that's the third page, and then turn over again,  
19 and we can see there that there are 55 Brief Guides  
20 listed in your paragraph 8 and that your paragraph 9  
21 informs us that there are in fact another three Brief  
22 Guides that are under review.

23 So that's in total 58 Brief Guides that your  
24 inspectors have to be across relating to mental health  
25 care; is that correct?

1   **A.** They have to be aware of the Brief Guides, yes.

2   **Q.** And in respect of the Brief Guides themselves we have  
3       seen they include a summary of what the policy position  
4       is and then questions in respect of evidence to be  
5       collated. They also contain footnotes and links to the  
6       national guidance itself, that's correct?

7   **A.** That's correct.

8   **Q.** And would you expect inspectors to always follow those  
9       links and review the national standards before doing an  
10      inspection that's going to be based on or related to the  
11      Brief Guide they're looking at?

12   **A.** I would expect them to use that resource as they needed  
13      to. So if it's an environment they're familiar with  
14      from their professional background they may not need  
15      that as much. Equally, if they've carried out an  
16      inspection and we have reasonable assurance from the  
17      evidence we've collected that regulations are being met  
18      and standards are -- good quality care is being  
19      provided, I wouldn't expect the teams to need to review  
20      that level of guidance in as much depth.

21   **Q.** Okay. In paragraph 10 of your witness statement, which  
22      is on the screen, you say you're not aware of any  
23      specific guidelines for resuscitation in mental health  
24      care settings, and we're going to come back to that, you  
25      say this:

1           "However, the CQC's website does refer to the  
2       Resuscitation Council UK guidelines within the guidance  
3       section for Regulation 12: Safe Care and Treatment".

4   **A.**   Yes.

5   **Q.**   Is it right that on the CQC's website there are in the  
6       region, do you know, of 100 links to other guidance  
7       underneath the regulation 12 header? Do you know that?

8   **A.**   I haven't counted them but I've -- I do believe that  
9       could be the case.

10   **Q.**   To what extent does the CQC expect its inspectors to  
11       make use of all of the guidance on the CQC website as  
12       well as the Brief Guides?

13   **A.**   I'd expect them to make use of the guidance as they  
14       needed to, to support their regulatory judgements. So  
15       if they have concerns about a particular area, they can  
16       access the guidance to see exactly what national best  
17       practice standards are out there and compare that to the  
18       evidence they've collected to help support judgement  
19       making.

20   **Q.**   But Mr Dunn, does that -- is that the wrong way round?  
21       Because that relies on inspectors noticing that there's  
22       an issue and then going to the guidance to find out  
23       whether or not they're right there's an issue instead of  
24       being on top of the guidance so that they can identify  
25       issues in the first place?

1   **A.** We've spoken already about the fact we don't just  
2       collect evidence; we have regular monitoring of  
3       services, we engage with providers, other stakeholders,  
4       and we receive a lot of information. So before we go on  
5       site to collect evidence we may be aware of a potential  
6       issue or a developing area of concern, and therefore our  
7       inspectors could review the guidance beforehand, but  
8       equally, the guidance is there afterwards as well, so  
9       they can cross-reference that evidence they've collected  
10      with that best practice.

11   **Q.** So the way you expect your inspectors to be on top of  
12      all the relevant guidance across all the ten core  
13      services that your mental health inspectors are  
14      inspecting is that they focus on the guidance relevant  
15      to the specific issue that they're currently looking at.  
16      Do you expect them to be on top of, for example, all 58  
17      Brief Guides and all of the links on the website at the  
18      same time?

19   **A.** We expect our inspectors to have a good understanding of  
20      the services they are regulating, through that regular  
21      engagement and through understanding of the sector and  
22      the providers that operate within it.

23           I think we have to be reasonable with the way people  
24      best use their time, and access resources to make sure  
25      they are using their, using their Brief Guides and other

1 best practice guidance at the right point because they  
2 may not come across the issues outlined in the Brief  
3 Guide regularly, so to be across that the whole time  
4 wouldn't necessarily support good regulation.

5 **Q.** There's a specific question on the website and it may be  
6 that you don't know this, but the RCUK guidelines on the  
7 CQC website are under the heading "Staff support and  
8 training" rather than under the heading "Resuscitation".

9 Do you agree that that could perpetuate a view that  
10 the guidance relates primarily to staff training and  
11 support rather than to the safe delivery of care to  
12 patients?

13 **A.** I believe that's the way we would review in line with  
14 regulations to ensure that the regulation around  
15 staffing was being met, that sufficient quality --  
16 sufficient quantity of well-trained staff are available  
17 to meet the needs of people at the service.

18 **Q.** Turning back then to the Brief Guides and perhaps we can  
19 put the Brief Guide that we had on the screen back up.  
20 That should be CQC027789.

21 How does the CQC expect its inspectors to use  
22 matters identified in Brief Guides when assessing  
23 providers?

24 **A.** Could you clarify the question, please?

25 **Q.** Yes. So these Brief Guides, as we've discussed, or

1           we've heard, are available to your inspectors?

2   **A.   (The witness nodded) .**

3   **Q.** And they can look at them, as I understand it, before

4           they inspect or after they inspect?

5   **A.   (The witness nodded) .**

6   **Q.** But how are you as the CQC actually expecting your

7           inspectors to use them? So when you publish this Brief

8           Guide, what are they supposed to do with them?

9   **A.** They are supposed to use it to help guide their

10          practice. It sets out evidence that -- as you can see,

11          evidence that can be required to help answer questions

12          about the regulation that's being -- that this piece of

13          evidence would be attributed to, so on the second page

14          of the Brief Guide we talk about reporting as well and

15          how we'd report on that issue under the --

16          unfortunately, this Brief Guide refers to the previous

17          assessment framework but how we would report and the

18          regulations that are linked to this Brief Guide.

19   **Q.** So I understand, this is a Brief Guide for Immediate

20          Life Support training for services that may use

21          restrictive interventions. Is it the case that every

22          time one of your inspectors goes to a service that uses

23          restrictive interventions, you'd expect them to take

24          this Brief Guide with them or read it before they went

25          so they knew what questions to ask?

1   **A.** I'd expect them to gather evidence that answered the  
2       questions and if they weren't able to do that then they  
3       could seek further evidence after the site visit.

4   **Q.** So are they taking it with them and asking the questions  
5       listed under "Evidence required"? Is that how it works?

6   **A.** No, they will gather evidence through multiple sources  
7       during the inspection, so them and members of the team  
8       will speak to people and they will seek evidence from  
9       people using the services, members of staff, they will  
10      review documentation on site including training records  
11      and other documentary evidence such as incident reports  
12      or care plans, and they will use -- they will  
13      triangulate all that evidence to decide where the  
14      judgements lie and the Brief Guide will help guide their  
15      judgement process. The list of questions are areas that  
16      need to be covered. They're not a list of verbatim  
17      questions that need to be asked.

18   **Q.** What, turning then to -- we'll leave this up -- turning  
19      then to CQC inspection teams and their knowledge of  
20      resuscitation and emergency response, what training and  
21      assessment materials do CQC inspection teams currently  
22      receive on resuscitation and emergency response outside  
23      of the Brief Guides? So what training does your team  
24      get on how resuscitation and emergency response should  
25      be done on a mental health inpatient unit outside of the

1 Brief Guide?

2 **A.** We don't have a formal training programme for that.

3 **Q.** We've heard evidence and we'll hear further evidence  
4 tomorrow about the wide range of circumstances in which  
5 an emergency can occur and a resuscitation can be  
6 required on mental health inpatient wards. How  
7 confident are you that your inspectors understand enough  
8 about the different circumstances in which an emergency  
9 response can be required to enable them to properly  
10 assess whether Trusts and providers have safe  
11 arrangements in place?

12 **A.** Can you repeat the first part of that question? Sorry.

13 **Q.** Yes, so the Inquiry has heard evidence about a wide  
14 range of circumstances in which somebody may need -- or  
15 a trigger event might happen, someone might need  
16 resuscitation on a mental health inpatient ward, for  
17 example, as a result of ligature or as a result of  
18 serious self-harm by cutting as a result of  
19 a restrictive intervention, so lots of different ways  
20 that somebody might go into cardiac arrest on a mental  
21 health ward.

22 And the question is: are you confident that your  
23 inspectors understand enough about the different types  
24 of circumstances in which a cardiac arrest might happen  
25 on a mental health inpatient ward, so that they're able

1 to properly assess whether the arrangements a provider  
2 has in place are safe?

3 **A.** Yes. Yes, so I would expect our inspectors to look at  
4 more than the potential incident of a cardiac arrest and  
5 need for resuscitation and if you're at that point  
6 I would expect the Brief Guide evidence to be collected  
7 and, you know, that would cover: do they know what to do  
8 in the event of? But in the build up to those different  
9 circumstances, our teams would assess through looking at  
10 assessments of risk, things like ligature heat maps for  
11 services, are there blind spots? Are there potential  
12 ligature points that haven't been removed? And we're  
13 very active in inspecting for those areas and  
14 highlighting with providers. Ligatures is a good  
15 example, but there are other elements that might be, for  
16 example, if people need particular types of diets, is  
17 that been provided? Has the assessment around choking  
18 been made as part of their care plan?

19 **Q.** What about deteriorating patient health? We've heard  
20 about deteriorating patients and NEWS2 being a system to  
21 monitor deteriorating patients. Are you confident that  
22 your inspectors have sufficient knowledge of that system  
23 to be able to assess whether a Trust's or provider's  
24 system for monitoring deteriorating patients is safe?

25 **A.** We'd be able to review the use of the system such as

1 NEWS2 or other tools, yes.

2 **Q.** And -- sorry, finally, a question on the regulatory  
3 significance the CQC might attach to any departure from  
4 the Brief Guide by a Trust or provider. Given that  
5 Brief Guides are issued, as you say, as a learning  
6 resource for inspectors, what significance or regulatory  
7 significance, if any, does the CQC attach to a departure  
8 from the Brief Guide by a Trust or provider?

9 **A.** Ultimately, it's the provider's duty to meet the  
10 regulations as set out in the Health and Social Care  
11 Act. So our teams will review the planned activities  
12 they have, or the care plans, policies, procedures that  
13 a provider has, to ensure they are complying with those  
14 regulations. So if there's a departure from the Brief  
15 Guide but they've got sufficient risk assessment and  
16 guidance to demonstrate the regulation is still being  
17 met, ultimately that's the boundaries we have as the  
18 regulator.

19 **Q.** Can we then put up next to this document the NICE  
20 Guidance NG10. So that's NICE026961.

21 And in your statement you say that this, the NICE  
22 Guidance, is for any setting where restrictive  
23 interventions might be used, including mental health  
24 settings.

25 So it's the CQC's position that NG10 applies to

1        mental health inpatient wards; is that correct?

2    **A.**    Yes.

3    **Q.**    And the relevant paragraphs for our purposes today are  
4        on page 33.    Can we put those up?

5            You can see there paragraphs 1.4.3 and 1.4.4, and  
6        the first explains that resuscitation equipment, or --  
7        sorry:

8            "Health and social care provider organisations  
9        should ensure that resuscitation equipment is  
10       immediately available if restrictive interventions might  
11       be used ..."

12           And that should include an automatic external  
13       defibrillator, a bag valve mask, oxygen, cannulas,  
14       intravenous fluids, suction and first-line resuscitation  
15       medications, and they should maintain equipment and  
16       check it every week.

17           And 1.4.4:

18           "Staff trained in Immediate Life Support and  
19       a doctor trained to use resuscitation equipment should  
20       be immediately available to attend an emergency if  
21       restrictive interventions might be used."

22           Now, we can see because we've got your guide next to  
23       it, that in the CQC guide, it says this, that:

24           "All clinically trained staff, doctors, registered  
25       nurses, who deliver or are involved in rapid

1       tranquillisation, physical restraint and seclusion are  
2       trained in ILS."

3             And then it says:

4             "Training compliance, policy and rota should ensure  
5       24/7 access to ILS-trained staff."

6             Now, do you agree that NG10 refers to staff, but  
7       does not say whether they should be clinically trained  
8       staff or not, as opposed the Brief Guide which says all  
9       clinically trained staff -- (overspeaking) --

10    **A.** I do agree with that and the later section of the Brief  
11       Guide refers that all staff who may be involved in  
12       restrictive intervention.

13    **Q.** Yes, we will come to that.

14             There's also a document that I handed around the  
15       room just before you came to give evidence, and just so  
16       that others understand what happened there -- that's  
17       a document you looked at in the preparation of your  
18       evidence for the Inquiry, it's a publicly available  
19       document and it's referred to in the Brief Guide and you  
20       provided that to the Inquiry yesterday and we've now  
21       circulated it in the room. And I'm going to ask that  
22       that's put up on screen as well.

23             And that's the NRLS -- it's a document without the  
24       URN. Oh sorry, to replace the document on the  
25       right-hand side. So this, we can see this is the

1 National Patient Safety Agency, it's a Rapid Response  
2 Report document. It's from 2008.

3 If we can look at the box at the bottom of the page  
4 "For immediate action" and it says this at number 4:

5 "All units where rapid tranquilisation, physical  
6 intervention, or seclusion may be used have access to  
7 staff trained in Immediate Life Support and to all  
8 equipment specified in NICE Guideline 25 (including  
9 AEDs)."

10 That would now be the equipment specified in NICE  
11 Guidance NG10 as we've seen.

12 But again, it's a reference here to staff trained in  
13 Immediate Life Support, not to clinical staff; is that  
14 correct?

15 **A.** Agreed, yes.

16 **Q.** And then finally can we have a look at the Resuscitation  
17 Council UK's Quality Guide for Inpatient Care, and  
18 that's at RSCUK022529 and again, that can replace the  
19 document on the right-hand side of the screen.

20 Can we turn to page 10 of that document, please. At  
21 point 5 it says this:

22 "Resuscitation Council UK's Immediate Life Support  
23 ... course is recommended as a minimum standard for  
24 staff who deliver or are involved in rapid  
25 tranquilisation, physical restraint and seclusion. This

1 guidance recommends that clinical staff in each mental  
2 health inpatient unit should receive regular update  
3 training in physical health skills in addition to ILS in  
4 response to an assessment of need undertaken by each  
5 organisation."

6 Now, again, in the RCUK guidance, we see reference  
7 to clinical staff but we don't see, for example,  
8 reference to registered staff so limited to nurses --

9 **A.** Yes.

10 **Q.** -- or doctors.

11 Now, as you can see, at the bottom -- sorry, I'm  
12 causing all sorts of havoc for the document managers  
13 today -- can we -- we think we can just have up now  
14 CQC027789.

15 So this is the CQC's guidance. What it does is it  
16 refers to the NICE Guidance recommendation that there be  
17 immediate access to staff trained in Immediate Life  
18 Support and to appropriate ILS medication and equipment.  
19 It then goes on to say, instead, at bullet point 2:

20 "All clinically trained staff, doctors, registered  
21 nurses, who deliver or are involved in rapid  
22 tranquilisation, physical restraint and seclusion are  
23 trained in ILS".

24 And then at the bottom of this page, in respect of  
25 the evidence required, asks this question:

1           "Are all relevant clinical staff trained in BLS and  
2 CPR and all staff who may deliver or be involved in  
3 restrictive interventions trained in ILS?"

4           Now, is it the CQC's position that only clinical  
5 staff require training in ILS, clinical registered  
6 staff, or is the position that all staff involved in  
7 restrictive interventions need ILS training?

8   **A.** Our position would be that the provider would need to  
9 have sufficient staff with the right skills, training  
10 and knowledge to meet the needs of their patients. So  
11 if they can demonstrate they have enough ILS-trained  
12 staff in the event of an incident where it was required,  
13 they could provide resuscitation in a timely way to that  
14 person, that would meet the requirements of the  
15 regulation.

16 **Q.** Do you accept that it's not clear from this document  
17 whether or not all staff who may deliver or be involved  
18 in restrictive intervention should be trained in ILS or  
19 only clinically trained staff, i.e. doctors and  
20 registered nurses, should be trained in ILS?

21 **A.** I do agree with that. I think this document needs an  
22 improvement to add that clarity, yes.

23 **Q.** Can we look, then, at the -- Professor Soar's report,  
24 the Inquiry's expert report which is part 2, INQY028308.  
25 If we can turn to -- sorry, I should say, Mr Dunn,

1       you've had an opportunity to see this section of the  
2       report before you gave evidence today?

3   **A.** I have, yes.

4   **Q.** You have.

5           Can we turn to page 7, please. And what  
6       Professor Soar has done is he's explained and noted that  
7       difference between the national guidance, as we've seen,  
8       and the CQC Brief Guide.

9           And he says this in paragraph 2.5(c), and that's the  
10       section of the report that I put to you earlier about  
11       the CQC Brief Guide carrying significant weight in local  
12       decision making, and he goes on to say:

13           "The CQC position does mean that mental health  
14       organisations do not have a driver to train  
15       non-registered staff in Immediate Life Support. The CQC  
16       does emphasise the need for 24/7 availability of  
17       ILS-trained staff."

18           Do you agree that as a result of what's said in your  
19       Brief Guide, i.e. all clinical staff, registered nurses  
20       and doctors require ILS training, that may be a driver  
21       for registered providers and organisations to not train  
22       non-registered staff in ILS?

23   **A.** I believe the wording of the Brief Guide could lead them  
24       to that conclusion. I don't believe that's a driver.  
25       I think the driver for these services should be meeting

1 the regulations which will be making sure they have the  
2 right trained staff for the -- the people they care for  
3 and the incidents that might occur.

4 **Q.** But you do accept that providers reading your guidance  
5 may think that the regulatory standard is to have their  
6 clinically trained, registered staff trained to ILS and  
7 not train their non-registered staff?

8 **A.** I think we're clear the Brief Guide isn't a regulatory  
9 standard; it's a guide to support the learning of our  
10 inspectors.

11 **Q.** Yes, I understand that's the CQC's position on what the  
12 Brief Guide is. But the question is, do you accept that  
13 reading that document, a mental health organisation, a  
14 Trust or provider, may understand it to mean they only  
15 need to have their clinically registered staff trained  
16 to ILS and not non-registered staff?

17 **A.** By reading that single bullet point, yes.

18 **Q.** At a minimum, at least, do you agree that that part of  
19 the Brief Guide may result in CQC inspectors not asking  
20 about ILS training for non-registered staff, and only  
21 asking about whether registered staff have ILS training?

22 **A.** We would ask what their arrangements are for ensuring  
23 that staff have the right training to meet the needs of  
24 the people in their service. So if there was to be an  
25 incident where ILS was required, how could the provider

1       give us assurance they'd have enough staff to cover all  
2       shifts 24 hours a day, seven days a week?

3   **Q.** And just to confirm your -- the evidence you've just  
4       given now about updating the Brief Guide, do you agree  
5       that there is scope to update this Brief Guide to remove  
6       the reference to "clinically trained staff" and to bring  
7       it in line with national standards?

8   **A.** I do agree with that, yes.

9   **Q.** Just looking back and thinking about NG10 and what that  
10      says, I'm not going to put it back on the screen, but in  
11      reference to the staff it says that they must be  
12      "immediately available"?

13   **A.** **(The witness nodded)**.

14   **Q.** Does the CQC interpret NG10 to require staff trained in  
15      ILS to be -- the requirement for them to be immediately  
16      available to mean that they must, in reality, be  
17      physically present and directly involved in any  
18      restrictive intervention or that they need to be present  
19      on the ward and able to respond?

20   **A.** I think the answer to that would depend on the  
21      circumstances of the environment, the size, layout of  
22      the ward, availability of, you know, how many nurses are  
23      on shift, for example, that would have that level of  
24      training or how many members of staff are available that  
25      would have that training. So it would vary depending on

1 the setting, but we would expect an immediate response  
2 to be as the person is showing that deterioration, that  
3 person to be -- that member of staff to be available to  
4 commence ILS if required.

5 **Q.** Professor Soar has also said in his report that the CQC  
6 Brief Guide falls short by not stating that 24 access to  
7 ILS-trained staff needs to be immediate, i.e. arriving  
8 at the patient within about the first minute after the  
9 call for help. That's a reference to the end of the  
10 second bullet point of the Brief Guide which says,  
11 "Training compliance, policy, and rota arrangements  
12 should be intended to ensure 24 access to ILS-trained  
13 staff" but it doesn't say there "immediate access to  
14 ILS-trained staff"?

15 Do you agree with that, that it ought to say "24  
16 access" -- it should say something to imply that the 24  
17 access is to ILS-trained staff who can be immediately  
18 there?

19 **A.** I see no harm in strengthening the Brief Guide to that  
20 effect. I think it may be implied otherwise, but  
21 I think strengthening it can only add clarity.

22 **Q.** Can we perhaps put the Brief Guide back up, which is  
23 CQC027789.

24 So we've seen the question in terms of evidence  
25 required on training. If we turn over the page, the

1 last question under "Governance" is this:

2 "The duty rota records evidence availability of  
3 staff trained in ILS for all shifts and is this  
4 considered when completing future rotas?"

5 Can I ask you in practice, what evidence are you  
6 expecting your inspectors to examine to assess whether  
7 or not a provider complies with this?

8 **A.** So as part of our normal assessment activity for when we  
9 carry out site visits and gather our evidence, we'd look  
10 at rotas and we'd also look at training records to see  
11 which staff had which levels of training. If the  
12 provider has any other mechanism for that oversight that  
13 they record, we'd ask to see that, as well. But rotas  
14 and training records would show that provision.

15 **Q.** And you're expecting your inspectors to cross-reference  
16 rotas with the training records for the staff showing on  
17 the rota?

18 **A.** Yes.

19 **Q.** Can we look at equipment. If we go back to the first  
20 page of the Brief Guide, we can see there that the fifth  
21 bullet point down says:

22 "Emergency equipment is immediately available  
23 (within three minutes if shared between wards),  
24 including basic life support equipment) eg automated  
25 external defibrillator, self-inflating bag mask devices

1 or mouth-to-mask devices)."

2 Do you agree that the national standard is in fact  
3 that an automatic external defibrillator needs to be  
4 applied so that a shock is given within three minutes?  
5 And that other emergency equipment is to be immediately  
6 available, i.e. immediately, not within three minutes?

7 **A.** Yes, I agree.

8 **Q.** And that this bullet point is therefore not reflective  
9 of the national standard?

10 **A.** I agree that it could be re-worded to be clearer.

11 **Q.** And in fairness, if we turn over to the next page and  
12 look at the evidence required in respect of equipment,  
13 there, the questions are: do patient areas have  
14 immediate access to BLS and ILS equipment and drugs?  
15 And that says "immediate access" rather than "three  
16 minutes"?

17 **A.** Yes.

18 **Q.** So it's a matter of bringing the bullet point on the  
19 first page in line with the national standards?

20 **A.** I agree.

21 **Q.** And -- but further on equipment, on the second bullet  
22 point it says this:

23 "If defibrillators are shared between wards, can  
24 these reach all patient areas within three minutes? (eg  
25 as demonstrated by timed practice runs)?"

1           Do you agree that for a shock to be given within  
2           three minutes, a defibrillator must reach the patient  
3           before three minutes is up?

4   **A.** I think that's fair.

5   **Q.** And again, can the Brief Guide be clarified or tightened  
6           in its wording to ensure that the national standards are  
7           being met?

8   **A.** Yeah, I'm sure it can be.

9   **Q.** I will ask you this, did you author this document?

10 **A.** I didn't, no.

11 **Q.** So are you able to explain why there are these  
12           differences between the CQC Brief Guide and the national  
13           standards?

14 **A.** I can't, no.

15 **Q.** And do you know whether that's something the CQC would  
16           be able to assist the Inquiry with?

17 **A.** We could certainly try.

18 **Q.** Can I then move, please, to inspections that have been  
19           carried out in EPUT in the last 12 months.

20 **A.** Yes.

21 **Q.** Now, as a person with operational oversight for  
22           inspections of EPUT and other providers of mental health  
23           care in Essex, can you tell us whether resuscitation in  
24           emergency response has been a focus of the CQC in  
25           respect of Essex in recent years?

1   **A.** It hasn't been a focus in the sense that we've only gone  
2       in to look at a key area on resuscitation but we have  
3       looked at safe as an important part as our assessment  
4       activity.

5   **Q.** And the inspections you have done, you've done an  
6       inspection of Ipswich Road and that took place on  
7       21 November, 2025, the inspection?

8   **A.** Yes.

9   **Q.** And the CQC also carried out an inspection of Ardleigh  
10      Ward on 21 January 2026?

11   **A.** **(The witness nodded)**.

12   **Q.** Mr Dunn, is it correct that those inspections occurred  
13      because you had specific concerns that had been raised  
14      with you about those two locations?

15   **A.** That's right, yes.

16   **Q.** And the third inspection was the Well-Led inspection you  
17      were on in March?

18   **A.** Yes.

19   **Q.** And was that a planned inspection in the sense it wasn't  
20      in response to any specific issues you were aware of but  
21      it was time for the Trust to have a Well-Led inspection?

22   **A.** Absolutely, yes.

23   **Q.** Now in respect of the inspection at 439 Ipswich Road  
24      there were a number of issues that your inspectors noted  
25      that relate to emergency response deteriorating patients

1 and resuscitation including multiple ligature risks  
2 around the building, broken appliance in the garden,  
3 including a vacuum cleaner, television and fan, garden  
4 tools in an unlocked shed including hose pipes and  
5 a black bin-bag, that's correct?

6 **A.** That's right, yes.

7 **Q.** And all of those items pose an obvious danger to  
8 patients, don't they?

9 **A.** Yes.

10 **Q.** Linked to that, the environmental audits were not  
11 identifying those risks to patients and didn't mitigate  
12 the risks they did find?

13 **A.** (No audible answer).

14 **Q.** And we've seen in the disclosure that EPUT explained why  
15 this was but at the time of the inspection your  
16 inspectors were concerned not to find any ligature  
17 cutters in the coach house?

18 **A.** That's right.

19 **Q.** They also found that not all staff were wearing personal  
20 alarms to summon help in an emergency, despite those  
21 alarms being available?

22 **A.** Yes.

23 **Q.** And there was a failure to fully investigate and  
24 identify learning from incidents, that's correct?

25 **A.** Yes.

1 Q. And at that time Basic Life Support training at 439  
2 Ipswich Road was only at 70%?

3 A. Yes.

4 Q. Whilst not directly relevant to resuscitation emergency  
5 response, your inspectors found a large hole in the  
6 gardens fence through which there was an absconsion risk  
7 and in fact thorough which a patient had absconded?

8 A. Yes.

9 Q. Now, there was a positive in respect of NEWS2; it was  
10 found that monitoring of NEWS2 was completed regularly?

11 A. Yes.

12 Q. And there was a mixed picture on whether audits were  
13 taking place as required; is that a fair summary?

14 A. That's right, yeah.

15 Q. The inspection rated 439 Ipswich Road as "inadequate"  
16 for "safe", and presumably you agreed with that  
17 assessment?

18 A. I did, yes.

19 Q. Following the inspection, is it right that the CQC sent  
20 a Letter of Intent to EPUT, who responded to that letter  
21 with an action plan?

22 A. That's right, yeah.

23 Q. And after that, and after the response, the results of  
24 the inspection of 439 went through your full enforcement  
25 process and the result was a warning notice?

1   **A.**   That's correct.

2   **Q.**   And EPUT have now responded to that warning notice?

3   **A.**   They have.

4   **Q.**   But it remains in place?

5   **A.**   That's right.

6   **Q.**   And the CQC's plan is to reinspect -- or it has

7       re-inspected at 439 Ipswich Road?

8   **A.**   That's right.

9   **Q.**   But the report has not yet been published?

10  **A.**   No.

11  **Q.**   Turning then to the CQC's inspection of Ardleigh Ward in

12       January 2026, during that inspection, your inspectors

13       noted a failure to respond to ligature alarms that had

14       gone off during the CQC's visit, so the CQC was on the

15       ward --

16  **A.**   That's right.

17  **Q.**   -- and staff members were not responding to ligature

18       alarms?

19  **A.**   Yeah.

20  **Q.**   There was a lack of support for staff on the ward when

21       incidents occurred.

22  **A.**   (No audible answer.)

23  **Q.**   There was a failure, inappropriate planning for physical

24       healthcare in respect of one patient who had a condition

25       that required monitoring and medication for whom there

1           was no update or support for those conditions noted in  
2           the care plan after it was produced?

3    **A.**   That's right.

4    **Q.**   There was a lack of consistent monitoring of patients'  
5           health?

6    **A.**   Yes.

7    **Q.**   There were high-risk items with which the patients could  
8           harm themselves available on the ward. And there was a  
9           lack of time for recording incidents and performing  
10          comprehensive handovers?

11   **A.**   Yeah, that's right.

12   **Q.**   Your inspectors also found that the resuscitation bag  
13          was messy and had no tag in place to secure items after  
14          checks were complete?

15   **A.**   **(The witness nodded) .**

16   **Q.**   And the inspectors found that checklists were completed  
17          intermittently and they were not assured that regular  
18          itemised checks were being conducted?

19   **A.**   That's right.

20   **Q.**   Finally in respect of Ardleigh, they found that staff  
21          were burnt out and considered that there were not enough  
22          staff at all times to ensure the safety and wellbeing of  
23          patients, including the fact that staff had not been  
24          able to assist with responding to alarms?

25   **A.**   That's right.

1 Q. And following this inspection, the CQC sent a Letter of  
2 Intent to EPUT?

3 A. **(The witness nodded)**.

4 Q. EPUT responded to that Letter of Intent?

5 A. That's right.

6 Q. And the CQC has now re-inspected Ardleigh Ward?

7 A. **(The witness nodded)**.

8 Q. And the report has not yet been published; that's  
9 correct?

10 A. Yes.

11 Q. Can I ask you a point of detail on this report. Can we  
12 go to it. It's CQC028184. And can we look at page 10,  
13 please.

14 Apologies, I'm not on the right page. Can we go to  
15 the next page. Oh no, apologies. That's the right  
16 page, yes. You can see at the bottom there that your  
17 inspectors discovered there'd been 21 incidents of  
18 restraint between 1 November 2025 and 31 January '26.  
19 There were two incidents of long-term segregation and  
20 rapid tranquilisation had been used 11 times during the  
21 same period.

22 A. **(The witness nodded)**.

23 Q. Now, Mr Dunn, I'm going to assume that you're familiar  
24 with this report.

25 A. Yes.

1   **Q.** There's no reference in the report to levels of ILS  
2       training or availability of ILS-trained staff. Would  
3       you have expected the report to cover that, given the  
4       Brief Guide we've been looking at today?

5   **A.** Not necessarily. So I would expect the report to  
6       reference the training that's been available to staff in  
7       general and bring out any areas of either very good  
8       practice or areas of concern. If there aren't concerns  
9       in relation to those specific training courses,  
10      I wouldn't necessarily expect to see that. As you can  
11      imagine, we expect a wide range of training to be  
12      provided across a lot of different areas which are vital  
13      for good quality patient care and meeting safe, you  
14      know, safety concerns, to list all of them would make  
15      the report relatively unaccessible (*sic*) for members of  
16      the public.

17   **Q.** Thank you. In respect of the Well-Led inspection in  
18      March 2026, and the report that was published in August,  
19      now, as you know, you weren't looking specifically at  
20      safety in that inspection, you were looking at the  
21      leadership of the Trust, the Well-Led point, and there  
22      were findings which we've heard about earlier in the  
23      evidence today about difficulties with learning in the  
24      organisation, backlogs that existed in respect of  
25      incident reviews, and missed opportunities for learning

1 as information on delays was not making it up to the  
2 board. Some patient safety reviews were taking over  
3 two years to complete, and there was a concern that  
4 repeated themes and trends in incident reviews that  
5 needed to be addressed to reduce the likelihood of  
6 recurrence could not happen.

7 Now, my understanding is you issued breaches for  
8 Well-Led in respect of that report but you did not  
9 consider that the problems identified were at the  
10 enforcement level requiring of a warning notice or other  
11 enforcement action.

12 **A.** For the Well-Led breaches, yes, that's right, yes.

13 **Q.** For the Well-Led, yes. And that's having reviewed EPUT  
14 as organisational leadership as a whole?

15 **A.** Yes.

16 **Q.** In respect of the issues you identified in terms of  
17 learning from incidents and incident reporting over  
18 those three reports, what can the CQC do when it  
19 finds -- in respect of what it can do in relation to  
20 registered providers when it finds persistent failings  
21 like that in respect of incident reportings? What are  
22 the options?

23 **A.** It would depend on the impact of those failings. When  
24 we take our enforcement action, for example, we need to  
25 consider the likelihood that it will continue; the

1 impact that that failure will lead to, and we'll use  
2 that to determine, is there a potential for enforcement  
3 and what level that enforcement should take on our  
4 Enforcement Decision Tree, which is available on our  
5 website and that will guide our decision making.

6 The persistence will be measured as well by future  
7 inspection activity, so the recent inspections we've  
8 done, if we have seen similar concerns to the concerns  
9 around the turn of the year for those two different  
10 wards, that would go into part of our decision making.  
11 So we don't just look at the evidence in isolation; we  
12 consider has there been evidence of previous breaches of  
13 this nature or other breaches? What is our confidence  
14 in the leadership at that service or at the Trust in  
15 terms of turning this around? And all of that gets  
16 taken into account in our decision making.

17 **MS SAGE:** Mr Dunn, those are all the questions I have for  
18 you at this point but we'll take a break and we will  
19 come back in ten minutes, so at 4.40, and it may be that  
20 there are some more questions for you then.

21 **THE WITNESS:** Of course, thank you.

22 **MS SAGE:** Thank you.

23 **(4.30 pm)**

24 **(A short break)**

25 **(4.42 pm)**

1     **THE CHAIR:** Ms Sage.

2     **MS SAGE:** Yes, a few more questions.

3             Mr Dunn, Professor Soar says, at paragraph 2.11 of

4     his report, that there's been a move in guidance from

5     national organisations such as NICE, the CQC, GMC, and

6     NHS England, not to specify a specific training course

7     from an organisation such as RCUK and to use more

8     generic terms. Is it part of the CQC's role to specify

9     specific training courses or providers that registered

10    Trusts and providers must use?

11   **A.** No, we can't mandate which providers or organisations of

12    training should be sourced by registered providers.

13    Providing they can show they are meeting the

14    requirements to provide the training support for their

15    staff to meet the needs of people in their care, that

16    satisfies the regulations.

17   **Q.** Professor Soar goes on to express the opinion that one

18    of the drivers of this change away from specifying the

19    RCUK ILS course, is to save on cost and training time.

20    Now you obviously cannot speak for the other

21    organisations, NICE, the GMC, or NHS England, but from

22    CQC's perspective, is Professor Soar's opinion, saving

23    on costs and training time, correct? Is that a reason

24    why the CQC does not specify training from RCUK?

25   **A.** To my knowledge that is not part of anything in CQC --

1 the formation of CQC's guidance. That is not  
2 a consideration for us, the cost isn't part of why we  
3 make our guidance or the Brief Guides.

4 **Q.** Now, there's no specific CQC Brief Guide for  
5 resuscitation in mental health inpatient settings as  
6 a whole.

7 **A.** Correct.

8 **Q.** Do you consider that a specific Brief Guide on  
9 resuscitation and mental health inpatient settings is  
10 required or would be helpful?

11 **A.** I'd like to consider it. I -- obviously, I wouldn't say  
12 definitely, yes or no right now, but I think we should  
13 consider it along with all of the Brief Guides that  
14 you've referred to previously.

15 **Q.** One of your other Brief Guides in this area, in respect  
16 of mental health inpatient care, is the Brief Guide  
17 relating to Patient and Carer Race Equality Framework.

18 **A.** Yes.

19 **Q.** The purpose of PCREF is set out in your document, which  
20 I'm not going to bring up, but it's making sure Trusts  
21 and providers co-produce and implement actions to reduce  
22 racial inequalities within their services.

23 **A.** That's right.

24 **Q.** And do you agree that that applies to the provision of  
25 all care services, and indeed, that the Brief Guide

1       itself refers to preventing ill treatment and that the  
2       implementation of PCREF is relevant to quality of care  
3       and to Regulation 12, provision of safe care and  
4       treatment?

5     **A.** Yes, PCREF, as we refer to it, is about equity and  
6       equality for all service users, so, yes.

7     **Q.** Do you agree that that should extend to ensuring that  
8       clinical training and guidance is appropriate for  
9       patients across diverse skin tones?

10    **A.** I agree.

11    **Q.** For example, and specifically, do you agree that if  
12       there are differences in how certain symptoms of  
13       physical deterioration appear in people of darker skin  
14       tones, that should be included in training and guidance  
15       on the recognition of physical deterioration?

16    **A.** I agree, so that the staff are able to meet the needs of  
17       the people in their care.

18    **Q.** The CQC Brief Guides themselves, those that relate to  
19       physical health care and resuscitation, don't appear to  
20       incorporate any guidance for inspectors or questions for  
21       inspectors to ask that relate to potential differences  
22       in presentation between patients of different skin  
23       tones. Is that something the CQC would consider  
24       incorporating into its guidance for inspectors or is it  
25       provided in guidance -- in different guidance already?

1   **A.** I'd have to go and think about that but the overarching  
2       guidance from the PCREF Brief Guide could well be  
3       applied to all Brief Guides to make sure that  
4       differences are recognised across the whole regulatory  
5       sort of offer from us.

6   **Q.** And one of the things you say in your statement in  
7       response to the Inquiry following up on Mr Benson  
8       Clarke's evidence in July is that you would welcome  
9       further input from RCUK into your training and  
10      assessment materials. Would you consider raising that  
11      issue specifically with them so that you can get  
12      guidance from them on -- for your inspectors on how to  
13      seek evidence that providers are considering darker skin  
14      tones in their guidance?

15   **A.** I'd be very open to that conversation.

16   **Q.** And then finally this: you gave some evidence about how  
17      inspectors review and use Prevention of Future Deaths  
18      reports from the coronial service, is there a specific  
19      mechanism for ensuring that issues raised in PFD  
20      reports, and here we're speaking about resuscitation and  
21      emergency response issues specifically, are followed up  
22      on during inspections, and if there is, is there  
23      provision for that to occur within a particular time  
24      frame?

25   **A.** So the provision is that, as our inspectors plan their

1 inspections, they'll review the evidence and the  
2 intelligence we hold. In the meantime, if they're not  
3 planning for an inspection, they review intelligence  
4 about services, and, like I said earlier, we have  
5 engagement with providers on a regular basis.

6 If we've -- spotting patterns and trends emerging in  
7 that intelligence that there's areas of concern, that  
8 may shorten the time frame before the next inspection  
9 but there isn't necessarily a set timeframe for "You  
10 must inspect within a certain length of time of  
11 receiving or identifying a person through a PFD."

12 **MS SAGE:** Thank you.

13 Mr Dunn, those are all the questions that I have for  
14 you.

15 Chair, do you have any other questions?

16 **THE CHAIR:** I don't, no.

17 **MS SAGE:** In which case ...

18 **THE CHAIR:** Thank you very much indeed for coming, and thank  
19 you for giving us your evidence so clearly.

20 **THE WITNESS:** Thank you.

21 **THE CHAIR:** We'll now rise and sit at 10.00 tomorrow.

22 **THE WITNESS:** We'll sit at 10.00 tomorrow, yes, thank you.

23 **(4.49 pm)**

24 **(The hearing adjourned until 10.00 am the following day)**

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