

Witness Name: Rebecca Lingard

Statement No.: 1

Dated: 03/09/2026

LAMPARD INQUIRY

FIRST WRITTEN STATEMENT OF REBECCA LINGARD

I, Rebecca Lingard, will say as follows: -

1. I am Rebecca Lingard, of East London NHS Foundation Trust, 9 Alie Street, E1 8DE.
2. My professional qualifications are MSc, BA, Dip in Nursing. I am a Borough Lead Nurse, for East London NHS Foundation Trust ("ELFT"). I have previously been an Honorary Lecturer - City University and Clinical MAPPA Instructor.
3. I have been in the caring profession for almost 35 years, starting my career as a care assistant on a dementia unit. I qualified as a registered Mental Health Nurse in 2003. I spent 4 years working on a busy inner London acute admissions unit. I have held several roles within ELFT since joining 2003, including Clinical Nurse Manager and Matron. I have special interests in psychiatric intensive care, specifically women's services, and have worked in this care setting for over 10 years. I was the Interim Operational Manager for the London Trial Site for the Liaison and Diversion Service (Criminal Justice Mental Health Team), helping to establish the service before handing over to a substantive operational lead September 2013.
4. In 2017, I became a contributing Author for '*Psychiatric and Mental Health Nursing: The Craft of Caring*', assisting in writing the chapter on Psychiatric Intensive Care.

I also have an MSc in Inter Professional practice completing a research project on patient's experiences of being nursed in different hospital environments.

5. In May 2019, I was invited to join a Working Party with Health Education England to help develop content and deliver teaching to Mental Health In-Patient Services in West Bengal. The project delivered a 'train the trainer' programme in November 2019 on de-escalation skills and reducing restrictive interventions. I also have a special interest in Trauma Informed Care and Human Rights Approaches to Health Care.
6. I provide this statement in response to the Rule 9(2) Request dated 11 August 2026.

Background and experience

7. I have been asked to provide details of the roles and experience I have of working on, and managing, mental health inpatient units between 1 January 2017 and August 2026. I confirm that, between 2017 and 2018, I held the role of Matron for a Woman's Psychiatric Intensive Care Unit, and a Women's Acute Inpatient Unit, both of which were for working age adults.
8. In 2018, I became the Lead for Nurse Development Programmes at ELFT, overseeing the review and progress for Nurse Development programmes at all bands, for mental health inpatient units and community health. In June 2019, I began a secondment as Associate Director to Norfolk and Suffolk Foundation Trust, with the remit of co-producing, designing and delivering a range of Nurse Development Programmes.
9. I am currently the Borough Lead Nurse for City & Hackney Centre for Mental Health ("City & Hackney") (previously known as the Homerton Mental Health Services unit) and have been in this substantive post since February 2020. I am responsible for all in-patient mental health settings including 4 acute adult wards, 1 early intervention service, 1 male psychiatric intensive care unit, 1 regional

mother and baby unit, 2 health-based place of safety suites, and hospital site services.

10. ELFT has a number of different mental health inpatient settings on multiple sites across London, Luton and Bedfordshire. Details of the Trust's overarching resuscitation policy and practice have been provided in Ruth Bradley's statement dated 19 June 2026, which I understand has already been provided to the Inquiry Team. Paragraphs 31-61 of that statement provide details of the Trust's resuscitation policy (the resuscitation policies are exhibited to that statement at **RB/2, RB/3**) which applies to all sites and explains the local differences in terms of emergency response where relevant. I am only able to speak to the processes and procedures at the City & Hackney inpatient setting and this statement is limited to that setting.

Training

11. We have been asked to provide details of the training that I have undertaken and that other members of staff are required to complete relating to resuscitation since 2017.
12. In terms of the training that I personally have completed in relation to resuscitation, as a registered nurse I am required to complete yearly updates on resuscitation training. As a registered nurse working on inpatient wards, I was expected to undertake the Immediate Life Support ("ILS") training. As a Borough Lead Nurse, I am now expected to undertake the Basic Life support ("BLS") training every year. The trainer providing the training also carries out the assessment for the training course. I am currently compliant with this training, and it is next due on 14th January 2027. It is an in-person training event and is 2 hours in duration.
13. We have been asked to provide details of the resuscitation training staff are required to complete. My colleague, Ruth Bradley, has provided detailed information in her statement dated 19 June 2026, which covers the training staff are required to complete relating to resuscitation including the Trust's training

providers (paragraphs 63-67, 80); the training that different levels of staff are required to complete (paragraphs 68, 80-83, 98); the duration, mode of delivery and frequency of that training (paragraph 69, 85-87); the types of training and content of the training (paragraph 75-78, 99). I refer the Inquiry team to that statement and the exhibits to that statement.

14. My understanding is that the Trust's resuscitation policy and practice including the resuscitation training is based on the Resuscitation Council UK (RCUK) guidance.
15. The training does indicate how to respond immediately to a medical emergency, either by calling 999 or by initiating local procedures where access to a full resuscitation team is available. For City & Hackney, this would involve initiating 2222 on the internal phone system, to call for assistance from the Homerton Hospital Emergency Team. This is also set out in the Trust's Resuscitation policy v13.0 section 7, exhibited to Ruth Bradley's statement at RB/3.
16. All of my training has taught me that on finding an unresponsive person, the first thing to do is to pull my alarm and summon assistance by shouting and indicating that there is a medical emergency. Staff either have a personal alarm, if they are substantive, or are able to sign one out from security at reception. It sounds an alarm which summons the duty senior nurse and the rapid response team which is made up from nursing staff - 1 from each ward. The member of staff assigned this duty is either an unregistered member of staff such as a health care support worker or a registered mental health nurse. It is the responsibility of the Duty senior nurse to ensure the make-up of the response team is robust and that the team have the appropriate level of training and skill at each shift.
17. On pulling the alarm, this also notifies the duty senior nurse and rapid response team to attend. I would then approach the unresponsive person safely assessing for any risk/danger. I then commence my ABCDE assessment, establishing signs of life, and initiating CPR immediately if there are no signs of life. I would ensure that the crash trolley and medical

emergency equipment is brought to the scene, and items such as a defibrillator would be used as indicated, and oxygen administered via a bag valve mask. I would also request that the duty doctor is summoned and establish if there are any doctors on the ward that could provide immediate assistance. The Duty Senior Nurse would then coordinate the rapid response team to go and meet the crash team from the Homerton, and escort them to the location of the medical emergency to ensure they know the exact location. At the same time another member of the rapid response team collects a separate crash trolley which aligns with the Homerton standards and includes a manual defibrillator to ensure compatibility with Homerton's clinical practice.

18. We are taught that we should not leave an unresponsive patient alone if at all possible. The only reason for leaving would be to summon help, and then to return to the unresponsive patient. If a member of staff is to be left alone with an unresponsive patient during an emergency the preference is that this should be a registered nurse rather than an unregistered nurse. The unregistered nurse would go for help.
19. I confirm that ILS includes the use of an Automatic External Defibrillators and training on airway management. Prior to 2026, I received training on the ILS which includes training on the use of a Guedel airway, nasal pharyngeal tube and how to complete a head tilt chin lift. During a medical emergency, I have been taught to administer high flow oxygen at 15 litres via a bag valve mask. When I became borough lead nurse in 2020, I was only required to do BLS instead of ILS, but continued to do ILS training until this year (2026) when I did BLS training.
20. In terms of training on administration of resuscitation drugs, we are not taught this on ILS or BLS. We are trained in relation to anaphylaxis only, we would give intramuscular adrenaline and salbutamol inhaler.
21. The ILS level 3 includes scenarios which cover overdose, sepsis, seizure, ligature, choking. Please see exhibit **RB/38** from Ruth Bradley's statement which provides

full details. That statement also gives details of other training provided by the Trust which covers a wide range of topics that are relevant to resuscitation and deteriorating patients.

22. In relation to diabetes, I believe this is covered by the 4 H's taught on the training (namely hypovolaemia, hypoxia, hypokalaemia, hypothermia) and the 4 T's also taught on the training (namely tamponade, tension pneumothorax, thrombosis and toxins).
23. Whilst as a registered nurse for many years I have taken part in multiple ILS training sessions, and for the first few years as a lead nurse I continued to do ILS training, for my last training in 2026. I have completed the BLS as this is the training I am required to do as a lead nurse, and which I am mapped against in the Trusts Training Needs Analysis. We have been asked whether this includes training on how to be part of a resuscitation team and/or how to lead an emergency response or resuscitation effort. The Trust now provides Duty Senior Nurse Medical Emergency Team Leader Training. From my recollection, the ILS training which I undertook, would deliver mock emergencies which we were expected to lead the response clinically.
24. As a participant on the ILS training, we had to lead a scenario and demonstrate that we were competent to work through that scenario and with a focus on leading the scenario.
25. As part of the resuscitation training, we are expected to participate in a scenario as a lead, and others to participate in different roles. The scenarios for BLS are less complicated than the scenarios on the ILS training. In City & Hackney, we now run simulations on a weekly basis which are run by the units Physical Health Lead Nurse and an additional Band 7 Clinical Nurse Manager. These simulations include a deteriorating patient and always include a cardiac arrest scenario. After the simulation there is a debrief to capture immediate learning. Then there is a second simulation which seeks to further establish and embed learning.

26. We have been asked to provide information about any barriers that affected staff members' ability to apply their emergency response or resuscitation training in practice. Whilst our staff regularly undergo resuscitation training, staff do find medical emergencies incredibly stressful. We often care for service users over a long period of time and build up good therapeutic relationships with them, so this does add to the stress of managing an incident with someone you know or have an attachment to, or therapeutic relationship with. In addition, medical emergencies are a relative infrequent occurrence, and therefore there are not the opportunities to continue to practice skills learnt during a live event that would help 'hone' the skills and develop confidence. This is why the Trust introduced simulations so that staff have the opportunity to practice their skills in a safe environment.

27. I do feel confident that I am able to recognise a deteriorating patient. For most of my nursing career, which spans over 30 years, I have worked within a variety of inpatient mental health settings. In addition, I have had over 10 years' experience of being a Duty Senior Nurse and leading on multiple medical emergencies, including full resuscitation.

28. The Resuscitation Council UK ILS certificate, once successfully obtained, is valid for one year and simulation training is intended to embed the skills learned between the yearly training sessions, and to increase staff confidence in dealing with physical health emergencies. We have completed a lot of work and training with our staff to enhance the knowledge and expertise needed to recognise a deteriorating patient and this is the focus on the resuscitation simulations. We have made some improvements in this area. Most recently, we have developed a video on resuscitation on mental health inpatient wards to support revision on the topic between the formal annual certification. This is due to launch imminently.

29. In terms of additional training that could be provided to ensure staff feel confident to respond to emergency incidents that may occur on mental health inpatient wards, whilst I acknowledge the Resuscitation Council stipulates annual training (which is what ELFT align to) it is my personal opinion (and not

that of ELFT) that the training should increase to twice yearly. Given that medical emergencies and full resuscitations are relatively infrequent, there is very little opportunity to embed the skills learnt on the courses. More frequent training would assist with this. In addition, a skills training lab for more formal training and simulations would be useful, however this is a national issue and not specific to ELFT. I understand that the Trust's position is that yearly training is adequate, and a priority is making sure that everyone is up to date on that, supplemented by simulation-based practice between.

Ward-based simulation training

30. As a Matron and Ward Manager previously, as well as my duties as a Duty Senior Nurse, I have participated in experienced multiple ward-based scenarios including medical emergencies and resuscitation incidents. I have also led the response team and have taken the position of the deteriorating patient. The simulations were led by the Trust Lead Nurse for Physical Health in post at the time.
31. The ward-based resus simulations would include, cardiac arrest, simulation of a ligature incident and associated loss of breathing/cardiac arrest, overdose. Only members from the Rapid Response Team would participate in the simulations/resus scenarios, and the chosen staff would be rotated to ensure we are supporting and training all staff who work in the unit.
32. In my experience, the resus simulations were unannounced. Now, in City & Hackney, the facilitators identify staff in advance and they are brought together in a space off the ward and the simulations are run. This is to ensure that the maximum learning can take effect and that staff are supported to learn and practice the skills in a supportive learning environment. The rationale for the simulations taking place off the ward is that this often has a detrimental impact on the service users who may witness the simulations and mistakenly believe it is a real-life event. The approach now taken to training is to avoid the

traditional approach of a 'Drill'. In City & Hackney bank staff are included in the simulations. We do not use agency staff.

33. My experience is that the resus simulations take place on different days and at different times. In City & Hackney they are conducted on a Thursday or Friday. We do not currently conduct resus simulations on night shifts or at weekends.
34. We have been asked specifically what the resus simulations at Homerton Mental Health Services has involved as regards calling for the assistance of the Homerton Acute Hospital Emergency Medical Team. Staff who attend the resus simulations are informed and reminded about using 2222 to summon the Homerton Emergency Medical Team, to meet them and escort them to the correct ward, and to collect the additional crash trolley which has equipment aligned to that of the Homerton Emergency Medical Team.
35. The physical health nurse and additional Band 7 Clinical Nurse Managers have received training in facilitating a resus/medical emergency simulation and they provide assistance in planning and carrying out the training.
36. All simulations and the outcomes are recorded. These are currently recorded on a teams form and submitted separately.
37. Management of Oxygen was identified as a learning point from one of the resus simulations. Learning from the simulation is shared immediately with the team locally who participated in the scenario.
38. I am not aware that the Trust has developed a standard that specifies how many simulations that staff in my role are expected to participate in each year.
39. I have been asked to comment on whether I have participated in drills as often as is required for my role. Further, if my view is that I have not, what the challenges have been in attending the required drill training. The weekly resus simulations are delivered to staff from the wards who have a substantive role.

This means the activity of the resus simulations is an additional duty. In addition, there are times when the in-patient unit is incredibly busy and acute, and at times it is difficult to deliver a resus simulation. When this occurs, we do endeavour to reschedule. When I worked in my role as a Duty Senior Nurse and a Registered Nurse working on an in-patient ward, I attended and participated in the resus simulations as needed. As a borough Lead Nurse I no longer have to do this. However, I have BLS training and, if I am present on a ward with a medical emergency, I would participate in the medical emergency response.

Induction to a new ward/unit

40. When you start work on a new ward/unit the induction training covers the emergency procedures including the location of emergency equipment ('grab' bag, automated external defibrillators, ligature cutters etc.) and what to do if an emergency occurs, including how, and who, to call for help. Then once on the ward, staff are given supernumerary time to establish localised protocols, locations of equipment.

41. There is now an induction checklist in situ at City & Hackney, but in relation to my own induction to a ward when I first joined ELFT, this would have occurred in 2003, and I cannot recollect or have access to any historical records.

Direct experience of emergency response/resuscitation incident

42. In my 23 years' experience of being a Registered Mental Health Nurse, I have been involved in multiple incidents of emergency medical responses including resuscitation events on mental health inpatient units. I can remember clearly one such event that took place on Rosebank Ward which was a female intensive care unit. It should be noted that this unit is sited on

the Tower Hamlets Centre for Mental Health and is not covered by an Acute Hospital Emergency Resus team. Unfortunately, I cannot recall the date or even the year, but my tenure on Rosebank was between September 2008 and July 2018. This scenario involved a middle-aged female with a diagnosis of a learning disability. She was being nursed on Rosebank psychiatric intensive care unit (PICU) due to increased levels of distress and agitation including violence to others. During a lunch time serving, I was made aware of an incident and staff shouting for help, I immediately left my office which was situated next to the dining room, and was able to quickly establish that the service user was choking. This is a known risk for service users who have a diagnosis of a Learning Disability. I could see that staff were trying to assist with back blows and abdominal thrusts which was the correct medical emergency response.

43. Staff pulled their alarms and summoned a doctor whilst I continued with my colleague to administer abdominal thrusts. We established that this wasn't effective and the patient continued to deteriorate. I believe we were instructed to lay the patient on the floor in order to continue our medical response actions. The crash bag was obtained, and we attempted to obtain vital signs of the service user. We struggled to establish a pulse and began emergency CPR including the positioning of an Automated External Defibrillator (AED) and bag valve mask with high flow oxygen at 15 litres. We began to follow the instructions and algorithm on the AED, which did not advise a shockable rhythm. We continued to administer CPR as directed by the AED and waited for the ambulance to arrive. Unfortunately, it is my recollection that the ambulance took approximately 20 minutes to arrive at which time they took over the medical emergency. There were identified staff members including myself, the ward managers and registered staff who directly managed the CPR until the ambulance arrived. We were supported by the DSN and the rapid response team. The patient was subsequently transferred to the Emergency Department at the Royal London Hospital. A few days later, I visited the patient in a high dependency unit and spoke with the matron to obtain a handover of the patient's progress. I made a second visit to the patient at the Royal London Hospital and also met with their

family. I am unclear on the timescale, but the service user fully recovered and was transferred back to Rosebank a few days later. On her return to the ward, she asked to speak with me, indicating that she felt something serious had happened to her. I asked if she wanted to know the details (sensitive that this disclosure may re-traumatise her), and made the decision to talk through what had happened.

Learning from incidents / Patient Safety Alerts

44. As far as I am aware the resus officer would deal with any safety alerts, learning notice, patient safety communication or training alert relating to deteriorating patients, emergency response and/or resuscitation. I am not aware of any recent alerts around equipment failure. There was a recent alert regarding recall of Guedel airways that were faulty from manufacture – on the Homerton site we didn't have any in stock.

Recommendations

45. It is my personal opinion that formal ILS and BLS training needs to be increased to every 6 months. In addition, we should continue to develop and improve our offer of simulation practice and Objective Structured Clinical Examinations known as OSCE's. These have recently been introduced. Drills (unannounced simulation or ward based scenarios) are not a recognised way of learning; staff freeze, do not learn and often leave the training event deflated. It is more appropriate that the training and simulation practice is one of a safe space that encourages learning and supports staff when they make mistakes in training. In addition, we would benefit from additional resources to develop a more formal simulation training laboratory to assist learning.

46. I hope this statement assists the Inquiry.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed

[I/S]

Position: Borough Lead Nurse for City & Hackney Centre for Mental Health

Dated: 03/09/2026