

OPENING STATEMENT OF COUNSEL TO THE INQUIRY

Chelmsford Civic Centre, 5 October 2026

Introduction

1. Thank you, Chair.
2. Chair, this is the Inquiry's eighth public hearing. We return for this hearing to the Civic Centre in Chelmsford, where we began this Inquiry's hearings in September 2024. It was here that you opened this Inquiry by inviting bereaved families to give deeply moving commemorative accounts about those who died and about the impact of those losses on their families' lives.
3. Since that time, the Inquiry has made considerable progress. Three of our hearings have been dedicated to evidence from bereaved families. You have received and heard evidence about the challenges in providing, and monitoring safe, and therapeutic inpatient mental healthcare from a wide range of organisations. In July this year, you heard from a number of members of staff at EPUT about their individual experiences. Work *outside* of hearings to investigate the systemic issues emerging has continued without break. Throughout this time, all those families who have been bereaved have remained, and will continue to remain, at the very heart of this Inquiry's work. At your direction, your team continues to work closely with the families who feel able to engage with the Inquiry.

Emotional Support

4. Chair, within this hearing we will be hearing some evidence which is traumatic in nature and contains descriptions around ligaturing, self-harm and death.
5. As you have made clear, Chair, the wellbeing of those engaging with the Inquiry is extremely important. For that reason, may I take this opportunity to reiterate that emotional support is available to all those who are participating in the Inquiry.
6. Anyone present in this hearing room is welcome to leave at any time, although you have requested Chair that they wait until a break in proceedings to come back in so as not to interrupt focus on the difficult, sensitive and sometimes, highly technical evidence that the Inquiry is hearing. Throughout the hearing, we will have here two support staff from Hestia, an experienced provider of emotional support. There is a private room where you can talk to Hestia support staff if you require emotional support. The Hestia support staff are wearing orange-coloured lanyards and scarves. Alternatively, please do speak to a member of the Inquiry Team and we can put you in touch with Hestia. All members of the Inquiry Team are wearing purple-coloured lanyards.
7. If you are watching the hearing online, you can find information about the emotional support available on the Lampard Inquiry website at LampardInquiry.org.uk and under the 'Support' tab near the top right-hand corner of your screen. You can also

contact the Inquiry Team's mailbox on contact@lampardinquiry.org.uk for this information.

8. We want all those engaging with the Inquiry to feel safe and supported.

Legal Representation

9. Chair, there will be a number of the Counsel to the Inquiry Team involved in this hearing over the next two weeks. You will be assisted this week by Teniola Onabanjo, Paul Wakerley, and Katie Sage. Next week you will also be assisted by Nicholas Griffin KC, and Claudia Hyde. Counsel to the Inquiry have engaged with their respective witnesses, working to ensure that each is given the opportunity to provide their best evidence. This Inquiry is independent from all other organisations and any individuals with an interest in this Inquiry however, and we continue to exercise great care to ensure that we retain that independence.
10. Your Counsel to the Inquiry Team works closely with the Inquiry Solicitor Team, under the lead of the Solicitor to the Inquiry, Catherine Turtle. You are also assisted by the Secretariat Team, led by Helen Gibson, whose members provide crucial operational, administrative and logistical support to enable the Inquiry to carry out its work.
11. Chair, you are also assisted by the Recognised Legal Representatives and Counsel teams of the Core Participants. A list of those representatives is available on the Inquiry's website.

The Interim Recommendations Hearing

12. Chair, earlier this year, having considered carefully the evidence from Bereaved Families that the Inquiry has received and heard over the course of our hearings thus far, you determined that at this hearing, the Inquiry would focus on issues that had emerged with regards two specific themes. As I outlined at the start of the Inquiry's hearing in July, those themes are:

- (a) Emergency Response and Resuscitation of deteriorating patients on mental health inpatient units;
- (b) Observations and the Use of Technology.

13. You directed your team to investigate these two areas further and without delay, because you are concerned that the issues arising may hold implications for the safety of **current** patients. These issues may also be of national impact, reaching beyond the boundaries of Essex. Chair, you determined that these investigations could not wait, and that subject to the evidence you receive, you may wish to consider making interim recommendations.

14. At *your* direction, your team has sought to obtain evidence in relation to both of these topics, and to carry out its investigations at pace, working nonetheless to exacting standards of rigour, impartiality and fairness. That, Chair is the balance that must be struck by this Inquiry in all of its work; with every member of your dedicated team recognising, at all times, that there are real, live and active issues in relation to the safety of patients at the base of

its investigations but in parallel, that its work must remain, in every aspect, unfailingly meticulous.

15. Chair, you have invited Core Participants to make oral and/or written submissions on these topics at the close of this hearing. In order to allow Core Participants and their legal representatives time to consider the evidence that we will hear over the next two weeks, the oral closing submissions for those wishing to make them, will be heard virtually on the 20 October 2026, with any written submissions to be received by 30 October 2026.

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

Emergency Response and Resuscitation

17. I turn now to outline the two topics that you identified earlier this year for urgent investigation. I will start with the provision of emergency response and resuscitation. Chair, the evidence you heard in the July hearing touched on some of the substantial and specific challenges potentially faced by staff on mental health units when responding to emergencies. There are specific considerations connected to emergencies in mental health settings. We also learned that the window of opportunity to improve outcomes for deteriorating patients in mental health settings is a very short one.

RCUK

18. On 20 July 2026, the Inquiry heard oral evidence from Adam Benson Clarke, the Director of Clinical and Service Development at Resuscitation Council UK, also known as RCUK for short.

19. RCUK is a non-statutory, Charitable Incorporated Organisation which describes itself as

“dedicated to saving lives by developing guidelines, influencing policy, delivering courses and supporting innovative research concerning resuscitation practice.”

20. Mr Benson Clarke described RCUK’s core remit as writing the National Guidelines for resuscitation for the UK. He explained the role that RCUK plays in setting standards for the provision of emergency response and resuscitation across all healthcare settings in the United Kingdom, what the purpose of those standards were, and why RCUK recommended a certain level of training for certain roles. RCUK’s *“Quality Standards: Mental health inpatient care”* document, first published in 2014 and updated in 2020, is due to be reviewed as part of RCUK’s work plan for 2026, although as yet, there is no confirmed timetable for publication.

21. One of the key criteria of RCUK Mental health inpatient care Quality Standards, as explained by Mr Benson Clarke, is that training must be to a level appropriate for the staff members’ expected clinical responsibilities, rather than related to any particular job title.

22. In his evidence, Mr Benson Clarke described cardiac arrest as the ultimate medical emergency, where seconds count. While he explained that a swift and effective response was of fundamental value, he told us that the most important interventions are those that prevent cardiac arrest altogether. That, he said, gives a greater chance of survival for managing individuals as they deteriorate.

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

24. Chair, the Inquiry learned in July that a larger proportion of cardiac arrests in mental health settings are secondary cardiac arrests which occur in response to a trigger. With a ligature event for example, cardiac arrest occurs at the end of a process that includes loss of consciousness and breathing stopping. Those cardiac arrests usually have non-shockable cardiac arrest heart rhythms (where the defibrillator will not work), time is short, and survival rates tend to be poor. The key interventions for this group of patients are therefore related to the **prevention** of cardiac arrest in the first place.

25. Mr Benson Clarke was asked about ligature-related asphyxia events. He emphasised that the first actions would be focused on

preventing the individual from going into cardiac arrest. Actions would be focused on calling for assistance, removing the ligature, looking to start chest compressions and doing basic level life support whilst waiting for other people to come to help.

26. Chair, you listened carefully to that evidence, as well as to the evidence of the staff members who touched on this topic during the July hearing,

27. Following that hearing, you directed your Inquiry team to obtain additional evidence, including expert evidence about:

- a. the special circumstances and the types of situations on mental health units that give rise to emergencies;
- b. the clinical position and clinical indications when such emergencies arise.

28. In addition to obtaining expert evidence, the Inquiry has worked to obtain evidence exploring the reality of the day-to-day workings of mental health units, and the challenges when emergencies arise which include: the ability of staff to recognise emergency situations; clinical response and emergency decision-making; availability and accessibility of vital equipment and the adequacy of interventions and resuscitation practices and procedures, past and present.

29. Chair, you were keen to understand how a member of staff who may be a first responder (whatever their title and position) is currently, or should be, trained to recognise patient deterioration and to use the skills required to prevent cardiac arrest, in the

distressing and inevitably traumatising circumstances in which cardiac arrest occurs

30. Over the coming week, the Inquiry will therefore hear oral evidence from the following witnesses:

- a. Two representatives from a **comparator trust** from whom the Inquiry has requested evidence, East London NHS Foundation Trust [**ELFT**]: Ruth Bradley and Rebecca Lingard.
- b. Three representatives from **EPUT**;
 - i. Nick Archer, Head of Deteriorating Patient Pathways and the EPUT Resuscitation Training Officer.
 - ii. Dr Kallur Suresh, Consultant Psychiatrist and Chief Medical Officer at EPUT;
 - iii. Ann Sheridan, Registered General and Mental Health Nurse and Executive Nurse at EPUT;
- c. **NHS England**: Thomas Simons and Dr Dawn Adamson, who will provide evidence about NHS England's quality standards and imminent changes to mandatory training.
- d. On behalf of the **CQC**, Stuart Dunn, who will provide further contextual evidence about how the regulator inspects and scrutinises emergency response and resuscitation provision.
- e. **Professor Jasmeet Soar**, a Consultant at Southmead Hospital, Bristol NHS Foundation Trust and a national and international expert in cardiac arrest treatments, guidelines and outcomes.

Comparator Trusts

31. Chair, when you started hearing the evidence about emergency response and resuscitation in July, the Inquiry had already received information from a number of comparator trusts as to

their policies and procedures. The Inquiry made further requests of two of those comparator trusts and we shall hear later today from witnesses from one of them ELFT (East London NHS Foundation Trust):

- a. Ruth Bradley, Director of Nursing at ELFT;
- b. Rebecca Lingard, the Borough Lead Nurse.

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

33. The purpose of the evidence from ELFT is therefore two-fold:

- a. Firstly, to explore how other, similar, mental health trusts approach the provision of emergency response and resuscitation;
- b. Secondly, to understand from Rebecca Lingard, a practitioner who has worked for many years in mental health services, the practical realities of dealing with an emergency situation arising on the ward.

34. I should say Chair, that during the course of her evidence, Rebecca Lingard will describe in detail the process of the emergency response that should occur on finding an unresponsive person, setting out the various stages involved in that response. She will also provide evidence about the practical realities of response and resuscitation in an emergency on a mental health ward. This necessarily involves content that can be described as traumatic, including references to self-harm and death that could cause deep distress to those following the evidence. This Inquiry cannot

shy away from calling difficult and distressing evidence where it is necessary to do so. I therefore take this opportunity again to reiterate that emotional support is available for those participating in the Inquiry, both via our website and, here in the hearing room, through speaking to Hestia or to any member of the Inquiry Team.

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

EPUT

36. I move now to EPUT. Prior to the July hearing, the Inquiry requested evidence in relation to resuscitation practices and procedures from all of our Core Participant trusts and healthcare providers. Those requests for evidence were to assist you in understanding whether the current and most recent and procedures in place are (and were) appropriate to ensure that those working on mental health inpatient units are properly prepared and/or equipped to react in emergency situations.

37. The Inquiry received responses from EPUT, St Andrew's Healthcare, Priory Group, Cygnet Health Care and North East London NHS Foundation Trust. We will hear oral evidence from

EPUT representatives during the course of this week. Evidence provided by the other Core Participant providers will be summarised for you Chair, and made available on our website. We will also address briefly the material the Inquiry has obtained from non-Core Participant trusts in different parts of England and from relevant organisations such as the Out of Hospital Cardiac Arrest Outcomes (OHCAO) registry and the East of England Ambulance Service.

38. Chair, the Inquiry has also received further evidence on this topic from staff witnesses whose statements were disclosed to Core Participants in advance of this hearing and will be published on the Inquiry website afterwards. Those staff witness statements include Judith Skargon, who sets out her involvement in drafting EPUT's Resuscitation Procedure between 2018 and 2023 and deals with the Trust's failure to adhere to NICE Guideline NG10, and further statements from Chloe Cawston and Louise Borton, who you will recall both gave evidence to you in July.

39. In her second statement to the Inquiry, Louise Borton, who has been a matron at EPUT since February 2021, addresses a number of matters relevant to emergency response and resuscitation. These include: training and preparedness for medical emergencies; emergency and resuscitation drills that have taken place previously, as well as current arrangements for medical emergency simulations; safety alerts, memorandums and implementation of learning; how competency is managed on the ward; the previous working arrangements with Basildon and Thurrock University Hospital; emergency incident response and learning; and recurring concerns.

40. Notably, Chair, within her second statement Louise Borton states that in September 2022 she raised specific concerns with Nicholas Archer, the Head of Deteriorating Patient Pathways at EPUT about staff having issues locating specific equipment during time-critical situations. We will be hearing from Mr Archer tomorrow morning and he will be asked questions about that. For that reason, and before Mr Archer's evidence is heard, a more detailed summary of Louise Borton's second witness statement will be read out.

Nicholas Archer

41. Turning then to Mr Archer's evidence, as Head of Deteriorating Patient Pathways and Resuscitation Training Officer, Mr Archer leads at EPUT on the development and implementation of strategies to ensure the safe and appropriate management of the deteriorating patient, and oversees EPUT's resuscitation training provision. His evidence, reflecting the key areas he oversees, will address:

- a. EPUT policy and practice, including changes he has implemented;
- b. staff training, required standards of training for staff on the ward and changes to training over the past few years;
- c. oversight, monitoring and audit in areas where he is responsible for that oversight, monitoring and audit;
- d. simulations and drills, and whether or not those are taking place as required;
- e. learning; including:
 - i. how the trust identifies areas for improvement;

- ii. in what ways and to what extent the trust learns from previous incidents as well as from good practice;
- iii. how such learning is implemented.

Dr Kallur Suresh and Ann Sheridan

42. On Wednesday, we will hear from Dr Suresh, Consultant Psychiatrist and Chief Medical Officer at EPUT, and Ann Sheridan, Registered General and Mental Health Nurse and Executive Nurse at EPUT. In broad terms, their evidence will address:

- a. the Trust's review processes for CPR policy;
- b. oversight of emergency response and resuscitation provision at Board level;
- c. steps taken to address a recognised need for improvement in the early identification of deteriorating patients and appropriate escalation;
- d. emergency equipment and drugs, including EPUT's particular requirements for lifesaving medications;
- e. staff training, including training budgets, orientation for locum, bank and agency staff; simulations; CPR drills and scenario training and availability of ILS-trained staff.

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

NHS England

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

45. Mr Simons' evidence provides an explanation of the current Core Skills Training Framework (CSTF) which is the principal national framework for statutory and mandatory training across providers of NHS services in England, as it relates to resuscitation.

46. In April 2024, NHS England announced its intention to reform the existing approach to Statutory and Mandatory training through the development of a new professional StatMand framework. This has been developed jointly by NHS England, the DHSC, the CQC, the HSSIB, NHS Resolution and a range of expert and staff stakeholders. NHS England has endorsed the framework, which is now undergoing final approval from ministers prior to publication.

47. NHS England has provided to the Inquiry the draft version of the framework, which imposes a number of competencies, including "role specific" competencies, which we will hear about in more detail. NHS England has told the Inquiry that the new framework recognises that staff working within mental health services may

be required to respond to emergencies that are less commonly encountered in other healthcare settings, and has included competencies relating to resuscitation following self-harm.

48. The Inquiry will be looking to examine the proposals and to understand the reasons for the development of the new framework. We will explore what the changes are and the likely impact of those changes.

49. Chair, you have already noted that the Inquiry has received material from NHSE relevant to this hearing very late in the day. Chair, you have expressed your dissatisfaction at this late disclosure, which in your view was wholly avoidable. It has inconvenienced you and the Inquiry team. It has further placed unnecessary pressure upon Core Participants, many of whom are bereaved families. Having to review sensitive material at such short notice and having to provide instructions to legal representatives on the same can cause significant distress. Chair, you have directed that NHSE be required to provide you with an explanation as to this late disclosure and assurances moving forwards that this will not occur again.

CQC

50. On Wednesday afternoon, Stuart Dunn will give evidence to the Inquiry on behalf of the Care Quality Commission ['CQC']. Mr Dunn is the Interim Director of Mental Health for the CQC.

51. The CQC have provided the Inquiry with a number of “monitoring and inspecting mental health services – Brief guides”, which are

described as a learning resource for CQC inspectors and inspection teams. These provide information, references, links to professional guidance, legal requirements or recognised best practice guidance about particular topics.

52. Included amongst these Brief Guides is the ‘Brief Guide: Immediate Life Support training for services that may use restrictive interventions’, which is not specific to mental health settings but refers to National Institute for Health and Care Excellence [“NICE”] guidance. That NICE guidance recommends that any setting where restrictive interventions (rapid tranquilisation, restraint or seclusion) are used should have immediate access to staff trained in Immediate Life Support [“ILS”] and to appropriate ILS medication and equipment.

53. The Inquiry intends to consider the status, in practice, of the CQC’s Brief Guides: how they are received, viewed and treated by the healthcare profession, including in mental health settings. The Inquiry also intends to look at the content of the relevant Brief Guides: their adequacy and appropriateness, and whether or not they reflect the relevant national standards.

54. To this end, Stuart Dunn will also address some of the evidence we heard from Mr Benson Clarke of RCUK in July. Mr Dunn will confirm the CQC’s view as to RCUK’s potential input into their work. Mr Dunn suggests that such input could include incorporating checklists and/or other protocols developed by RCUK into existing Brief Guides. The Inquiry may wish to explore the feasibility of input from the RCUK to assist the CQC in its inspection work and, potentially, to monitor implementation.

Expert evidence: Professor Soar

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

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

57. Chair, the Inquiry has also instructed Professor Soar to provide his expert opinion on some of the guidelines, policies and procedures issued by relevant authorities, as well as the relevant policies, procedures and training provision relating to emergency response and resuscitation in place at EPUT

58. Chair, it is important to highlight now - although I will do so again on the morning of his evidence later this week - that Professor Soar's evidence, particularly his evidence in relation to special circumstances giving rise to cardiac arrest and the associated clinical indications, will necessarily include detailed descriptions of the physiological processes that take place following self-injury

and other trigger events, the different mechanisms by which those processes can be brought about, and the ways in which they can lead to cardiac arrest and, ultimately, to loss of life. For some, this evidence may be simply too graphic and too challenging to hear. May I say again, for those engaging with the Inquiry who are following online or who are present in the room, please be assured that emotional support is available; the Inquiry's emotional support counsellors stand ready to assist those who need support.

Prevention and treatment of cardiac arrest

59. Turning firstly to cardiac arrest, the Inquiry will hear expert evidence from Professor Soar about the differences between primary cardiac arrest – when the heart stops beating first due to a primary heart problem – and secondary cardiac arrest – when the heart stops beating secondary to causes which have led to a process of physiological changes in the body.

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

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

62. Professor Soar will address some of the complexities in identifying deterioration and cardiac arrest, which he explains can be difficult for healthcare staff let alone lay people. Professor Soar will explain to the Inquiry the interventions that can be undertaken in mental health inpatient settings for a deteriorating patient.

Special circumstances

63. The Inquiry has already heard some evidence from Mr Benson Clarke about what are known as special circumstances. As I outlined a few moments ago, the Inquiry asked Professor Soar to provide an expert clinical opinion about the particular circumstances that may cause deaths in mental health inpatient settings. These special circumstances reflect trigger scenarios – such as asphyxiation by ligature or airway obstruction, overdose, or other serious self-harm – that may be more likely to occur in mental health inpatient settings, and which lead to secondary cardiac arrest. Professor Soar's evidence will also include information about the critical timeframes between injury and cardiac arrest – in every case, this is a matter of minutes.

Quality standards and Training

64. Professor Soar will also address the RCUK's Quality Standards for mental health settings, as well as changes to training requirements.

65. One key feature of the RCUK mental health Quality Standards identified by Professor Soar, is that staff should be trained and

updated regularly to the level of proficiency and skill appropriate to each person's expected role. As we heard from Mr Benson Clarke, the standards do not differentiate between registered and non-registered clinical staff. This is important because there is an observable increase in the use of non-registered staff in clinical roles in all healthcare settings. Professor Soar cites a Kings Fund report, published in 2024, that for adult mental health services in 2012/13, the skill mix of adult acute wards comprised 60% registered nursing staff and 40% support staff (i.e. non-registered staff). By 2022/23, this staffing mix had reversed.

66. The level of training specified in the Quality Standards is focused on what an individual is expected to **do** as part of their clinical role rather than their specific clinical role. In Professor Soar's opinion, there is no reason why a non-registered member of clinical staff should not undertake Immediate Life Support training for example. The fact that ILS training is suitable for non-registered staff is, he explains, important in mental health settings because the first responders to an emergency are often non-registered staff. Professor Soar confirms that ILS-level training is already being completed by people in non-clinical roles outside healthcare, including police officers and members of the Armed Forces, who have no clinical registration and, unlike a healthcare assistant, have no day-to-day exposure to patients.

Guidelines, Standards, Policies and Procedures

67. The Inquiry also invited Professor Soar to provide expert opinion on consistency across RCUK Guidelines, Quality Standards, CQC Guidance, NICE Guidelines and other relevant national standards.

68. National standards include those set by NHS England. Resuscitation training currently falls under ‘mandatory training’ for all NHS staff within NHSE’s Core Skills Training Framework [‘CSTF’].

69. The Inquiry understands however, that the CSTF is due to be replaced by a national programme with a new competency-based framework. As I have already outlined, the Inquiry will hear further detail from NHSE about those changes. Professor Soar has reviewed the proposed resuscitation element of the new framework and observes that the basic level for most staff including in mental health settings is probably lower than at present. He considers there will still be gaps to be filled, for example it is not clear how the new framework will address guidance on the need for ILS trained staff for settings using tranquilisation or restraint.

EPUT Policies

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

71. Professor Soar will point out however, that for *all* healthcare organisations, including EPUT, it is the translation and implementation of policy and procedure documents into the delivery of safe and effective patient care that matters. System

focused and engineered interventions such as removing ligature points are the most effective interventions. Least effective are interventions that require staff to be more vigilant, to work harder, or to rely on staff memory, because human factors are the most prone to failure.

72. EPUT's CPR Policy appears to be generic for all trust settings which means that some issues that are specific to mental inpatient settings are not always addressed explicitly within the policy. We will explore a number of the observations that Professor Soar makes about the content of EPUT's documentation including CPR Policy, mandatory training policy, and Basic Life Support Lesson Plans, on Thursday.

73. As I have already outlined however, Professor Soar is emphatic in his central opinion. Where a trigger event may give rise to secondary cardiac arrest, the best possible chance of saving a patient's life is to **prevent** that secondary cardiac arrest. That may be by appropriately trained and equipped staff reacting and intervening quickly when a patient is discovered in medical emergency, or better still, by appropriately trained and equipped staff making sure that no trigger event takes place in the first place. It is for this reason amongst others, that this Inquiry has looked so carefully at how observations are carried out in mental health inpatient settings.

Observations and the Use of Technology

74. Chair, I turn then to the Inquiry's investigation into observations and the use of technology within mental health inpatient

settings. With the exception of one witness from whom we will hear this morning, we will hear the evidence on this topic in the second week of this hearing.

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

76. As you will recall Chair, in October 2025, the Inquiry heard evidence from Zephan Trent, the Executive Director of Strategy, Transformation and Digital at EPUT, from Laura Cozens, Head of Patient Safety and Quality at Oxehealth Limited, and from Hat Porter, a representative of a national campaign group, Stop Oxevision.

77. That evidence provided important information as to the use of the Oxevision system at EPUT, and the nature of the system more generally. The Stop Oxevision evidence provided you with context about the lived experience of some of the patients who have been subject to the use of vision-based patient monitoring systems, as well as setting out their concerns about the use of such systems.

78. Having heard evidence in October 2025, you identified several areas you wanted to explore further in relation to Oxevision. Those areas included, but were not limited to:

- a. the purpose and use of Oxevision in mental health inpatient settings;

- b. the potential benefits and harms associated with the system, including any unforeseen or unintended consequences of its use;
- c. the strength of the evidence base in support of the use of the system;
- d. the adequacy and operability of EPUT's governance, training and Standard Operating Procedures relating both to observations generally, and Oxevision in particular;
- e. the processes and decision-making that informed EPUT's pilot, evaluation, and ultimately EPUT's wide deployment of Oxevision.

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

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

81. Ms Archibald also considered the evidence provided by families of those who have died whilst under the care of EPUT. Following the hearing in July, the Inquiry instructed a further expert who has undertaken the same exercise. That is Dr Francesca Denman, Consultant Psychiatrist, about whom I will say more in a moment.

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

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

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

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

This Hearing

85. Chair, over the course of this hearing, you will hear evidence from seven further witnesses in relation to observations and use of technology. For the most part that evidence will be heard in the second week.

86. Firstly however, in order to accommodate availability, you will hear later this morning from Mr Gareth Harry, NHS England's National Delivery Director for Mental Health, Learning Disability and Autism. He will provide evidence as to NHS England's approach to new technologies being considered for use in healthcare settings, and NHSE's understanding of the Oxevision system.

87. Next Monday, 12 October, the Inquiry will hear evidence from Dr Francesca Denman, an expert Consultant Psychiatrist. Dr Denman will provide opinion from her perspective on observation practices generally in mental health inpatient settings, as well as her views as to the role and capabilities of the Oxevision system. Dr Denman describes what are, in her view, some of the system's limitations. Her evidence builds upon that which the Inquiry heard in July from Ms Archibald and will inform the Inquiry as to the expected practices and standards for undertaking observations in mental health inpatient settings, as well as identifying where and how there have been departures from those standards.

88. Furthermore, the Inquiry will draw on Dr Denman's considerable experience of clinical leadership within NHS mental health trusts. Between 2012 and 2021, she was the Medical Director of Cambridgeshire and Peterborough NHS Foundation Trust. She will assist the Inquiry in understanding and appraising EPUT's approach to the trial and deployment of the Oxevision system on its inpatient wards, and the relevant considerations for an NHS trust when evaluating and assessing whether new technologies meet an organisation's requirements. Dr Denman is well placed to speak to the broader governance aspects of how the system was deployed and used at EPUT, and whether and to what extent the Trust responded appropriately to emerging concerns.

89. The Inquiry will hear evidence again from Laura Cozens of LIO, the organisation formerly known as Oxehealth. Miss Cozens has now provided the Inquiry with a total of four witness statements, the most recent being an unsolicited witness statement received by the Inquiry on the 24 of September 2026. That statement was accompanied by a letter from the Oxehealth Board to you Chair, which, we were told, was also circulated by LIO to Core Participants via their legal representatives. This is another example of late disclosure of material to the Inquiry, the difficulties with which I have already outlined.

90. Ms Cozens' Fourth Statement considers the capabilities and role of Oxevision as LIO sees them. The Inquiry intends to address the matters covered in Ms Cozens' Fourth Statement during this hearing, as well as wider issues which arise from LIO's earlier evidence, both written and oral. In doing so, it will consider all the evidence provided, from all Core Participants, with an open mind.

91. Following Ms Cozens' evidence on 13 October 2026, the Inquiry will hear from Derrick Trimble, the Oxevision Project Manager at EPUT. His evidence sets out how EPUT viewed the Oxevision platform, and the organisation's experiences of the system during the roll out and since. His evidence will supplement the evidence we will hear from senior EPUT witnesses.
92. Those witnesses will be Zephan Trent and, once again, Dr Kallur Suresh. As I previously outlined, Mr Trent gave evidence to the Inquiry in October 2025. He will be joined by Dr Suresh, EPUT's Chief Medical Officer. Together, they will give evidence addressing a number of matters arising from the evidence heard last July. These include: (i) EPUT's evaluation of the Oxevision system prior to its widespread deployment; (ii) EPUT's approach to consent over Oxevision's period of use; (iii) the Trust's systems for training and audit; (iv) emerging concerns as to Oxevision's use; and (v) how EPUT considers that Oxevision assists in the management of patients' physical health needs.
93. On Thursday 15 October, the Inquiry will hear evidence from Robert Reid, Deputy Director for Innovative Devices at the Medicines and Healthcare products Regulatory Agency ['MHRA']. He will speak to MHRA's oversight of new technologies and its assessment of the Oxevision system. Taking that evidence alongside other witness statements obtained from the Department of Health and Social Care ['DHSC'], the National Institute for Health and Care Excellence, the CQC and the British Standards Institution ['BSI'], the Inquiry aims to understand the supervisory landscape and the principles which support and

regulate the deployment of new technologies in mental health care settings. It will be a matter for you, Chair, as to whether that landscape provides sufficient monitoring, or whether the evidence of how the system has operated in relation to Oxevision suggests that improvements in that system of oversight, assessment, and regulation are required.

Concluding Remarks

94. Chair, our hearing here in Chelmsford will conclude on Thursday 15 October. As I outlined earlier, you have invited Core Participants to make oral submissions to you on the topics of emergency response and resuscitation, and on observations and the use of technology at a virtual hearing on Tuesday 20 October.

95. As you have recognised, Chair, whilst this Inquiry is founded in Essex, these topics, like so many of the issues which you are investigating appear to extend well beyond that county and have a wider reach.

96. Finally Chair, the Inquiry is grateful to all Core Participants and external organisations for their input and engagement into these important subjects so far.

Rebecca Harris KC

Rachel Troup

Thomas Hayes

Samuel Glanville

Counsel to the Lampard Inquiry