

Witness Name: Ann Sheridan

Statement No: 6

Dated: 1 June 2026

Rule 9 reference: EPUT Rule 9 (149)

LAMPARD INQUIRY

SIXTH WITNESS STATEMENT OF ANN SHERIDAN

I, Ann Sheridan, will say as follows:-

Introduction

1. I am the Executive Nurse within Essex Partnership University NHS Foundation Trust ('EPUT') and have held this position since February 2024.
2. I am a registered Mental Health Nurse, a registered General Nurse and a qualified Social Worker.
3. This statement is made in response to the request by the Inquiry to EPUT on 23 April 2026 under Rule 9 of the Inquiry Rules 2006, with reference "Rule 9 (149)". EPUT was asked in that letter to provide information related to resuscitation following the formation of EPUT on 1 April 2017. Rule 9 (149) incorporated Part A and Part B – Part A relates to policies and training and should be read in conjunction with this statement in response to Part B.
4. In this witness statement I have provided responses to the Inquiry's questions on behalf of EPUT. Not all matters related to the Trust are within my own personal knowledge, and therefore I have relied on information and documents provided by the Inquiry Project Team and subject matter experts. Former employees have not been approached to provide information related to the response I provide. The contents of the statement are true to the best of my knowledge and belief.
5. I would like to offer my sincere and personal condolences to all those who have lost loved ones whilst they were receiving care within mental health services in Essex, and in particular to the individuals named within this statement. I recognise the profound impact of these losses on families, friends, and the staff who cared for them. This statement seeks to respond to questions from the Lampard Inquiry in relation to resuscitation. In doing so, it is necessary to use clinical and procedural language when describing physical health presentation, deterioration, and resuscitation processes. I appreciate that this terminology may at times appear impersonal, and I wish to emphasise that this is not intended to diminish the human impact of these tragic events or the enduring grief experienced by those affected.

Approach to the Rule 9 request

6. This response has been prepared with information sourced directly through the review of documents contained within Relativity, a platform which has been purchased by EPUT especially for document searching and collation for the Inquiry. To supplement the

information contained within the policy documents, subject matter experts provided further details in order to provide a response to the Rule 9 request.

7. The subject matter experts provided documentation in response to the Rule 9 request and have undertaken a review of local and shared drives to identify and retrieve the relevant records.
8. The statement will address the questions in the Rule 9 request in the following structure:

Part B: Learning from incidents

- a. Additional context
- b. Incidents identified
- c. Implementation of evidence-based resuscitation and deteriorating patient systems

PART B: Learning from incidents

Additional Context

9. The recognition and management of the deteriorating patient is a fundamental aspect of safe care within NHS mental health inpatient services. People admitted to mental health wards often have poorer physical health and higher rates of long-term conditions than the general population, placing them at increased risk of acute physical illness. There is a known risk of diagnostic overshadowing, where physical symptoms may be mistakenly attributed to mental illness, delaying diagnosis and treatment.
10. Although the principles of recognising and responding to deterioration are the same across healthcare settings, mental health services differ from acute hospitals in their patient population, workforce expertise, and access to medical equipment and treatment. Mental health staff are primarily trained in the assessment and management of mental illness and have less frequent exposure to and experience of medical emergencies than staff working in acute care hospital settings.
11. Managing physical deterioration in mental health settings can be particularly challenging. Patients may lack capacity, refuse treatment, attempt to abscond, or become distressed or aggressive, requiring staff to balance emergency medical intervention with patient safety, dignity, and legal considerations. Early recognition of deterioration is therefore essential and relies on routine physical health monitoring,

timely observations, use of the National Early Warning Score (NEWS2), structured assessment, effective communication, and prompt escalation of concerns.

12. Mental Health Trusts are expected to meet the same standards of patient safety and clinical effectiveness as all NHS providers. National guidance from the Resuscitation Council UK, NHS England, the Care Quality Commission (CQC), and NICE requires organisations to ensure staff are competent in recognising and responding to deterioration, maintain appropriate resuscitation equipment, and provide robust systems for physical health assessment and escalation. Effective management of deterioration and resuscitation helps prevent avoidable harm, improves patient outcomes, and supports parity between physical and mental healthcare across the NHS.

Incidents identified

13. The Trust currently undertakes a comprehensive and structured approach to identifying, addressing, and disseminating learning arising from internal investigations, Prevention of Future Deaths (PFD) reports, and relating to resuscitation practices and procedures.
14. The Trust have in place a process for actions to be taken following an incident, as set out in the fourth statement of Ann Sheridan in response to Rule 9 (12). This includes immediate clinical intervention, followed by learning from such incidents.
15. During the period in which a number of these incidents occurred, the Trust was operating within a highly pressured context, including reliance on temporary staffing and the impact of the COVID-19 pandemic restrictions. This created challenges in maintaining consistency of practice, continuity of care, and full embedding of clinical standards, particularly in relation to the recognition and management of the deteriorating patient and resuscitation procedures.
16. Subsequent strengthening of governance, oversight, and quality improvement capability has enabled the Trust to move towards a more systematic, reliable, and embedded approach, ensuring that learning is effectively translated into sustained improvements in practice.

Summary of cases, learning and actions

17. As part of the Rule 9 request, the Inquiry provided EPUT with eight patient incidents to review and provide an overview of how the Trust has disseminated learning and taken action specifically related to resuscitation. Some of the incidents included learning

broader than that of resuscitation alone, details of this learning and actions taken have not been included in this statement as this is outside of the scope of the request.

18. In reviewing the eight patient incidents identified by the Inquiry, EPUT have also included three additional incidents which were not included within the Rule 9 request. To identify these additional cases, we reviewed data from the incident reporting system, Datix, from 2017 to 2023 and searched it for keywords related to Cardiopulmonary Resuscitation (CPR) and resuscitation to determine which incidents had resuscitation related learning. The additional patients are Sophie Alderman, Marion Michel and Bethany Lilley, as detailed in Annex 1.
19. To provide the details in this section of the statement, we have reviewed the relevant action plans produced by the Trust as a result of internal investigations and any Prevention of Future Deaths (PFD) reports and responses. I provide details of each incident, the learning and action taken in Annex 1.
20. When a resuscitation happens, immediate learning and necessary actions are identified. There is then further learning gained through the patient safety incident review process, involving an investigation, agreeing if further changes are required and implementation of those changes. This accumulative learning will occur over a period of time. Because of this, some of the incidents identified occurred while learning and actions from earlier incidents were still being worked through.
21. While learning was identified following each incident, there were instances where sustained implementation and embedding of improvements were not fully achieved, contributing to recurrence of similar themes, including training and communication. Contributory factors included:
 - Variable uptake and consistency of training, particularly amongst temporary and redeployed staff (during COVID-19), impacting confidence and adherence to resuscitation and escalation protocols.
 - Gaps in oversight and assurance mechanisms, where early audit and monitoring processes did not always provide sufficient real-time visibility of compliance across all wards and teams.
 - Challenges in embedding standardised processes, including equipment checks and escalation pathways, in a workforce with high turnover and reliance on agency staff.

- Reduced opportunities for face-to-face training and supervision during the COVID-19 pandemic, limiting reinforcement of learning and practical competency development;
 - Inconsistent dissemination and local ownership of learning, meaning that improvements were not always translated into sustained changes in frontline practice.
22. In response to the concerns identified within inpatient mental health services, the Trust introduced its “Safety First, Safety Always” strategy in 2020 – 2023 **[AS4-014]**, underpinned by a culture of learning. This programme has been personally overseen by the Chief Executive, ensuring strong organisational grip, visibility, and accountability, and supported by strengthened clinical leadership, governance structures, and dedicated quality improvement resource.
 23. This was further reinforced by a number of key programmes. The Time to Care programme redesigned the inpatient model and implemented an enhanced staffing approach to ensure patients receive the right care, at the right time, by the right person. This included increased staffing to support physical healthcare, alongside the introduction of Resuscitation Link Workers to strengthen capability and oversight.
 24. Wider changes that impact on the environment and staff include the Trust’s estates improvement programme which centred on improving the safety of the Trust estates and reducing the likelihood of opportunity of self harm events leading to resuscitation events. International nursing recruitment has significantly improved substantive staffing levels on inpatient wards, including staff with enhanced physical health expertise.
 25. To further strengthen safety oversight, the Trust introduced daily inpatient safety huddles, improving real-time visibility, escalation, and shared learning from patient safety concerns. The Trust also changed its service delivery model to include a leadership model that had greater clinical visibility and ownership.
 26. In 2022, the Trust additionally appointed experienced resuscitation and deteriorating patient leads, with acute healthcare and Immediate Life Support (ILS) expertise. This has significantly strengthened the Trust’s capability in both resuscitation response and the recognition and management of the deteriorating patient, supporting more consistent, timely, and effective clinical intervention.
 27. Since this period, the Trust has strengthened its approach to implementation, oversight, and assurance, including enhanced governance processes, improved training

compliance monitoring, targeted support to inpatient areas, and a stronger focus on embedding learning into everyday clinical practice with reference to resuscitation and management of the deteriorating patient.

28. The Trust has moved from reactive learning to a more proactive, embedded improvement, ensuring that:
- Learning is now disseminated across all services through the weekly Emerging Incident Review Group (EIRG) and learning forums;
 - Actions are clearly monitored and tracked through governance frameworks at both care unit level and via the EIRG.
 - Improvements are evidenced through audit, training compliance, and operational performance tracked through local forums to Trust Board via the Quality Committee;
 - There is a clear line of sight from incident → learning → action → improvement.
29. This approach has directly contributed to improvements in the recognition and management of the deteriorating patient and the delivery of safe, timely resuscitation care, including enhanced escalation processes, increased staff competency and confidence, improved equipment readiness, and stronger adherence to clinical protocols.
30. As a result, the Trust can demonstrate tangible improvements in practice, including more timely identification of clinical deterioration, more effective emergency response, and greater consistency in resuscitation procedures.

Implementation of evidence based resuscitation and deteriorating patient systems

31. EPUT has strengthened its approach to resuscitation and the management of the deteriorating patient through the appointment of two dedicated resuscitation practitioners with acute hospital experience. These roles bring specialist expertise in emergency care, cardiac arrest management, and the recognition of clinical deterioration, supporting mental health inpatient teams who may have less frequent exposure to acute medical emergencies.
32. In addition, both practitioners are accredited ILS trainers with the Resuscitation Council UK, enabling the Trust to deliver structured, high-quality training in line with national standards. Collectively, this combination of clinical expertise and nationally recognised training capability enhances staff competence, improves consistency of practice across

wards, and supports earlier recognition and more effective management of deteriorating patients

33. The development of these systems has been directly informed by learning from multiple incidents, as set out in the action plan. Learning from incidents involving Carol Taylor, Sophie Alderman, Elise Sebastian and Madison Naylor identified gaps in recognising deterioration, summoning help, and effective emergency communication, including the process for calling 999 and escalating to medical support. In response, the Trust strengthened escalation pathways, improved communication processes, and embedded structured approaches to recognition and escalation within training and practice.
34. Learning from Carol Taylor, Michael Nolan, Jason Standing, Madison Naylor and Bethany Lilley highlighted gaps in clinical skills, particularly in relation to oxygen delivery and the use of emergency equipment. This led to the introduction of externally delivered ILS training, enhanced refresher sessions, and a strengthened focus on practical skills and equipment use.
35. Learning from Morgan-Rose Hart, Michael John Woods and Sharon Langley emphasised the importance of regular simulation, drills, and practical exposure to emergency scenarios, particularly in settings where staff have limited experience of resuscitation events. This informed the expansion of simulation training, drop-in refresher sessions, and structured emergency drills across inpatient wards.
36. Learning from Jason Standing, Elise Sebastian and Madison Naylor also identified the need to improve documentation, situational awareness, and handover processes. In response, the Trust introduced standardised resuscitation documentation, embedded within grab bags and aligned to SBAR communication processes to support clear and effective information sharing during emergencies. SBAR stands for Situation, Background, Assessment, and Recommendation, preventing communication breakdowns and ensuring patient safety.
37. At a system level, learning from Marion Michel highlighted the need to distinguish clearly between medical and psychiatric emergencies. This informed the review and amendment of Trust policy, ensuring clearer escalation pathways and more appropriate clinical decision-making.
38. Within EPUT, resuscitation and deteriorating patient systems have therefore been strengthened through embedding a structured, Trust-wide approach to the prevention, recognition, escalation, and management of physical deterioration across all inpatient

mental health wards, in line with Resuscitation Council UK guidance and supported by specialist expertise.

39. EPUT has clear governance arrangements for resuscitation services, including up-to-date policies, defined staff training requirements, and effective systems to ensure early identification and response to deterioration before cardiac arrest occurs. This requires clinical leadership, regular audit of practice, and clear Board-level accountability for patient safety and resuscitation outcomes.
40. A core component of safe practice within EPUT is the consistent use of NEWS2 across inpatient services. This is supported by routine physical health observations, admission screening, and ongoing monitoring that is tailored to individual patient risk and clinical presentation. NEWS2 has been fully embedded into EPUT escalation pathways to ensure that deterioration is identified early and that appropriate clinical responses are triggered in a timely manner, including escalation to medical staff, urgent review, or transfer to acute hospital services where required.
41. It is recognised that some patients, due to their presenting mental health condition or previous trauma, may decline the taking of vital signs and, consequently, a full NEWS2 assessment. To address this, we have established a non-contact physical observation tool, enabling staff to observe key indicators of a patient's condition in a non-intrusive manner.
42. The tool provides clear guidance on when and how to escalate concerns and offers significant patient safety benefits, particularly in situations where physical examination is not possible or may cause distress or disruption to the patient.
43. Effective implementation also depends on staff competence and ongoing development. All EPUT clinical patient facing staff working in inpatient mental health settings receive regular, role-appropriate training in resuscitation, recognition of deterioration, and escalation procedures. In line with Resuscitation Council UK standards, staff should be confident in using structured assessment tools such as ABCDE and communication frameworks such as SBAR to ensure clear, timely escalation of concerns. This is reinforced through regular simulation training, multidisciplinary emergency scenarios, and mock cardiac arrest drills to maintain confidence and competence in managing rare but high-risk clinical events. The ABCDE approach is a systematic, priority-based framework used across the NHS to assess and treat critically ill or deteriorating patients. It stands for Airway, Breathing, Circulation, Disability, and Exposure. The primary goal

is to identify and treat life-threatening conditions immediately before moving to the next step.

44. EPUT inpatient wards are equipped with standardised resuscitation equipment, including defibrillators, oxygen, suction, airway management equipment, and emergency medications, with robust systems for daily and weekly checks to ensure readiness for use. Clear emergency response procedures are in place, including activation of emergency response systems, with clearly defined staff roles and responsibilities during a medical emergency to ensure a coordinated response.
45. EPUT is working in partnership with local acute hospitals and the ambulance services, to strengthen pathways which include clearly defined escalation routes, agreed transfer pathways, and joint working arrangements.

Review and monitoring of resuscitation and deteriorating patient systems

46. EPUT uses a triangulated approach to review and monitor its resuscitation and deteriorating patient systems. This brings together clinical and governance data, patient and family experience, staff feedback, and external assurance, including Care Quality Commission (CQC) inspection findings. By combining these different sources of information, the Trust is able to gain a more comprehensive understanding of performance, identify areas of risk, and target improvement activity where it is most needed.
47. This approach is informed by learning from multiple incidents. In particular, learning from Carol Taylor, Sophie Alderman, Elise Sebastian and Madison Naylor identified issues in recognising deterioration, summoning help, and escalation processes, which are now specifically monitored through audits of physical health observations, NEWS2 compliance, and escalation practice.
48. Evidence from patients, staff, and CQC inspections presents a broadly consistent picture of how the Trust manages physical deterioration and medical emergencies within its inpatient mental health services. Patients and families generally describe care as compassionate and responsive, particularly when physical deterioration is recognised and acted upon promptly. However, some have reported concerns about delays in recognising physical health problems, including occasions where symptoms may initially have been attributed to mental illness. These themes reflect findings from incidents such as Carol Taylor and Elise Sebastian, where recognition and escalation were key issues, and are now monitored through audits, incident reviews, and complaints analysis.

49. Staff report through CQC focus groups, a commitment to patient safety and confidence in responding to emergencies, including initiating Basic Life Support, using emergency equipment, and escalating concerns appropriately. They also highlight challenges associated with the relatively low frequency of medical emergencies in mental health settings, as well as managing deterioration alongside behavioural distress, capacity issues, and treatment refusal. Staff consistently identify ongoing training, simulation exercises, and practical learning opportunities as important in maintaining competence and confidence. This reflects learning from incidents including Morgan-Rose Hart and Sharon Langley, which highlighted the importance of training, simulation, and practical exposure. As a result, staff competence and confidence are monitored through compliance with ILS/BLS training, participation in simulation exercises, and engagement with refresher learning.
50. CQC inspections have found that EPUT has systems in place to support the recognition and management of deteriorating patients, including the use of NEWS2, emergency equipment, and escalation procedures. However, inspections have also identified some variation in physical health monitoring, documentation, and the timeliness of escalation. These findings are consistent with themes from incidents involving, Jason Standing, Elise Sebastian, Madison Naylor and Bethany Lilley, which identified the need to strengthen documentation, communication, and handover processes. Monitoring therefore includes review of resuscitation documentation, SBAR handover quality, and incident investigations involving emergency response and ambulance transfer. Positive external feedback has been received from the Ambulance Service following an observed inpatient resuscitation, with staff commended for their prompt response, effective teamwork, and appropriate use of resuscitation procedures and escalation pathways. This was noted in a Safety Action Alert in September 2022 **[AS-267]**.
51. Taken together, the triangulated evidence indicates that EPUT has established systems for resuscitation and deteriorating patient management, with the key area for ongoing improvement being the consistent early recognition and escalation of physical deterioration, particularly where diagnostic overshadowing may occur. This is reflected in the Trust's Quality Account 2024/25 **[AS6-001 – EPUT Quality Account 2024]**, which identifies “The Management of the Deteriorating Patient” as a key quality priority, recognising that early identification and timely intervention are critical to reducing harm and improving patient outcomes. This reflects recurring themes across incidents, particularly Carol Taylor, Elise Sebastian and Madison Naylor, where delays or uncertainty in escalation were identified.

52. The Trust currently monitors the quality of physical health care through routine physical health audits, which assess the quality, completeness, and consistency of monitoring across inpatient wards. Particular attention is given to patients receiving psychotropic medication, patients requiring post-rapid tranquillisation monitoring, and those with long-term physical health conditions. Audit findings are reviewed through local governance structures, with improvement actions implemented where performance falls below expected standards.
53. Early recognition of deterioration is monitored through physical health assessments on admission, routine observations during inpatient care, and the use of NEWS2 as the Trust's standard early warning scoring system. Compliance is reviewed through ward-level audits, quality visits, and other assurance processes. Escalation practice and documentation are also examined through incident investigations, complaints reviews, and clinical supervision, including consideration of the use of structured assessment approaches such as ABCDE.
54. The Trust also reviews the timeliness and effectiveness of escalation through the deteriorating patient review process. This includes incidents involving ambulance attendance, emergency transfers to acute hospitals, cardiac arrests, and significant deterioration events. Reviews consider the time taken to recognise deterioration, escalate concerns, obtain medical review, arrange transfer where required, and utilise structured communication tools such as SBAR. Learning themes are reported through governance structures and incorporated into quality improvement programmes. These reviews reflect learning from incidents such as Jason Standing and Madison Naylor, where these elements were identified as areas for improvement.
55. Staff competence and confidence are supported through a workforce assurance and training programme. This includes monitoring compliance with Basic Life Support (BLS), Immediate Life Support (ILS), and deteriorating patient training, as well as NEWS2 competency assessments and participation in simulation exercises and mock emergency scenarios. This directly reflects learning from Carol Taylor, Morgan-Rose Hart and Sharon Langley, where the importance of practical training and maintaining competence was identified. Training increasingly reflects the specific challenges of mental health settings, including behavioural disturbance, treatment refusal, capacity considerations, and emergency transfers to acute hospital care.
56. Learning from incidents and feedback is embedded through the Trust's patient safety and governance arrangements. Themes arising from incidents, near misses, complaints,

mortality reviews, Learning from Deaths reviews, patient safety investigations, and staff and patient feedback are routinely analysed. Significant incidents and investigation progress are reviewed through the Emerging Incident Group, chaired by the Executive Nurse, and learning is shared across wards and services to identify recurring themes, reduce variation in practice, and drive continuous improvement in patient safety.

57. To provide effective oversight, EPUT maintains a Deteriorating Patient and Resuscitation quality priority reporting process overseen by the Chief Medical Officer that is reviewed through governance structures. Regular reporting to Quality of Care Group, and the Trust Quality Committee through to Board ensures deteriorating patient management remains a strategic patient safety priority.
58. EPUT continues to strengthen its approach to the early recognition and management of physical deterioration, with this identified as a key safety improvement priority for 2026–28 under the Trust’s strategic focus on delivering person-centred Fundamentals of Care. This work aims to improve patient safety, reduce avoidable harm, and achieve better physical health outcomes for mental health inpatients by embedding consistent physical health assessment, reducing diagnostic overshadowing, and strengthening escalation.
59. EPUT is reinforcing that physical health is integral to every patient interaction. The Trust is also actively sharing its improvement journey regionally and developing collaborative approaches with partner organisations to support continuous learning and system-wide improvement.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed:

[I/S]

Dated: 1 June 2026

Annex 1: Summary of patient cases

Patient name	Date of death	Key issues identified	Actions taken	Dissemination and assurance	Evidence of impact
Carol Taylor	21 November 2023	Key Issues Identified in Safety Action Plan: Ensure awareness of how to use oxygen cylinders. Refresh training on the use of CPR equipment. Key Issues Identified in PFD: There was no system that prevents staff that are non-compliant with mandatory training, including basic life support training from being able to work on EPUT in-patient wards. Address concerns around calling 999.	Actions Taken per Safety Action Plan: Internal Safety Alert. Training video was developed and shared. Drop-in 'refresher' sessions offered. Actions Taken per PFD response: Process for summoning help in a medical emergency is included in both BLS and ILS training. Training compliance is monitored monthly. Implemented 'Calling (9)999 in a medical Emergency poster.	[AS6-002 - TAYLOR, Carol – Safety Action Plan] [AS6-003 - TAYLOR, Carol - PFD Response]	Staff are clearer on how to respond in a medical emergency through safety alerts, training videos, and ongoing learning. Regular refresher sessions help maintain staff skills and confidence. Training compliance is monitored, helping ensure staff remain up to date.
Sophie Alderman	19 August 2022	Key Issues Identified in Safety Action Plan:	Actions Taken per Safety Action Plan:	[AS6-004 – ALDERMAN, Sophie – Safety Action Plan]	Staff can quickly call emergency services using a

		Introduction of a mobile phone DECT phone as a means of communication on inpatient wards which enable staff to contact external sources e.g. 999 and to contact other internal resources e.g., on-call medical staff. For all Qualified staff to have completed their ILS training. For all sites to have access to training equipment to enable scenario based on site emergency drills.	Ward cordless phone purchases for use in case of emergencies. 'Calling (9)999 in a medical emergency' displayed in ward setting. Rapid response requirements are now included in induction processes. Training equipment in place on site to enable ward based simulations to be undertaken. Resus link practitioners attending face to face scenario / simulations workshops.		cordless phone while staying with the patient. Clear signage helps staff know how to make a 999 call correctly. This supports a faster and more effective response in emergencies.
Morgan-Rose Hart	12 July 2022	Key Issues Identified in Safety Action Plan: It is acknowledged that training is useful to prepare staff (use of drills), but also as a way of controlled exposure to staff after the incident as it was traumatic.	Actions Taken per Safety Action Plan: The Head of Deteriorating Patient Pathways delivered a number of drop-in sessions for nursing staff at the Derwent Centre, providing one-to-one practice in CPR and emergency life-saving skills, and also co-facilitated	[AS6-005 – HART, Morgan-Rose – Safety Action Plan]	Staff are more confident and skilled in CPR and emergency care through hands-on practice. Regular refresher sessions help staff remember and use these skills. Staff are better prepared to respond to real

			several post-incident CPR drills.		emergencies through practice drills. Teamwork and communication improve as staff practise working together. Emergency responses are more consistent due to regular training and shared learning.
Michael Nolan	10 July 2022	Key Issues Identified in Safety Action Plan: Staff have a permanent method to adequately support: 1. Contact to external agencies, specifically emergency services on a mobile handset so staff can speak to them at the scene 2. Contact internal departments, specifically to on-call colleagues during an emergency. Staff to ensure completion of their ILS	Actions Taken per Safety Action Plan: ‘Calling (9)999 in a medical emergency’ poster was reintegrated to the ward. The ward purchased a cordless phone which staff can use in case of emergencies. Pinpoint pager and radio has been issued to medical staff. Memo sent to Staff to contact the On –call Doctor via the radio and state ‘Medical Emergency’ and state the location.	[AS6-006 - NOLAN, Michael - Action Plan] Case Study was presented at the Learning Oversight Subcommittee (LOSC) in March 2025 with key learning points and next steps. The Case Study was presented by the operational team for the service.	This action had already been completed previously. Additional steps have been taken to raise awareness and embed learning. Additional actions have included ongoing training, drills, and awareness-raising initiatives, to improve staff preparedness, consistency, and coordination in emergency responses. Case study presented at Learning Oversight Sub Committee highlighting learning and key steps.

		training and BLS training be involved in regular Medical emergency drills.	Alert sent out via Datix regarding the importance of using a mobile phone to make a call to emergency services, over using a landline. Since September 2022, the Trust has procured a significant number of Resuscitation Council UK Immediate Life Support (RCUK ILS) training places via A to E training solutions. In addition, we have sought volunteers on the In-Patients wards to become Resus Link Practitioners. Link Practitioners to play a key role in strengthening our response to emergency situations on our wards. Nurses and healthcare assistants/support workers can volunteer to become Resus Link Practitioners. The correct flow rate of oxygen delivery is reinforced during the RCUK ILS training and is mentioned during the life support 'drop in' refreshers sessions, which		
--	--	---	---	--	--

			NA and DS facilitate, upon request. Ongoing regular Medical emergency drills conducted by Site officer, Ward managers and matrons to ensure that learning is embedded.		
Marion Michel	4 March 2022	Key Issues Identified in Safety Action Plan: The Trust to review its protocol for rapid response to emergency incidents with specific focus on the distinction between a medical and a psychiatric emergency.	Actions Taken per Safety Action Plan: Policy amended, reviewed and approved.	[AS6-007 – MICHEL, Marion – Safety Action Plan]	Clarified and strengthened emergency response processes by distinguishing between medical and psychiatric emergencies, ensuring staff follow appropriate escalation pathways and improving the timeliness and appropriateness of care.
Jason Standing	5 January 2022	Key Issues Identified in Safety Action Plan: Ensure compliance with requirement for the newly established immediate life support training (ILS). Ensure quality of handover to ambulance staff.	Actions Taken per Safety Action Plan: External ILS training was procured for all nursing staff from September 2022 and the training provider also adapted that training to address specific concerns from this incident around the delivery of oxygen.	[AS6-008 – STANDING, Jason – Action Plan]	Improved staff competence and confidence in managing medical emergencies, through the ILS training provided to all nursing staff. Adaptation of the training to specifically address identified gaps in oxygen delivery, ensuring learning

			Oxygen delivery was also emphasised in drop-in 'refresher' training sessions across the Trust, beginning in 2022. These sessions were implemented by the Head of Deteriorating Patient Pathways and Resuscitation Training Officer, a role created in May 2022. The Resuscitation Event Forms were subsequently added to grab bags for completion contemporaneously in order that they also form part of the SBAR handover with ambulance staff.		from the incident has been embedded into practice. Increased focus and reinforcement of critical clinical skills, evidenced by ongoing drop-in refresher sessions across the Trust, with a particular emphasis on oxygen delivery, supporting the maintenance and consolidation of skills over time. Dedicated leadership and oversight provided through the Head of Deteriorating Patient Pathways and Resuscitation Training Officer role. Strengthened clinical documentation and communication during emergencies, through the introduction of Resuscitation Event Forms within grab bags, enabling documentation during resuscitation events. Improved quality and structure of handover to ambulance services through integration of these
--	--	--	--	--	---

					forms into SBAR communication processes. Improved consistency and reliability of emergency response through standardised documentation and better alignment of training, processes, and multidisciplinary working.
Elise Sebastian	19 April 2021	Key Issues Identified in System Improvement Plan: When making the phone call to emergency services, not all staff knew to; Use the prefix '9' to obtain an outside line before calling the emergency number 999. To call the on call doctor at the same time as the emergency services. The investigation found that there was confusion over the address and postcode	Actions Taken per System Improvement Plan: Improved signage - All phones have signs to add additional 9 to emergency 999 call. Posters are also visible and instructs staff to call duty doctor at the same time. Staff to be made aware as part of induction. Mobile phones are available on the ward and can be brought to the patient's bedside in the event that a 999 call is required. Communication team have liaised with East of England Ambulance Service to confirm	[AS6-009 - SEBASTIAN, Elise - System Improvement Plan] [AS6-010 - SEBASTIAN, Elise - PFD Response]	Improved clarity and consistency in emergency call processes with signage on all phones reinforcing the correct dialling process and posters prompting contact with the duty doctor. Increased staff awareness and knowledge, supported through induction and ongoing training. Enhanced ability to summon help at the point of care through the availability of the cordless phones. Improved accuracy of information provided to the East of England emergency services through an

		for the St Aubyn Centre location and information on the NHS website was incorrect or confusing. The investigation found the cardiac arrest event forms, if used, could act as an aide memoire to prompt recall and improve situational awareness during resuscitation events. However availability of these forms was limited and not used. The investigation found that systems and processes did not align with Resuscitation Council UK quality standards in mental health inpatient care or equivalent training, entitled 'Immediate Life Support (ILS)'. The Trust's 'in house' grab bag training did not train or assess team leadership and effective team membership, thus not providing staff with clear knowledge of how	the site details and correct Website details are shared. The resuscitation form was discussed during Grab Bag training and is now stored with the Grab Bag, with an additional version available on Datix for completion. ILS Training is in line with Resuscitation Council standards and is to be delivered to all staff. From September 2022, the Trust replaced its internal EES training with external ILS training. Actions Taken per PFD response: 'Calling (9)999 in a medical Emergency' documents developed, implemented and shared as an Internal Safety Alert in June 2023. Learning reemphasised as part of a 'Learning Matters' live event in June 2025 relating to deteriorating patients and resuscitation.		engagement process with the service. Strengthened documentation and handover processes evidenced by resuscitation forms being available within Grab Bags and Datix, supporting recording of information. Increased training compliance and capability in resuscitation through ongoing simulation and structured ILS training events. Sustained organisational learning through safety alerts and Trust-wide learning events.
--	--	---	---	--	---

		best to work together during a resuscitation attempt.			
Michael John Woods	26 December 2020	Key Issues Identified in System Improvement Plan: The investigation found that the emergency response and resuscitation attempt was not to the expected standard.	Actions Taken per System Improvement Plan: Increased simulation training will be subject to ongoing assurance through regular monthly review of training compliance and uptake.	[AS6-011 - WOODS, Michael John - System Improvement Plan] [AS6-012- WOODS, Michael John – Action Plan Quality Review]	Per Quality Review of Action Plan May 2022: Grab bag training includes use of equipment and the CPR audit form to replenish equipment – this was tested by asking staff who had attended the training as part of the review. The training needs analysis identified that CPR Drills need to take place every three months. The Head of Deteriorating Patient Pathway and Resuscitation Training Officer was asked to undertake a review of current arrangements to inform future service development and improvement.

Madison Naylor	27 September 2019	Key Issues Identified in Action Plan: Review the use of electronic suction machines in the Trust and if in use these should be included in the routine equipment checking procedures. If portable electric suction machines are in use on the wards, training should be provided to all staff and local training records should be held by the ward manager. BLS training programme should be reviewed to include identification of all equipment contained in the emergency grab bag to ensure that all staff are familiar with the equipment and how to identify it training records should be held by the ward manager. Registered Nurses should be reminded of	Actions Taken per Action Plan: Ensuring checks on electronic suction machines. Ensuring training on the use of this equipment, which was reported to be included in the competency framework. Induction programme to include training on portable electronic suction machines. Familiarisation with grab bag equipment, which was reported to be covered in the Trust's EES training. Nurses within the relevant team to be reminded of their responsibilities in respect of ensuring they have completed necessary training, coordinating and supervising resuscitation and completing Cardiac Arrest Audit forms, which was reported as having been completed within supervision sessions.	[AS6-013 - NAYLOR, Madison - Action Plan] [AS6-014 – NAYLOR, Madison – Action Plan Quality Review]	Per Quality Review of Action Plan July 2021: All electronic suction machines were removed from the unit. Grab bag training and other emergency procedure training commenced on the unit. This has been facilitated by the Nurse Consultant, Physical Health. The plan for the scenario training will be quarterly. This is in addition to mandatory training which the Trust provides; it focusses on a practical approach to resuscitation and other emergency response skills. The incident report form process has been revised so that staff have to indicate a resuscitation attempt is made and it is hoped that this will prompt completion of the Cardiac Arrest form, thus an increase in completion rate. Resuscitation attempts involving CPR are infrequent in the mental
-----------------------	----------------------------------	--	---	--	--

		their NMC Code in respect of ensuring that they maintain the knowledge and skills needed for safe and effective practice and to act without delay if they believe there is a risk to patient safety. This recommendation relates specifically to use of / training in the use of suction apparatus. Registered Nurses should be reminded of their responsibility in coordinating and supervising resuscitation and emergency response where possible. All registered nurses should be reminded of the importance of completion of the Cardiac Arrest Audit form following such events.			health setting – the implementation of regular physical health monitoring supports the early detection of deterioration in physical health and consequently prompt transfer to acute care services when indicated. This resulted in strengthened staff confidence and accountability in emergency response, supporting improved recognition and management of deterioration and reinforcing early escalation to acute services.
Sharon Langley	10 August 2019	Key Issues Identified in Action Plan:	Actions Taken per Action Plan:	[AS6-015 - LANGLEY, Sharon - Action Plan]	Per Action Plan Re-audit February 2020:

		The staff involved in the resuscitation attempt had not experienced an actual resuscitation before and their performance may have been improved with more exposure to training and simulation, therefore, the service should continue to promote and encourage the uptake of the Enhanced Emergency Skills (EES) course amongst HCA staff members and enhance its programme of simulated resuscitation.	CPR drills were undertaken. EES training, or its replacement Immediate Life Support (ILS) training have never been part of HCA mandatory training. HCA's would not be expected to have received the appropriate anatomy or physiology training required to benefit from EES or ILS training. Actions Taken per PFD response: The Trust strengthened its approach to resuscitation and the management of the deteriorating patient through the introduction of drop-in 'refresher' resuscitation training, the issuance of a Trust-wide Safety Learning Alert (September 2022) to disseminate learning from good practice, and the delivery of a 'Learning Matters' session (May 2023) focused on recognising and responding to clinical deterioration. In addition, a structured communication tool to support effective information exchange with	[AS6-016 – LANGLEY, Sharon – Action Plan Re-audit] [AS6-017 – LANGLEY, Sharon – Action Plan Quality Review] Learning was disseminated Trust-wide through a Safety Learning Alert and a 'Learning Matters' session focused on deteriorating patients and resuscitation, supplemented by drop-in refresher training to reinforce learning in practice. A communication tool was also developed to support consistent information exchange with ambulance services.	The Grab bag is routinely checked and audited with a daily inspection of the defib and oxygen tank and a weekly detailed inspection. This means that there is a robust assurance processes in place to ensure emergency equipment readiness. Life support training is mandatory for all staff on the ward and enhanced emergency skills is mandatory for qualified staff. This equips staff with the competence to respond effectively and safely to medical emergencies. Per Quality Review of Action Plan January 2023: A new Trust-wide leadership role (Head of Deteriorating Patient Pathway and Resuscitation Training Officer) was established to strengthen the management of deteriorating patients, resulting in the implementation of ILS training for senior staff to
--	--	--	---	---	--

			ambulance services was developed. EPUT developed drop-in 'refresher' resuscitation training. The Trust had issued a Safety Learning Alert in September 2022 relating to learning from good practice, and had developed a live 'Learning Matters' session, which was delivered in May 2023 relating to the management of the deteriorating patient and resuscitation. A communications tool for interactions with the ambulance service was also in development.		enhance leadership in emergencies, alongside the introduction of ongoing support mechanisms, including virtual drop-in sessions to promote continuous learning and staff engagement.
Bethany Lilley	16 January 2019	Key Issues Identified in Action Plan: Further training should be provided to staff on resuscitation and, specifically, the need to secure an airway by use of adjunct and administration of oxygen in line with the Cardio Pulmonary	Actions Taken per Action Plan: No changes to policy were made, following review. CPR drills were completed.	[AS6-018 – LILLEY, Bethany – Action Plan] [AS6-019 – LILLEY, Bethany – Action Plan Re-audit] [AS6-020 – LILLEY, Bethany – Action Plan Quality Review]	Per Action Plan Re-audit July 2020: CPR drills completed and current training includes calling ambulance in all life threatening situations. Per Quality Review of Action Plan February 2022:

		Resuscitation Policy (Appendix 2). The CPR Policy for Basildon Mental Health Unit should be reviewed to consider inclusion of the need to call an ambulance as a matter of urgency in all situations where there is a threat to life. Further face-to-face training should be provided if necessary.			Resus training remains in place for all ward staff. Additional CPR drills take place across the wards to support monitoring staff skills and identify need for improvement. It is acknowledged there has been some disruption to the NHS Level 4 Incident response to the Pandemic.
--	--	--	--	--	--