WITNESS NAME: Ann Sheridan and Dr Kallur Suresh
STATEMENT NO: 1 Dated: 4th September 2026
RULE 9 REFERENCE: Rule 9 (149) (b)

LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF
DR KALLUR SURESH AND ANN SHERIDAN

INTRODUCTION

I, Ann Sheridan will say as follows

1. I am the Executive Nurse within Essex Partnership University NHS Foundation Trust ('EPUT') and have held this position since February 2024. I have been in employment with EPUT since February 2024. I am a Registered General Nurse, a Registered Mental Health Nurse and a qualified Social Worker.

I, Dr Kallur Suresh will say as follows

2. I am a Consultant Psychiatrist and Chief Medical Officer at Essex Partnership University NHS Foundation Trust ("EPUT"). I have held this post since December 2025. Prior to that I held the role of Deputy Medical Director for the West Essex Care Unit and Consultant Psychiatrist and West Area Medical Director for North Essex Partnership University NHS Foundation Trust ("NEP").

3. I started working for NEP in 2004 initially as a Consultant Psychiatrist for older people in the Harlow area. In 2005, I was appointed as Associate Medical Director for West Essex. I held this role until the merger of NEP and the South Essex Partnership Foundation Trust ("SEPT") in April 2017.

4. This statement is made in response to the request by the Inquiry to EPUT dated 11 August 2026 under Rule 9 of the Inquiry Rules 2006, with reference "Rule 9 (149) (b)". The Chair to the Lampard Inquiry would be assisted by the provision of further information and documentation relating to resuscitation, following the Inquiry's review of EPUT's responses to Rule 9(149) Parts A and B. This statement is a supplementary corporate statement, responding to the further questions raised by the Inquiry in addition to, and to be read alongside, the earlier statements provided in response to Rule 9(149) Parts A and B.

5. The Inquiry has requested that the names and roles of the Subject Matter Experts who assisted with the preparation of Dr Suresh's Thirteenth Witness Statement and Ann Sheridan's Sixth Witness Statement be provided, and that if Subject Matter Experts assist with the response to this Rule 9 request, their names and roles be set out in this statement. The Subject Matter Experts (“SMEs”) who assisted with the preparation of the earlier statements and who have also assisted in the preparation of this supplementary statement includes but is not limited to the names and roles as set out in **Appendix One**

6. In this witness statement we have provided responses to the Inquiry's questions on behalf of EPUT. Not all matters related to the Trust are within our own personal knowledge, and therefore we 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 we provide. The contents of the statement are true to the best of our knowledge and belief.

7. We continue to offer our 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. We recognise the profound impact of these losses on families, friends, and the staff who cared for them.

Approach to the Rule 9 Request

8. This response has been prepared with information sourced directly through the review of documents contained within Netwrix and Relativity. A sample of the search terms includes: “2222”, "annual" +"audit" +"2222 calls" +"annual audit" +"2222" +"Basildon" +"Thurrock" +"University" +"Hospital" +"BTUH". Silver Command, Silver Command W/5 Minutes, Silver Command log, Silver Command meeting, Variations of "Silver" +"Command” +”log" +"minutes" +"2019".

9. Searches have also been undertaken of the Trust’s shared drives: PSIM Team, Integrated Risk, Clinical Governance, for Patient Incidents and Audits

10. To supplement the information contained within any documents located, SMEs provided further details in order to provide a response to the Rule 9 request and where this is so attributable it is set out in the body of the statement. It is the Trust’s position that not every single search term can be specified in this section on the basis that individual SMEs were not only asked for to assist with responses through discussion, but may have undertaken their own searches of documents, on their own emails, shared drives or within policy to assist their response.

11. Where the approach to any particular issue changed during the Relevant Period, this is explained together with the reasons for any change. Where there are gaps in information, reasons are provided as to why.

12. In responding to the questions in this Rule 9 request, where reference is made to any staff member or a group of staff, this is done by role (e.g. Doctor, Staff Nurse, Agency Nurse, Bank Nurse, Staff HCA (Healthcare Assistant), Bank HCA, Agency HCA, Locum) rather than using terminology such as "clinical"/"non-clinical" and

"registered"/"non-registered", in line with the Inquiry's request, unless the context requires otherwise.

13. The statement will address the questions in the Rule 9(149)(b) request in the following structure:

- Part 1: Documentation (Questions 3)
- Part 2: Emergency Equipment and Drugs (Questions 4–6)
- Part 3: Service Agreement with BTUH (Questions 7–9)
- Part 4: Deteriorating Patients (Questions 10–15)
- Part 5: Implementation of CPR Policy at Ward Level (Question 16)
- Part 6: Training (Questions 17–45)
- Part 7: Deviation from NICE Guideline NG10 (Questions 46–48)
- Part 8: Special Circumstances (Questions 49–50)
- Part 9: Simulations, CPR Drills and Scenario Training (Questions 51–52)
- Part 10: Availability of ILS-Trained Staff (Questions 53–54)
- Part 11: Staff (Questions 55–58)
- Part 12: Resuscitation Experts (Questions 59–63)
- Part 13: Budget (Questions 64–66)
- Part 14: Partnerships (Question 67)
- Part 15: Learning from Past Incidents (Questions 68–72)
- Part 16: Deaths Occurring After the Relevant Period (Questions 73–81)
- Part 17: Interim Recommendations (Question 82)

PART 1: DOCUMENTATION

CPR Policy Audits

14. This section of the statement addresses the Inquiry's requests for documentation set out at Question 3(a) to (j) of the Rule 9(149B) request. The requests span a range of documents relevant to EPUT's approach to resuscitation across the Relevant Period, including policy documentation, audit records, clinical guidelines, protocols, and standardised documentation in use on EPUT's inpatient mental health wards.

15. EPUT has conducted a thorough search of its records in order to locate and provide the documents requested. Where a document has previously been provided to the

Inquiry as part of EPUT's responses to the Rule 9(149) request (Parts A and B), this is identified below by reference to the relevant exhibit.

16. Where a document as requested does not exist in the precise form anticipated by the question, or where the terminology used in a policy does not accurately reflect the nature of the underlying process, EPUT has sought to explain this clearly, and to provide such documentation as does exist together with a full explanation of the relevant process.

17. Where documents cannot be located, or where gaps in documentation exist, EPUT has provided an explanation.

18. The reference to a "three-yearly audit" at paragraph 13.3 of CPR Policy v3.0 (KS12-021) more precisely describes a structured triennial review of the policy itself and its associated processes. The purpose of this review is to assess whether the policy and its associated processes remain appropriate and current, and to ensure that they are aligned with the latest national guidance applicable to resuscitation in mental health inpatient settings. The review is, in substance, a policy assurance and governance exercise rather than an operational or clinical audit of specific resuscitation events or outcomes.

19. Upon completion of the triennial review, the updated policy documentation is submitted to the relevant internal groups and committees for approval before it is formally adopted and disseminated across the organisation.

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

21. The Inquiry has requested that EPUT provide the annual audit of 2222 calls pursuant to an agreement with Basildon and Thurrock University Hospital Trust (BTUH) to provide resuscitation services. Despite extensive searches and requests made to individuals who might have knowledge of these audits, EPUT has been unable to locate them. EPUT has approached the current and former Associate Director of Inpatient and Urgent Care Services, Matrons, the former SEPT Senior Performance Manager and Service Managers.

22. According to the Service Specification with BTUH it was BTUH’s responsibility to undertake these audits and provide them to the Associate Director of In-Patient and

Crisis & Home Treatment Services, Senior Nursing Officer, Matrons and Ward Sisters/Charge Nurses. The former Directors who would have been in post at this time are no longer employed by EPUT. Changes in titles, structures and personnel have made it difficult to locate audit documents, which may have been sent directly to named contacts.

23. Historically, EPUT maintained its ligature risk assessment documentation across two separate instruments: a standalone Ligature Risk Assessment and Management Policy (previously exhibited as AS02-13) and a standalone Ligature Risk Assessment and Management Procedure (previously exhibited Rule 9(16) - 127). The policy set out the overarching governance framework and organisational requirements, whilst the procedure contained the operational and step-by-step guidance intended to direct staff practice in identifying, assessing, and managing ligature risks within inpatient mental health settings.

24. During 2021/22 the Trust undertook a comprehensive review of its policy framework, which included seeking feedback from staff regarding the accessibility and usability of Trust policies and procedures. The feedback received identified several recurring themes. Staff reported that receiving several policy and procedures could be confusing; that there was an inconsistency of the information contained within each document; the procedural documents were often lengthy and complex, sometimes incorporating multiple processes within a single document. In response the Trust commenced a programme of work aimed at simplifying and standardising its governance documentation.

25. Following a substantive review of the Trust's Policy and Procedure Framework, a decision was taken to consolidate policies and procedures. Therefore, the procedural content previously held within the standalone Ligature Risk Assessment and Management Procedure was incorporated into the Ligature Risk Assessment Policy.

26. As part of this programme, EPUT initiated the eSOP Project. The objectives of the project were to record, digitise, optimise and monitor the use of standard operating procedures, thereby supporting staff to deliver Mental Health and Community Health Services in a safe, effective and consistent manner. Alongside this work, the Trust reviewed and simplified its approved document templates.

27. One of the key outcomes of this programme was the introduction of the SOPHIA platform. SOPHIA is the Trust's central electronic repository for approved policies, clinical guidelines and standard operating procedures. The Trust adopted SOPHIA as

the single platform for accessing these documents in order to reduce the risk of staff relying on outdated, superseded or conflicting versions. The system also supports interactive standard operating procedures and provides staff with access to evidence-based guidance, step-by-step instructions and process flowcharts. This approach was designed to improve accessibility, support consistent practice and reduce unwarranted variation in care delivery.

28. To complement the introduction of SOPHIA, the Trust adopted a revised document structure. Rather than maintaining separate policy and procedure documents, the intention was for each subject area to be supported by a concise policy statement document underpinned by a series of focused Standard Operating Procedures (“SOPs”). In addition, "Policy at a Glance" documents were introduced to provide staff with an accessible summary of key requirements.

29. Implementation of this new approach was planned in phases. The first phase involved consolidating existing policy and procedural documents and uploading them to the SOPHIA platform. This enabled all approved documentation to be available from a single source while preserving the existing content. The second phase involves the progressive review of documents at their scheduled review dates, with authors restructuring them into the new format comprising a policy statement supported by separate SOPs. This phased approach was adopted to ensure the work could be undertaken in a controlled and manageable manner.

30. The current Ligature Risk Assessment Policy CP75 is accordingly the consolidated document. It contains both the policy framework and the procedural guidance previously set out in the separate Ligature Risk Assessment and Management Procedure. Pending future review and restructuring in accordance with the Trust's revised documentation framework. At the point of consolidation, no substantive changes were made to the content, requirements or expectations contained within the original documents. The exercise was administrative in nature and was undertaken to support migration to the SOPHIA platform and the wider document modernisation programme.

31. The Inquiry has requested details and copies of any audits conducted, between the merger of NEPT and EPUT on 1 April 2017 and the current date, of documentation completed following resuscitation events. No such audit has been conducted. However, the documentation produced following a resuscitation event is reviewed.

This includes a Datix incident report and a Resuscitation Event Report Form. The outcome of the CPR event must be clearly documented in the patient record.

32. The Head of Deteriorating Patient Pathway and Resuscitation Training Officer will confirm if the Resuscitation Event Report Form has been completed in order to identify examples of good practice, any knowledge or technical/non-technical skills shortfall and potential learning opportunities. Please see CLPG14A CPR Procedure previously exhibited as KS12-013.

33. EPUT's Senior Datix Manager has conducted a search of Datix for any report where the answer to the question, "was CPR used" was yes. The data has been provided in a spreadsheet and is exhibited (KS.AS01-001 redacted version, KS.AS01-002 unredacted version).

34. The Inquiry team will note that up until 2020 there are blank fields for columns R onwards. This is because the Datix reporting was changed at this time to prompt the reporter to complete the additional question fields once there had been a positive response to the question "was CPR used".

35. EPUT does not maintain separate CPR policies or procedures specific to older adult patients, child patients, or any other particular patient group. The CPR Policy v3.0 (KS12-021) represents EPUT's single consolidated policy governing the approach to resuscitation across all inpatient settings, and its requirements apply uniformly irrespective of the age, presentation, or clinical characteristics of the patient in question. No separate patient-group-specific CPR policy or procedural document has been developed or maintained alongside the principal policy.

36. Whilst the policy and procedural framework applicable to resuscitation is consistent across patient groups, EPUT does recognise that the clinical needs of certain patient populations require a differentiated approach to training. Specifically, in respect of babies who are residing alongside inpatient mothers, staff working on Rainbow Wards are offered additional Basic Life Support training which incorporates infant specific content.

37. The standardised resuscitation documentation referred to at paragraph 36 of Ann Sheridan's Sixth Statement is exhibited at (KS.AS01-003).

38. The current version of the Secure Services Protocol for the Rapid Response to an emergency incident has previously been exhibited at KS12-050.

39. The amended version of the Protocol following the death of Marion Michel has previously been exhibited as Exhibit 2d to Rule 9(78). Despite searching via Netwrix across the policy team drives and on Relativity, EPUT has been unable to locate any earlier EPUT versions of the Protocol. There was a similar protocol in place at SEPT which has been located and can be provided if required.

40. The current version of the Resus Flow Chart (KS12-047) is exhibited at (KS.AS01-004).

41. The current version of the Break Glass Escalation Procedure appended to HR40-Deployment of Temporary Workers Policy at Appendix 4 is exhibited at (KS.AS01-005).

PART 2: EMERGENCY EQUIPMENT AND DRUGS

42. This section of the statement addresses the Inquiry's questions at Questions 4, 5 and 6 of the Rule 9(149B) request. These questions concern three related but distinct aspects of EPUT's arrangements for responding to medical emergencies on its inpatient mental health wards: the medicines available to staff during a medical emergency and the authorisation framework governing their administration; the addition of Naloxone to EPUT's resuscitation drugs framework; and the requirements placed on staff during induction in relation to familiarising themselves with the location of emergency equipment within their clinical area.

43. EPUT addresses these matters below.

Emergency Drugs - CG27 and Medication Administration

44. EPUT confirms that Exhibit MK2-130 (CG27, dated 7 March 2023) represents the version of in place at the time of that response. At the time of writing this statement, a revised version of CG27 was ratified on 25 August 2026 (KS.AS01-006).

45. Registered nurses and doctors are required to complete specific medicines management training and meet NHS mandatory training requirements before they can safely administer medicines in a ward setting. This is underpinned by the NMC Standards of Proficiency, the Royal College of Nursing (“RCN”) and Royal Pharmaceutical Society (“RPS”) guidance, along with the NHS England Core Skills

Training Framework. Before commencing employment registered staff are also required to complete local Trust medicines management training, and competency assessments in safe administration, drug calculations, and legal/professional duties.

46. EPUT maintains its own requirements for the administration of lifesaving medication in addition to these regulatory and professional requirements. Medicines management forms a core practice training requirement for all qualified nursing staff within mental health services. Staff are required to attend a full day Medicines Management training annually. The table below sets out, for each medicine: the staff roles authorised to administer it; the specific training required prior to administration; and whether the attendance of an Advanced Life Support ("ALS") qualified person is required.

Medicine	**Staff Roles Authorised to Administer**	**Training Required**	**Attendance of ALS qualified person required**
Aspirin	All staff on guidance of emergency response service	No additional training provided, although administration and dosage guidance is given.	No
Glyceryl Trinitrate	All staff	No additional training provided although administration and dosage guidance is given.	No
Glucagon	Staff with the required training and competency	No additional training provided although administration and dosage guidance is given.	No
Glucose Solution/Gel	Staff with the required training and competency	No additional training provided although administration and	No

		dosage guidance is given.	
Midazolam	Staff with the required training and competency	No additional training provided although administration and dosage guidance is given.	No
Procyclidine	Staff with the required training and competency	No additional training provided although administration and dosage guidance is given.	No
Salbutamol	All staff	No additional training provided although administration and dosage guidance is given.	No
Naloxone	Staff with the required training and competency	See details below	No
Flumazenil	Staff must have required competencies	No additional training provided although administration and dosage guidance is given.	No
Rapid-acting insulin	Staff with the required training and competency	No specific training required	No
Adrenaline – for the treatment of anaphylaxis	Staff with the required training and competency	CG27 requires inpatient nursing and community staff to complete training in anaphylaxis through ILS training undertaken yearly which includes guidance on	No

		administration and dosage.	

Naloxone

47. The Inquiry has noted that v10.0 of the Trust's CPR Procedure incorporates the addition of Naloxone as an available drug. Despite extensive searches of available records and enquiries made of relevant personnel, EPUT has been unable to identify any documented rationale, or to locate any individual with knowledge of the circumstances, explaining the decision to include Naloxone in v10.0 of the CPR Procedure.

48. Naloxone would not have been subject to broad dissemination in the traditional sense; rather, it was incorporated into the ward drug list through the standard medicines management process. In practice, this means that once approved for inclusion on the ward list, its availability was confined to the clinical areas in which it was stocked, and staff working on those wards were expected to be familiar with its use as part of routine medicines management. There would have been no separate or wider dissemination process, as the presence of the drugs on the ward list itself served as the mechanism by which staff became aware of and had access to it.

49. The legal and clinical framework governing the administration of Naloxone on EPUT's inpatient mental health wards is established by two instruments read together: EPUT's own Clinical Guideline CG82 (Clinical Guidelines for the Use of Naloxone and the Human Medicines Regulations 2012 (as amended).

50. The Human Medicines Regulations 2012 (SI 2012/1916), as amended by the Human Medicines (Amendment) Regulations 2024 (SI 2024/1125) provide that Naloxone maybe administered parenterally to a person for the purpose of saving their life in an emergency, without the need for a prescription and without restriction as to who may administer it. This provision reflects the established position in law that Naloxone, as an opioid antagonist used to reverse life-threatening opioid toxicity, may be administered by any person in an emergency regardless of whether that person holds a clinical qualification or registration. The administration of Naloxone by a member of staff in an emergency is therefore lawful under the Human Medicines Regulations, without the requirement for a patient-specific direction, a patient group direction, or a prescription.

51. In addition to the statutory framework, EPUT has produced Clinical Guideline CG82 (Clinical Guidelines for the Use of Naloxone), which provides the operational framework governing the use of Naloxone across EPUT's inpatient settings. CG82 sets out the clinical indications for the administration of Naloxone, the appropriate dosage and route of administration, and the responsibilities of staff in recognising opioid toxicity and responding accordingly.

52. EPUT's position (and the legal position as set out in the Human Medicines Regulations 2012) is that the administration of Naloxone in a life-threatening emergency is not restricted by professional role. Staff working on EPUT's inpatient wards can administer Naloxone in an emergency as a matter of law. This is not a position which is unique to EPUT, however, to ensure that staff are equipped to recognise opioid toxicity and to administer Naloxone safely and effectively in practice, staff are trained in its use, and this is recorded on the "Staff Training for Naloxone Competence Assessment Form".

53. The training incorporates:

    a. Identification of patients at risk of opioid overdose

    b. Recognising the signs of opioid overdose

    c. Management of Opioid Overdose

    d. Administering Naloxone (by intramuscular injection or intranasal route).

Staff Induction - Emergency Equipment Familiarisation

54. For the purposes of paragraph 9.1 of CPR Policy v3.0 (KS12-021), "clinical area" refers to the nurse's office or clinic room. The location of emergency equipment is addressed as part of the ward induction process, during which the new staff member, whether permanent, bank or agency, is orientated to the ward environment. Each staff member is required to engage fully in the induction process and to familiarise themselves with the information provided. The local induction is recorded and signed.

55. Appendix 3 of HRPG21 (Exhibit 16) sets out the local workplace induction checklist for locum, bank and agency staff. The inductor is required to complete a ward orientation on SOPHIA upon arrival for their first shift of each new ward, and instances where the staff member has not worked on that ward for more than 4 weeks. This is a mandatory requirement for every new ward. The ward orientation is ward specific and expressly requires the inductor to cover the location of ligature point areas and hotspots; the specific ligature risk assessment for that ward; location of emergency equipment and

medication (e.g., resus kit); alarm systems (door top/pin-point/pit alarm, nursing call alarm); security arrangements including rapid response nurse; and anti-barricade doors.

56. The orientation also applies to staff returning from sickness absence, or other periods of long-term leave which last over 4 weeks. The current versions of the induction forms are those as set out in Exhibit 16 and Exhibit 17 to Rule 9(149)(A).

57. The Trust notes the existence of a singular overarching checkbox in Exhibit 16 and acknowledges that this in itself cannot provide immediate assurance that each section has been specifically addressed, however it is the Trust's position that box can only be completed once all sub sections are covered; the form allows for narrative comments to be added where there are issues that require noting on induction.

58. The Inquiry has noted that Exhibit 17 does not contain the same level of detail as Exhibit 16. For example, it does not include a prompt to explain location of ligature cutters, ligature risk assessment and hot spots. The Trust confirms that these areas are captured within the ward orientation, and existing checklists specified under Health and Safety Issues, Responsibilities and Information (including incident/accident reporting and risk assessments). Staff are required to confirm they have read the ligature inspection and hotspot checklists. The sections relating to Medical Emergency and Psychiatric Emergency are the areas where the use of ligature cutters are covered within the induction process.

59. Given that the ward orientation is not limited by the checklist, the Trust is assured that temporary workers are apprised of business critical and safe working arrangements through the existing local processes. The induction checklist is simply a record that an induction has occurred and does not reflect the extent of the local induction that occurs.

60. Induction forms for temporary staff are retained by the ward manager. Induction forms for substantive and bank staff are retained by Human Resources.

61. The Trust confirms that doctors undertake a separate local induction, (KS.AS01-007). Doctors undertake a placement induction at each change of placement, which includes movement between wards, this is typically undertaken by their supervisor, namely the consultant psychiatrist on the wards.

PART 3: SERVICE AGREEMENT WITH BTUH

62. This section of the statement addresses the Inquiry's questions at Questions 7, 8 and 9 of this request. All three questions concern EPUT's service agreement with Basildon and Thurrock University Hospital NHS Foundation Trust ("BTUH") for the provision of crash team services to EPUT's inpatient mental health wards, the circumstances surrounding a specific resuscitation event that predated the formal commencement of that agreement, and the current position regarding EPUT staff's ability to call the BTUH crash team following the termination of the agreement.

63. The documents available to the Trust indicate that an agreement was in place between BTUH and SEPT's Basildon Mental Health Unit from at least 2005 however no such formal agreement has been located.

64. A service specification dated 2016 lasting least 3 years is attached as, (KS.AS01-008).

65. During the period of the Service Level Agreement with BTUH (1 April 2019 to 31 March 2020), staff were expected to contact the crash team immediately upon discovering a patient requiring resuscitation. The mechanism for doing so was the internal 2222 paging system. Staff were not directed by any formal written guidelines to call the crash team within a specified number of minutes of discovering the event; rather, the expectation was that the call would be made without delay, as part of the immediate response to the emergency.

66. The service level agreement with BTUH governed the provision of crash team services by BTUH. The service specification does not contain any indication of the expected response time. However, it does indicate that the response to 2222 cardiac arrest calls was available 24 hours a day, 365 days a year. EPUT invites the Inquiry to request further details from BTUH.

67. The recollection of the Service Manager (Inpatient and Emergency Services, Mid and South) is that no exact response time was communicated to ward staff during the period of the agreement. The crash team's attendance was understood to be as prompt as operationally possible, but (as far as can be recalled) no specific time target was set or monitored.

68. During the period of the BTUH agreement, staff were required to call an ambulance in addition to the crash team in circumstances where a patient required transfer to an acute care setting, including, in particular, where the patient required transfer to an

Accident and Emergency department or to the Resuscitation unit. EPUT did not have the means to transfer patients from its inpatient mental health units to an acute hospital without the attendance of the ambulance service.

69. The operational position in practice was that once staff were aware that the crash team had been called and was on its way, the ambulance service was also contacted, given the limitations on EPUT's capacity to convey patients for acute care. No formal written instruction specified the precise timeframe within which staff were required to call the ambulance service following discovery of the emergency.

70. EPUT is not aware of any formal measurement exercise or data collection programme specifically designed to assess whether the BTUH agreement produced an improvement in resuscitation response times or patient outcomes during the period April 2019 to March 2020.

71. Notwithstanding the absence of formal outcome data, EPUT's Service Manager (Inpatient and Emergency Services, Mid and South) who worked during the period of the agreement formed the view, based on their direct experience, that the availability of the crash team was beneficial to the management of medical emergencies on EPUT's inpatient wards.

72. The Inquiry is aware of a successful resuscitation attempt which took place on 17 March 2019 [E129331] attended by the crash team from BTUH The 3-Day Report and related Root Cause Analysis Report are exhibited (KS.AS01-009 and KS.AS01-010). This occurred before the service agreement with BTUH dated (1 April 2019 to 31 March 2020), however documentation indicates that this arrangement had been in place since at least 2005. Therefore, it was recognised practice for the BTUH crash team to attend in response to a call made by ward staff. The Service Manager for Linden and Crystal Centre confirmed that the BTUH crash team, and an ambulance was called whenever a patient was found in an unresponsive state.

73. As set out above given the limitation of material available to confirm otherwise it is unclear if any service level agreements formalised existing services utilised within BTUH or were revisions to previous agreements of a formal nature. From recollection this service had been available throughout the Relevant Period, and that staff understood they were able to summon the BTUH crash team when faced with an unresponsive patient. Changes occurred during the COVID-19 Pandemic when the BTUH crash team was required to alter its operational procedures in light of infection and control requirements, including changes to PPE protocols, and the resource was

reclassified as critical to the acute hospital's own operations. At the time staff on the ward were EES trained and whilst crash trolleys were available, they were in practice operated by the BTUH crash team upon attendance rather than by EPUT's own staff. Ward staff understood their role was to ensure that the trolley was stocked and in a ready state; but staff were not trained to use it.

74. Following the termination of the formal service agreement with BTUH on 31 March 2020, access to the BTUH crash team is no longer available to staff working on EPUT's inpatient mental health wards. With effect from 1 April 2020, the BTUH crash team was formally retracted from the Basildon site. Staff were notified that, in the event of a cardiac or respiratory arrest or sudden collapse at the Basildon site, they were required to contact the paramedic service on 999 and that there would no longer be access to the 2222 service. This change was communicated to staff by way of a staff notice issued at the point of the transition (KS.AS01-011). The new policy, designated CLPG14, was made available on the Trust intranet with effect from 1 April 2020. Trust staff do not currently engage the crash team.

75. Notwithstanding the clear position from 1 April 2020, EPUT is aware of one incident that occurred in the period immediately following the termination of the agreement in which the BTUH crash team attended an EPUT ward. This attendance occurred in the early period following the removal of the 2222 service and represented an instance where the BTUH crash team attended when they should not have done so.

PART 4: DETERIORATING PATIENTS

76. Questions 10 to 15 concern the identification and management of deteriorating patients on EPUT's inpatient mental health wards.

NEWS2 Adoption

77. NHS England issued a Patient Safety Alert in April 2018 requiring all acute hospital and ambulance trusts to fully adopt NEWS2 for adult patients by March 2019. Mental health services were not expressly included in that requirement. EPUT's MEWS charts were updated in 2018 and rolled out across the Trust with an extensive training programme. Staff, particularly in the north of the Trust, were still becoming familiar with that tool.

78. Given the different clinical context of mental health and learning disability services, and in the absence of a national requirement, the Trust continued to use MEWS in inpatient mental health settings. The Clinical Governance and Subcommittee Group approved this recommendation, subject to approval by the Executive Physical Health Sub-committee, (KS.AS01-012).

79. At the end of February 2020, the command-and-control Trust response was launched as part of the emerging pandemic, during which physical health observation protocols were adapted to respond to the pandemic - as such as review of policies setting out the use of NEWS2 was underway. This review was postponed formally as a result of the pandemic, however they were ratified on return to business as usual which coincided with the creation of the role of Head of Deteriorating Patient Pathway and Resuscitation Training Officer and as such was amended.

Non-Contact Physical Observation Tool

80. EPUT confirms the "non-contact physical observation tool" referred to at paragraph 41 of Ann Sheridan's Sixth Statement, is Exhibit 21 to R9(149)(A) and sits within the broader framework of EPUT's CPR policy.

81. The tool is structured around the established ABCDE framework and provides staff with an accessible means of assessing a patient's condition across five domains without requiring physical contact.

82. Critically, the tool directs staff that where any indicator in the red section applies to the patient, they should escalate immediately. This escalation trigger is central to the tool's clinical utility: it is designed to ensure that the non-contact pathway does not result in a diminution of clinical vigilance where a patient declines or is unable to consent to physical assessment but instead provides a structured alternative that preserves the prompt escalation response that full NEWS2 scoring would otherwise generate.

83. The Non-Contact Physical Observations tool complements EPUT's A-E Assessing a Deteriorating Patient Aide-Mémoire. Both tools are discussed together as part of EPUT's Immediate Life Support (ILS) training. In addition to their inclusion in ILS training, the tool is physically located within the resuscitation bag and is also laminated and displayed in the ward office, to be immediately accessible to staff who may need to use it in an urgent situation. The tool is not covered within RCUK BLS training. However, it is part of the NEWS2 guidance and is signposted to all staff during the life support refresher sessions.

CQC Inspection Findings

84. The relevant CQC reports identifying variation in physical health monitoring, documentation, and timeliness of escalation are exhibited at (KS.AS01-013 and KS.AS01-014). The variations were identified following inspections conducted on 22 and 23 August 2017 (report published 11 October 2017) and 1 May 2018 (report published 26 July 2018).

Physical Health Monitoring

85. Following the 2017 inspection, the Trust acted promptly and systematically. Audits were conducted across the three wards in question, including a review of the Electronic Patient Records ("EPR") to identify and mitigate risks arising from recording gaps. Recording requirements were formally confirmed and communicated to staff via written correspondence, with further reinforcement delivered through attendance at Quality and Safety meetings.

86. The audit findings drove the introduction of a dedicated e-form within the EPR system, Remedy (Paris), ensuring that physical health data was recorded centrally, improving both consistency and accessibility. Dedicated MEWS (Modified Early Warning Score) documentation folders were also introduced on the wards, ensuring that monitoring paperwork was immediately available to clinical staff at the point of care.

87. Following the 2018 inspection, a Trustwide action plan was implemented to address the CQC's finding that care plans did not always reflect patients' specific physical health needs. Targeted actions were taken to ensure that patients with identified physical health needs had corresponding, individualised care plans in place.

Timeliness of Escalation

88. Physical health recording gaps were escalated through clinical and EPR leads to clarify reporting expectations and establish mitigating actions. Existing ward handover and quality meetings were utilised to reinforce compliance and surface concerns requiring management oversight, forming part of the wider safety monitoring framework established in the wake of the inspection.

89. Following the 2018 inspection, EPUT implemented a comprehensive Trustwide improvement programme to strengthen physical healthcare, patient safety, and governance. The programme was overseen at executive level and encompassed improvements to physical health assessments, care planning, documentation standards, and the accessibility of health information, supported by regular

performance reporting and assurance activities. All physical health-related actions were subsequently reported as complete, with demonstrable improvements in monitoring consistency, staff competence, and organisational oversight (KS.AS01-015).

Patient Safety Alert - RCUK Algorithm

90. It is standard practice across NHS mental health trusts, and indeed across a wide range of healthcare settings, to adopt the RCUK algorithm in its published and unamended form. The RCUK produces its algorithms as authoritative, evidence-based guidance intended for adoption across healthcare settings.

91. The expectation within the NHS is that organisations will implement the RCUK's published guidance. The RCUK does not produce bespoke versions for individual trust types or settings. Most NHS trusts, including both acute and mental health, reproduce the standard national RCUK algorithm in their policies, patient safety alerts, and training materials without local amendment.

92. Exhibit AS-267 focused on medical learning, specifically the clinical learning arising from the patient safety incident that prompted the alert, rather than on the operational question of AED location, which is addressed separately through the induction process and through the physical placement of AEDs on the resus trolley or in the pocket of the resus bag.

93. EPUT does not consider that the reproduction of the unamended RCUK algorithm in AS-267 created a material risk of confusion for staff in practice. Staff are trained and inducted on the location of emergency equipment on their ward, and the AED is co-located with the resus trolley or resus bag. EPUT acknowledges, however, that local annotation of the algorithm to reflect EPUT-specific AED availability could have provided additional clarity, and EPUT will have regard to the desirability of such localisation in any future patient safety communications of this nature.

Early Recognition and Escalation

94. EPUT has taken a multi-layered approach to addressing the recognised need for improvement in the early recognition and escalation of physical deterioration. The principal steps are as follows.

<u>Implementation and Embedding of the NEWS2 Tool</u>

95. The National Early Warning Score 2 (NEWS2) is the nationally mandated standardised clinical tool for identifying and scoring physiological parameters that indicate patient

deterioration. NEWS2 is now adopted Trust wide as the standard protocol for monitoring and escalating concern about a deteriorating patient.

96. In practical terms, the NEWS2 chart operates as follows: physiological parameters, such as respiratory rate, oxygen saturation, temperature, blood pressure, pulse rate, and level of consciousness, are recorded and a score is generated. Staff are trained to understand the scoring system and to act in accordance with the clinical escalation thresholds that the score generates.

The A-E (ABCDE) Assessment Approach

97. Alongside NEWS2, the A-E (Airway, Breathing, Circulation, Disability, Exposure) structured assessment approach is a core element of the clinical framework for responding to a deteriorating patient. At paragraph 51 of his First Witness Statement, Dr Kallur states that "staff will use the Assessing a Critically Unwell Patient aide memoir following the ABCDE approach [Exhibit KS-014] covered in ILS Training". Additionally, the Non-Contact Observation Tool referred to above further complements this response.

98. NEWS2, the A-E approach and the Non-Contact Observation Tool form part of the ILS training programme. NEWS2 is the early-warning and monitoring tool used proactively during a patient's care, whilst the A-E approach and the Non-Contact Observation Tool are structured clinical assessments applied once deterioration has been identified and a response is being mounted.

99. NEWS2 protocol, the A-E assessment approach and the Non-Contact Observation Tool are promoted and discussed actively through several mechanisms beyond formal ILS training, as set out below.

Promotion Through Workshops and Reflective Practice

100. EPUT promotes their use through clinical workshops and structured reflective practice sessions. These sessions are not limited to the ILS training but are delivered as ongoing learning opportunities. Medical emergency scenarios are run during workshops, in which staff are required to apply NEWS2 scoring and undertake A-E assessments in response to a simulated clinical presentation.

Learning from Events - SWARM Huddles

101. A further mechanism by which EPUT promotes awareness of the early recognition and escalation of physical deterioration is through Serious, Worrying and Reoccurring Multiple (SWARM) huddles following patient safety incidents. SWARM

huddles are rapid, structured learning events that take place in the immediate aftermath of a patient safety incident. They provide an opportunity to identify and share learning points with relevant staff in a timely manner. Learning arising from SWARM huddles that relates to deteriorating patient recognition and escalation, including, for example, application of the NEWS2 scoring system and use of the assessment tools is shared with staff through this mechanism.

ABCDE Approach and ILS Training

102. Whilst the ABCDE approach, use of the aide memoir and non-contact patient observation tool are only covered in ILS Training. Staff attend the CPR simulations and are also invited to attend the workshops. The tools are discussed with all staff present during these life support training sessions.

PART 5: IMPLEMENTATION OF CPR POLICY AT WARD LEVEL

103. Responsibility for implementing the CPR Policy at ward level rests with the Service or Unit Manager for the relevant ward or unit. This is consistent with the CPR Policy (CLP14), which states that Service and Unit Managers are responsible for ensuring all staff, including new employees, whether temporary or substantive, are made aware of the policy. That responsibility means ensuring that the policy is operationalised within the ward environment, that staff are familiar with its requirements, and that any local arrangements necessary to give effect to its provisions are put in place and maintained.

104. The location of resuscitation bags within each ward or clinical area is determined at ward level, in collaboration with relevant subject matter experts. This may include involving the resuscitation training officer or the health and safety and compliance team.

105. Appendix 5 of CPG75 requires that ligature cutters must be kept in at least two places on the ward. Those locations are the Resuscitation Grab Bag kept in the Clinic/Treatment Room, and in a labelled Red Pouch attached, using Velcro, to the wall in an easily accessible place within the nursing office.

106. The requirement that one set of cutters be kept within the nursing office reflects a deliberate approach to emergency accessibility. The nursing office is typically a centrally located and consistently identifiable point on the ward, generally occupied by staff, and is therefore a location that can be readily accessed when cutters are required at speed. The further requirement that the location of cutters be clearly signposted using an A4 poster reinforces the importance placed on immediate identifiability.

107. Prescribing the same designated locations across all wards provides consistency for staff and reduces ambiguity, which is of particular importance in a time-critical situation where knowing exactly where the equipment is held is essential. This is not a matter of convenience, but a considered safety measure designed to ensure that ligature cutters are both accessible and immediately identifiable at the point of need.

108. In practice, within EPUT's inpatient settings, the AED is stored either in the front pocket of the resuscitation bag or on top of the resuscitation trolley. This co-location of the AED with the resuscitation bag or trolley is intentional: it ensures that the AED is retrieved as part of the immediate response to a cardiac arrest without the need for staff to locate it separately.

109. Wards are restricted access areas, with access controlled by swipe cards or similar arrangements. The access arrangements must ensure that emergency services can gain timely access to all areas of the ward without compromising the security requirements of the unit. The assessment of access for emergency services forms part of the Fire Safety arrangements and is determined through:

a. Annual fire risk assessment. The Trust Fire office undertakes annual statutory inspections as well as additional documented inspections to review actions identified in between the formal fire risk assessment and give advice on maintaining access routes.

b. The assessment of access routes for ambulances is undertaken by Estates and the Risk and Operational teams to consider the requirements of each individual site. The Trust's Section 136 suites have dedicated routes and parking bays for those patient transfers.

c. In an emergency scenario, ward staff provide support to incoming emergency services personnel through communicating the location of the incident, ensuring barriers are left open when the emergency services have been

contacted and ensuring staff are available at the entrances to guide personnel into the building. This is an allocated role within the CPR procedure.

110. EPUT provides support to those individuals who carry responsibility for the matters referred to above through access to a range of subject matter experts who are available to contribute to local decision-making. Those subject matter experts include the resuscitation training officer, the health and safety and compliance team, and the estates and facilities function. Each of these roles brings specialist knowledge to bear on the decisions made at ward level regarding the implementation of the CPR Policy, including decisions about the location of emergency equipment and the assessment of emergency access routes.

111. Responsibility for assessing the skills mix of staff on each shift and for ensuring that staff on each shift understand their roles in the event of a medical emergency rests jointly with the Nurse in Charge and the Ward Manager or Rostering Manager for the ward concerned, operating within the framework established by EPUT's Rostering Policy (HR61 sV3.0).

112. At the rostering and planning stage, Team Managers and Roster Managers are responsible for ensuring the safe staffing of the ward and team, and that there are sufficient staff in the right place at the right time. Managers are required to ensure that rosters reflect minimum staffing levels, covering both the number of staff required and the skill mix required, including the experience, competencies, and gender of staff, by shift and by day. One of the stated principles of the Rostering Policy is to minimise clinical risk associated with the level and skill mix of clinical and non-clinical staffing levels.

113. At shift level, the Nurse in Charge, with service management, is responsible for ensuring that daily staffing matches staffing levels to patient acuity, providing control and assurance from bedside to board. This is achieved through the SafeCare system, which enables the Nurse in Charge to compare staff numbers and skill mix alongside actual patient demand in real time, allowing informed decisions to be made and acuity-driven staffing to be maintained. SafeCare submissions are required twice daily, in the morning and in the afternoon, at specified times on the HealthRoster system. The Ward Manager and Rostering Manager are responsible for reviewing the SafeCare information for their ward and, if clinically required, implementing the relevant procedure.

114. HR61 provides that the use of bank and agency staff for nights and weekends should be avoided, where possible. If staff wish to change their rostered off duty, that can swap with another member of staff of the same grade, providing it is approved and it does not adversely affect the skill mix, safety or service quality. The agreed ratios of registered versus unregistered staff must be maintained.

115. Where a gap in the skills mix is identified, the Ward Manager or Roster Manager is required to check with all ward and department staff whether they are available to undertake bank duties for particular shifts, ideally at equal grade, and if that is not possible, a clinical judgment regarding the skill mix on that shift must be considered and explored in order to meet safe staffing requirements.

116. The practice is that the Nurse in Charge allocates relevant emergency response roles to staff on the shift should a medical emergency arise, consistent with the broader responsibility of the Nurse in Charge for the safe management of the ward and its staffing at shift level.

117. In addition to the mechanisms described above, wards can escalate any gaps in staffing to sit-rep including the availability of appropriately trained staff and take necessary steps to address those gaps before or during the shift to maintain safe staffing levels.

PART 6: TRAINING

118. This section of the statement addresses the Inquiry's questions under the heading of Training.

Training Needs Analysis

119. The Trust sets and manages its skill mix ratios in line with the principles outlined in HR61 – Rostering Policy – Skill mix and CLP84 – Safe Staffing – Ratios & Skill mix. These documents establish that each service must maintain an appropriate balance of roles and competencies, ensuring that staffing on any given shift reflects the required blend of registered, unregistered, and support staff. Skill mix is therefore determined by the needs of the service and the defined staffing ratios, enabling teams to maintain safe and effective practice through a consistent approach to allocating the right combination of skills. All Training Needs Analysis is conducted based on national alignment to Core Skills Training Framework set out by NHS England throughout the period.

Required Training Levels by Role and Ward Type

120. The level of training (BLS, ILS or ALS) currently required by EPUT for staff in each of the following roles, across each of the ward types (older adult; adult; PICU; CAMHS; Mother and Baby Unit) is set out in the table below:

Staff Group	Older adult	Adult	PICU	CAMHS wards	Mother & Baby units	Assessment undertaken by	Quals of Trainer/ assessor
Doctor	ILS	ILS	ILS	ILS	ILS	External Trainer	Teaching Qual i.e PTTLLS ILSi
Clinical / Service Manager	ILS	ILS	ILS	ILS	ILS	External Trainer	Teaching Qual i.e PTTLLS ILSi
Ward Manager	ILS	ILS	ILS	ILS	ILS	External Trainer	Teaching Qual i.e PTTLLS ILSi
Staff Nurse	ILS	ILS	ILS	ILS	ILS	External Trainer	Teaching Qual i.e PTTLLS ILSi
Bank Nurse	ILS	ILS	ILS	ILS	ILS	External Trainer	Teaching Qual i.e PTTLLS ILSi
Agency Nurse	ILS	ILS	ILS	ILS	ILS	External Trainer	Teaching Qual i.e PTTLLS ILSi

Staff HCA	BLS	BLS	BLS	BLS	BLS	Internal Trainer	Teaching Qual i.e PTTLLS BLSi
Bank HCA	BLS	BLS	BLS	BLS	BLS	Internal Trainer	Teaching Qual i.e PTTLLS BLSi
Agency HCA	BLS	BLS	BLS	BLS	BLS	Internal Trainer	Teaching Qual i.e PTTLLS BLSi
Locum doctor	ILS	ILS	ILS	ILS	ILS	External Trainer	Professional Registration ALSi
Head of Deteriorating Patients Pathway and Resuscitation Training Officer	ALS	ALS	ALS	ALS	ALS	External Trainer	Professional Registration ALSi

121. Staff are assessed for competency in RCUK BLS training by the workforce training team who are currently delivery RCUK BLS (this will be delivered as a function of the physical health faculty in the future) The Trust currently outsources RCUK ILS to an accredited RCUK course provider and their team will assess staff competence using several different assessment modalities. The RCUK ILS training will be delivered as a function of the physical health faculty in the future. Please see the table below for the Assessment Methods employed and the Assessor.

Training type	Provider	Assessment methods	Assessor
BLS	EPUT workforce training	Simulation/independent demonstration of skill by candidate	BLS Instructor

ILS	External (A to E Training Solutions)	Skills stations and Simulation/independent demonstration of skill by candidate	ILS Instructor
Paediatric BLS	External (MSEFT resus team) and EPUT staff (Train the trainer)	Simulation/independent demonstration of skill by candidate	Paediatric BLS Instructor

122. The workforce training team have ensured that all instructors have attended the RCUK basic life support instructor (iBLS) course. RCUK ILS instructors either qualified RCUK ALS instructors, or instructor candidates (those undertaking a supervised teaching session) or ILS instructors

ILS Training and KS-010

123. The Trust is unable to answer why RCUK ILS is not listed under mandatory training requirements. The training requirement of the Agency worker (depending on their role) should mirror the EPUT mandatory training requirement i.e. RCUK ILS for agency workers in a nursing capacity on an inpatient ward. The document describes the escalation process which the temporary staffing team follow if the workers does not have the required level of training. It is important to note that RCUK ALS contains all elements of the RCUK ILS training, as well as additional enhanced elements.

124. The Trust's intranet site from where KS-010 was obtained is in the process of being amended.

Protected Training Hours

125. EPUT's position on the protection of resuscitation training hours is governed by its HR21 policy. Resuscitation training, as a component of EPUT's mandatory training requirements, is subject to the framework established by HR21. That framework operates on the following basis.

126. Responsibility for ensuring that mandatory training, including resuscitation training, is completed is shared between the individual member of staff and their line manager. The individual member of staff bears personal responsibility for attending their mandatory training; the line manager bears a corresponding and equal responsibility for enabling that attendance to take place. This dual responsibility

framework reflects the Trust's recognition that protected training time cannot be secured by staff acting alone but requires facilitation by management.

127. EPUT is committed, as a matter of policy, to releasing staff from their duties to attend mandatory induction and training requirements. Resuscitation training hours are accordingly protected in the sense that a manager is not permitted to prevent a member of staff from attending a mandatory training course save in exceptional circumstances, such as critical staffing shortage, serious incident, patient safety reason, major unforeseen event. Where exceptional circumstances are said to exist, the onus rests on the manager to justify the decision to prevent attendance rather than on the member of staff to justify their need to attend.

128. By reference to paragraph 6.5.3 of EPUT's HR21, a manager may prevent a member of staff from attending mandatory training only in exceptional circumstances. The policy establishes that this is a high threshold: prevention of attendance is the exception and not the rule, and the policy does not contemplate routine operational pressures as a sufficient basis for preventing a member of staff from completing their mandatory resuscitation training requirements. This can include instances where:

a. there is an immediate and unavoidable service need;

b. staffing levels are insufficient to maintain safe patient care; or

c. other urgent operational requirements prevent the release of staff from clinical duties.

129. The above is not an exhaustive list and other examples can be dictated by Trust wide or national critical levels giving rise to circumstances where training needs to be postponed. That said, cancellation of training is the expectation rather than the norm and it is EPUT’s expectation that all staff maintain compliance with the required training standard for their role.

130. Where a manager does prevent attendance in reliance on exceptional circumstances, the following procedural safeguards apply by virtue of paragraph 6.5.3 of HR21:

- The manager is required to submit a written rationale for their decision to their Director. The decision to prevent attendance cannot therefore be taken informally or without accountability; it must be documented and escalated to Director level.

- The individual member of staff whose attendance has been prevented has the right to seek advice from the Human Resources Directorate or from their trade union or professional body. This preserves the individual's ability to challenge a managerial decision to prevent their attendance at mandatory training.

131. The procedural framework at paragraph 6.5.3 therefore provides a meaningful governance mechanism around the exceptional circumstances' exception: it requires the manager to justify the decision in writing to a director, preserves the individual's right to challenge the decision, and ensures that the question of rescheduling is addressed.

EES Training History

132. The training was developed in collaboration between EPUT's Training Team, relevant subject matter experts within the Trust, and an external training provider - Healthcare Training Ltd. Healthcare Training Ltd created the course framework on the basis of the established principles of Immediate Life Support, supplementing those principles with additional content and training scenarios drawn specifically from Trust-specific incidents and the lessons identified from those incidents. The resulting programme therefore reflected both nationally recognised clinical standards and EPUT's own institutional learning from resuscitation and emergency response events occurring within its inpatient settings.

133. Healthcare Assistants (HCAs) were included within the scope of EES training provision. Similarly, grab bag training, was provided to HCAs as well as to registered nursing staff. Grab bag training was first provided to inpatient staff from 6 January 2020 until September 2022, at which point it was superseded by the introduction of ILS training.

134. Based on information currently available, EPUT has not identified evidence of a formal grab bag training programme beyond the period referred to above, although enquiries have been undertaken to validate the position and clarify the timeline associated with the transition to ILS training.

Mandatory Training Index

135. In respect of the Mandatory Training Index (Exhibit 15 to R9(149)(A)): staff defined as 'clinical non-registered mental health' for BLS training purposes are all support staff or HCA staff in a Mental Health inpatient setting. Staff defined as 'registered nursing staff and medics in Mental Health' for ILS training purposes are nurses and doctors.

Competence Failures

136. Staff who fail a Mandatory Training assessment more than twice are formally referred to their line manager to initiate the appropriate HR supported management procedures. While initial action may be taken through informal intervention, established HR processes are in place to guide managers in addressing repeated noncompletion ensuring staff receive the necessary support and that organisational compliance standards are maintained.

137. Staff competence is assessed at the time of training delivery and can be reviewed during a medical emergency simulation, life support refresher session or if concerns relating to competence are escalated. Staff repeat their ILS training annually and are informally reassessed during part of that mandatory refresher.

138. EPUT's approach operates on a graduated basis if a member of staff is unable to achieve the required level of resuscitation competence:

139. Initial additional support: Staff who fail to achieve competence are provided with additional support, supervision, and further opportunity for reassessment.

140. Local management arrangements: If the required standard is not achieved following repeated attempts, the matter is escalated to local management when consideration is given to:

a. The individual's specific training needs;

b. Their competence and scope of practice;

c. Any associated risks arising from the competence gap; and

d. Available mitigation.

141. Formal management tools: The local management response may include:

a. A development plan;

b. Additional supervision;

c. Further training opportunities; and

d. Managerial oversight.

142. EPUT confirms there is no separate Trustwide policy dealing exclusively with staff who fail to achieve resuscitation competence after three attempts. Instead, such

situations are managed through existing supervision, appraisal, capability, and professional management processes, tailored to the individual circumstances and any patient safety considerations.

Transition from EES to ILS

143. BLS level competency was assessed within the EES training as is the case with ILS, so staff were not required to have completed additional training.

144. EES training was last delivered in December 2019. With effect from 6 January 2020, grab bag training commenced as the primary resuscitation training programme for inpatient staff. ILS training was subsequently introduced, at which point it replaced grab bag training entirely. The introduction of ILS training therefore represented the culmination of a phased evolution in EPUT's resuscitation training provision: from EES (delivered until December 2019), through grab bag training (delivered from January 2020), to ILS training (which superseded grab bag training upon its introduction).

145. The transition from EES and grab bag training to ILS training reflects the direction of national clinical guidance and policy on resuscitation training in healthcare settings, and in particular the guidance produced by the Resuscitation Council UK (RCUK).

146. In respect of staff in the Mother and Baby Unit: the position regarding adult and paediatric life support training is that additional specific paediatric BLS training is available to all staff.

CPR Competency Requirements

147. EPUT's approach to assisting staff in meeting the required competency level drew on the standards established by the Resuscitation Council UK. The RCUK's own guidance makes clear that it is the responsibility of the healthcare organisation, and not the individual to define the level of resuscitation training required for each staff group and to ensure that training is provided to enable staff to achieve and maintain the required level of competency. The reference in the CPR Procedure to a "requirement for Trust staff to achieve a level of competency in CPR that is appropriate to their role" should accordingly be understood in that context: it placed a reciprocal obligation on staff to engage with the training provision that EPUT made available, rather than placing the burden of identifying or sourcing appropriate training on staff individually.

148. Once the member of staff is attending the training session, the required level of competency (including the assessment process) is clearly outlined during the facilitation of the RCUK BLS and ILS training. The ILS instructor guidance specifically states candidates should be advised that the skills taught are subject to continuous assessment and that they must demonstrate competence in these skills throughout the course.

149. Where a member of staff does not demonstrate the required level of competency during a training session, that individual will be provided with targeted and individualised support to enable them to achieve the required standard. That support is delivered by the trainer and takes the form of direct observation of the staff member's performance, followed by structured coaching and mentoring to identify and address specific areas of weakness. Where necessary, the trainer will provide additional explanation of the relevant clinical principles, demonstrate the correct technique, and afford the member of staff a further opportunity to practise the relevant skill in a supported environment before reassessment. This approach reflects the RCUK's guidance that resuscitation training should be competency-based rather than time-based - that is to say, that the objective of the training is the achievement of a defined clinical standard rather than the completion of a fixed number of training hours - and that where a participant does not initially achieve that standard, the appropriate response is additional supervised practice and coaching rather than a straightforward record of failure.

150. There is, and always has been, a joint responsibility from both the employer and employee to ensure mandatory training (including BLS and ILS) is both delivered and attended. The policy has simply been amended to more accurately reflect this.

Agency, Bank and Locum Staff Training

151. The responsibility for resuscitation training differs depending on the category of temporary staff member concerned, as follows.

152. Bank staff are employed directly by EPUT and are subject to the same training obligations as substantive members of staff (KS.AS01-016). Bank staff are allocated mandatory training requirements commensurate to their role in the same way as substantive staff, and have the same access to EPUT's training provision, including BLS and ILS training. Responsibility for ensuring that bank staff complete their mandatory training requirements accordingly rests with EPUT in the same way as it does for substantive staff.

153. Agency staff are not employed by EPUT. In line with national expectations for the deployment of agency workers in NHS settings, agency staff are required to complete all statutory and mandatory training, including life support training at the level required for their role, in accordance with the Core Skills Training Framework (CSTF) prior to undertaking shifts at EPUT. Responsibility for ensuring that agency staff have completed the required training to the required standard before being deployed rests with the respective agency.

154. The Trust utilises the NHS Workforce Alliance for the supply of clinical and healthcare staff through the Workforce Alliance: RM6281 – Provision of Clinical and Healthcare Staffing framework. In line with this framework all workers must have training aligned to CSTF of which resuscitation is identified.

155. The Trust does not keep a local record capturing life support training for locum doctors; such information is retained by the Agency that employs them. The Trust requests that staff supplied are trained to the standards required and in alignment with the Workforce Alliance framework.

BLS Training Content

156. Training requirements relating to Basic Life Support (BLS) have been reviewed against national guidance**.** Non-physical (non-contact) observation tools are not a requirement of BLS under Resuscitation Council UK (RCUK) guidelines. RCUK's Adult Basic Life Support Guidelines focus on recognition of deterioration, calling for help, CPR, and safe use of an AED; they do not mandate or reference non-contact observation technologies or tools as part of BLS competency. Observation practice sits outside the scope of RCUK's BLS curriculum and is instead governed by local clinical risk protocols, mental health inpatient standards, and organisational policy.

157. The Trust implemented face-to-face Ligature Awareness Training on 13 May 2023 following a review of ligature related training provision. This programme was introduced to strengthen staff competence in identifying, responding to, and managing ligature risks within inpatient mental health environments. The session is delivered over 3.5 hours and includes:

a. Anatomy of a ligature – understanding ligature points, materials, mechanisms of injury, and contributory environmental factors.

b. Scenario-based competency assessment – structured practical scenarios enabling staff to demonstrate safe decision-making, escalation, and intervention.
c. Integration of NEWS2 – recognising physiological deterioration within the scenario, applying the National Early Warning Score (NEWS2) to support clinical judgement and escalation.
d. Coverage of non-contact physical observations – embedded within the scenario to ensure staff understand when and how non-contact observations are appropriate, including limitations, risk considerations, and documentation expectations.

158. This training is delivered to all inpatient mental health staff, including Health Care Assistants (HCAs). The face-to-face format supports practical skill development, real-time feedback, and assurance that staff can apply learning in high-risk clinical environments.

159. These measures demonstrate that while non-physical observation tools are not part of national BLS requirements, the organisation has implemented a clinically relevant ligature-awareness training programme that incorporates observation practice within a risk-based training model aligned to mental health inpatient needs.

Cardiac Arrest Definition and Pulse Check

160. The date of the BLS Lesson Plan KS12-054d is March 2023.

161. The CPR policy defines cardiac arrest as including the absence of a central pulse. However, this specific element is not taught as part of the Immediate Life Support ("ILS") training. The Basic Life Support ("BLS") lesson plan dated March 2023 included reference to the absence of a central pulse; however, this was a legacy of the Emergency Equipment and Simulation ("EES) training materials that were prepared by an external consultant. In practice, staff were instructed that if a patient was found to be unresponsive and not breathing normally, they should commence CPR and call for help. This approach is consistent with the Resuscitation Council (UK) guidelines, which emphasise recognition of unresponsiveness and abnormal breathing as the primary indicators for initiating resuscitation, rather than requiring the assessment of a central pulse.

162. The reference to a central pulse in the CPR Policy appears solely within the definition section, where cardiac arrest is defined. That definition reflects a medically

accurate clinical description of cardiac arrest. The reference does not appear in any operative provision of the Policy and does not inform the content of training delivered to staff or the clinical practice expected of them.

163. Checking for a pulse was not a feature of BLS training in the Trust post 2015 when guidelines changed and it was removed from the algorithm. However, in 2020, RCUK released COVID guidelines which did include a pulse check, owing to national infection control guidance around proximity and management of aerosol generating procedures.

164. The training materials for EES were prepared and produced by an external consultant. The EES training was delivered internally by EPUT and, at the time of delivery, did include a requirement for staff to check for a pulse as part of the resuscitation sequence. This requirement was consistent with and aligned to the national guidance that was applicable at that time.

165. When EPUT subsequently transitioned from EES training to Basic Life Support (BLS) training for unqualified staff, it appears that the requirement to check for a pulse was inadvertently retained as a legacy element from the preceding EES training materials, rather than being removed at the point of transition. Once this discrepancy was identified, the relevant training content was reviewed and amended, and the requirement to check for a pulse was removed so as to realign the training with the current national guidance issued by RCUK.

166. ILS training has at all material times been externally provided and delivered in alignment with national guidance. As such, the content has been dictated by the relevant external training provider in accordance with prevailing national standards. A pulse check does not form part of the current ILS training, consistent with the current Resuscitation Council UK ("RCUK") Guidelines.

167. EPUT confirms that a pulse check is no longer included in any of its current BLS training materials, in line with the 2025 RCUK Guidelines.

168. EPUT accepts it is often difficult to assess whether a patient has a pulse for the purposes of determining whether they are in cardiac arrest, acknowledging that can result in delays. Factors such as the positioning of an individual, the position of their bed or seating arrangements, or physiology, such as their anatomy amongst several other factors unique to that individual or situation all are considered when assessing

for a pulse. Trust staff are trained to call for help as soon as possible and should do so immediately.

BLS Lesson Plans - Differences and "Shout for Help"

169. The Trust delivered KS12-054F from 2023 onwards. The Basic Life Support (BLS) programme is fully aligned to EPUT policy and incorporates CLPG14a/b, CLP88, SBAR and NEWS2, with initial, formative and summative assessment to ensure competence. KS12-054G reflects the period in which the Trust introduced COVID related adaptations, combining BLS with pandemic specific requirements and using DATIX and the Resuscitation Event Form rather than policy documents, assessed through observation. KS12-054H represents an earlier iteration of the Trust's BLS offer, providing a simplified session delivered by one trainer using basic manikins and an AED, with basic observational assessment. Across these versions, the content evolves: respiratory anatomy appears only in KS12-054G, agonal breathing videos are included in KS12-054F and KS12-054H, and CPR guidance differs between the policy aligned approach in KS12-054F and the standard guidance applied in KS12-054G and KS12-054H.

170. In 2025 the National Guidance changed to "Shout for Help" immediately and this is what is currently taught. The 2025 RCUK BLS guidance states shout/call for help and then call 999 and this is mirrored in policy. The Trusts drop-in refresher sessions address different ways of calling for help i.e. pull pinpoint, pull buzzer or shouting down the corridor.

ALS Training

171. EPUT does not provide ALS training to its staff. Staff within EPUT are not required to hold RCUK ALS provider status as a condition of their employment or as part of their mandatory training obligations. The decision not to provide ALS training to staff reflects a combination of clinical, operational, and equipment-based considerations.

172. Some medical staff deployed on rotation within EPUT's inpatient settings may individually hold RCUK ALS provider status by reason of their prior training and clinical background, but this is not a requirement imposed by EPUT and is not a matter that EPUT verifies or records systematically.

173. During the Relevant Period, ALS trained staff may have been present at EPUT's inpatient sites in two categories. First, medical staff deployed on rotation within EPUT's inpatient settings may individually have held RCUK ALS provider status by

reason of their prior training. Second, external NHS staff, specifically anaesthetists and Operating Department Practitioners (ODPs) providing anaesthetic support for the delivery of Electro-Convulsive Therapy (ECT), may also have held ALS provider status, given the clinical environment in which they ordinarily work.

174. EPUT does not keep a record of ALS training for doctors however newly employed doctors and trainees are required to provide evidence of completing courses elsewhere. The evidence is sent to the Mandatory Training team for the staff member's tracker to be updated.

175. There is no national guidance mandating that staff in mental health inpatient settings to hold a RCUK ALS qualification. The RCUK's own description of the intended audience for the ALS course makes clear that it is designed for healthcare professionals who require advanced life support skills as part of their core clinical duties, and for those who teach those skills on a regular basis. The RCUK identifies the primary audience for ALS training as doctors, paramedics, and nurses working in acute care areas - including Emergency Departments, Coronary Care Units, Intensive Care Units, High Dependency Units, operating theatres, acute medical admissions units, and resuscitation, medical emergency, and Critical Care Outreach teams.

176. EPUT does not have the clinical equipment necessary to deliver advanced life support interventions as defined by the RCUK ALS curriculum. In particular, EPUT's inpatient mental health wards do not have manual defibrillators with a pacing option, nor do they routinely hold the specific medications required to deliver advanced life support. Without the necessary equipment in place, ALS training cannot translate into a deliverable clinical intervention in an inpatient setting, and training staff to a standard that exceeds the capability of the clinical environment in which they work can risk creating a false expectation of the level of resuscitation that can be achieved. It is EPUT's understanding from its membership of National Forums that many inpatient mental health facilities offer in house Level 3 training courses with a few delivering ILS. EPUT is therefore at the leading edge in terms of the training provided to staff.

177. EPUT is not aware of any formal risk assessment having been carried out specifically in respect of the decision not to provide ALS training to its staff. The rationale for that decision is set out above and reflects the alignment of EPUT's approach with the applicable national guidance and the RCUK's own definition of the intended audience for ALS training, rather than the outcome of a documented local risk assessment process.

178. EPUT has not put in place any formal arrangement to ensure that an ALS trained individual is present during a resuscitation event on one of its inpatient mental health wards. EPUT acknowledges that, during the Relevant Period, some medical staff on rotation and some external NHS staff providing ECT anaesthetic support may have individually held ALS provider status and may therefore have been available to assist in the event of a resuscitation event occurring at the relevant time and place. However, the presence of such individuals was not planned, recorded, or guaranteed; it was a matter of operational circumstance rather than deliberate clinical provision.

Bespoke and Ad Hoc Training Sessions

179. The sessions focus upon the identification and management of a deteriorating patient and the RCUK BLS algorithm, with an opportunity to practice both the technical and non-technical skills associated with CPR. The sessions are delivered upon demand, and this may be either proactive or reactive, depending upon the situation or following a medical emergency.

180. Ad-hoc sessions are delivered upon demand and there is no predetermined frequency, unless the session is to be delivered to staff over several different days. They are delivered to both nursing and HCA staff, and similar sessions have been delivered to students and apprentices.

181. Staffing rotas are drafted to enable staff to be available to attend, however, the numbers can vary due to ward acuity and sickness on the day of delivery. A register of those attending is taken by the training officer or the PNE who has requested the delivery of the session.

182. In addition to drop-in sessions provided at the Derwent Centre, drop-in sessions have been facilitated at Saffron Walden, Epping, Rarweth Court, Clifton Lodge, Pater Bruff Unit/Hennage, St Aubyn Centre, Poplar (Rochford), Brockfield House, The Lakes and CICC (Rochford). A register of attendance is kept for all sessions.

183. In respect of the position taken in the Sharon Langley action plan that HCAs would not be expected to have received anatomy or physiology training required to benefit from EES or ILS training: the reason EPUT considered anatomy or physiology training was required to benefit from EES or ILS training is there is a requirement for the candidate to have a pre-existing underpinning knowledge of anatomy and physiology, as this will be expanded upon during the training i.e. an appropriate and accurate airway and breathing assessment (parts of the ABCDE approach).

Non-Technical Skills and Accessibility of Training

184. Non technical skills, including leadership, situational awareness, task allocation, and decision making, are an embedded and explicit component of the ILS training programme, including task allocation and the identification of reversible causes. Additionally, non-technical skills are discussed and practised through small group discussions, workshops, and simulation exercises. The use of simulation provides staff with an opportunity to practise non-technical skills in a realistic and dynamic clinical scenario, where the consequences of failures in leadership, situational awareness, and decision-making can be observed and reflected upon in a safe learning environment.

185. Some elements of situational awareness are covered within BLS training, including patient and environmental awareness and AED safety. However, BLS training does not cover the full range of non-technical skills addressed within ILS, and does not extend to the broader clinical management content, such as task allocation, identification of reversible causes, and team leadership - that forms part of the ILS curriculum. However, BLS trained staff will also attend simulation exercises, discussions and workshops.

186. Up to August 2026 all staff had access to an individual training tracker which provides a personalised overview of their mandatory training compliance, including their resuscitation training requirements and renewal dates. The tracker was designed to provide staff with a twelve-week advance alert when a training course was approaching its renewal date, giving staff and their line managers sufficient notice to arrange attendance.

187. Where a member of staff wished to book onto a training course following receipt of an alert, the tracker provided a direct link which, when selected, generated a booking request. That request was then processed by the Training Team, who undertook the booking on the staff member's behalf and provided confirmation of the booking once it had been made. In addition to the twelve-week alert generated by the tracker itself, the Training Team proactively sent regular reminders to staff when their training was approaching expiry, providing an additional prompt to ensure that mandatory training, including resuscitation training, was completed within the required timeframe.

188. With effect from August 2026, EPUT has implemented an enhanced self-booking system through the Electronic Staff Record (ESR) platform. Under the new system, staff can self-book directly onto training courses via their training compliance

matrix on ESR, which is the functional equivalent of the individual training tracker previously in use. The introduction of self-booking on ESR removes the need for the staff member's booking request to be processed and confirmed by the Training Team, thereby streamlining the booking process and reducing the administrative burden associated with arranging training.

189. EPUT confirms that there are currently no waiting lists for any resuscitation training courses, including BLS, ILS. Staff who identify the need to book or renew their resuscitation training are therefore able to do so without any delay attributable to course capacity constraints.

190. The table shows the percentages of staff compliance rates for refresher training on BLS, ILS or Grab Bag in each year from 2020 to 2026 are as follows:

	Trained	**Trained**	**Trained**
	BLS	**ILS**	**Grab Bag**
Apr-20	70%	N/A	73%
Apr-21	86%	N/A	87%
Apr-22	89%	N/A	87%
Apr-23	81%	N/A	92%
Apr-24	85%	100%	N/A
Apr-25	84%	75%	N/A
Apr-26	88%	77%	N/A
Aug-26	90%	85%	N/A

191. It is important to note that all figures presented are a point-in-time snapshot, and as such only reflect the compliance position at any given moment during the year.

192. The 2020-2021 compliance figures were materially impacted by the COVID-19 restrictions when venue capacity was limited. Whilst training continued, it was at a reduced capacity. Clear trajectories were established to reach compliance at pace once restrictions were lifted.

193. In 2023 with the move to ILS all HCA staff that previously undertook Grab Bag or EES were added to BLS numbers showing an apparent dip in compliance for 2023, again a trajectory to meet compliance was established and realised at pace.

194. In 2025 alignment to the National Framework increased compliance targets from 85% to 90%. This more stringent benchmark means that figures which would previously have been considered compliant were now below target. The Trust set a trajectory to reach compliance by September 2026; this has been achieved ahead of target in August 2026 for BLS Training.

In-House Training - Physical Health Faculty

195. The ILS training material will be provided by the Resus Council UK once the Trust is approved as an accredited RCUK course provider.

196. In terms of learning materials, Phase 1 of the faculty will deliver a physical health faculty facilitating physical health education needs, including advanced practice, tailored to a mental health setting and BLS. This will include a tailored teaching schedule to standardise training delivery. A competency framework will be developed to assess when a participant has successfully completed and passed ILS training. A feedback mechanism for BLS and ILS course participants will also be established.

197. Staff at EPUT who have received ILS training through the faculty will be able to demonstrate competencies in line with the NHS Competency Framework, which takes into consideration the themes identified in national reports and research and incorporates elements of knowledge and skills needed for registered clinical staff working in mental healthcare and/or learning disability settings to meet the physical health needs of service users with serious mental illness and/or a learning disability.

198. The faculty will provide trainers who can deliver BLS and ILS training and provide advanced physical health training. In terms of the qualifications required of in-house trainers they will have appropriate ILS instructor credentials (Clinical debriefing training, experience of delivering Clinical Skills/Resuscitation Training, ALS (Advanced Life Support) Instructor Status, ILS (Immediate Life Support) Instructor Qualification. The faculty will be managed by the current Head of Deteriorating Patient Pathways and Resuscitation Training Officer. Two dedicated ILS trainers have recently been recruited, who will not provide direct patient care. Their role is specifically provision of training alongside occasional support for advice and support for complex physical health issues.

199. The anticipated timeline for the completion of set up of the Physical Health Faculty is early 2027.

PART 7: DEVIATION FROM NICE GUIDELINE NG10

200. NG10 covers the short term management of violence and aggression in adults, young people and children in mental health, health and community settings. It is concerned with the prevention of, and response to, incidents of violence and aggression, including through de-escalation, physical intervention and restrictive interventions. Paragraph 1.4.4 of NG10 addresses the specific requirement for appropriate staffing and competencies in settings where restrictive interventions may be used. It does not constitute a resuscitation guideline and is not directed at the management of cardiac arrest. Accordingly, NG10 is not the primary or appropriate governing framework for EPUT's CPR Procedure. The reference to NG10 in the introduction to EPUT's CPR Policy/Procedure was included to acknowledge the interface between restrictive intervention settings and the physical safety of patients, not to incorporate NG10 as a governing standard for resuscitation practice.

201. Paragraph 1.4.4 of NG10 provides that in any setting where restrictive interventions may be used: (a) there should be immediate access to staff trained to at least immediate life support; and (b) a doctor trained to use resuscitation equipment should be immediately available to attend. The Trust acknowledges that this provision exists within NG10. However, the Trust notes two important contextual matters.

202. First, NG10 is a guideline concerned with the management of violence and aggression - it is not a resuscitation or cardiac arrest management guideline. Its reference to life support standards in paragraph 1.4.4 is made in the specific context of restrictive physical interventions (such as restraint) and the risk of harm arising from those interventions. The import of this provision is to ensure that, when restrictive interventions may be used, appropriately trained staff are on hand to respond to any adverse physical consequence that may result from that intervention.

203. Second, whilst the Trust accepts that the letter of paragraph 1.4.4 requires a doctor trained to use resuscitation equipment to be "immediately available to attend," the Trust's position is that it has sought to comply with the spirit and intent of that requirement by ensuring that an appropriately trained member of staff is present or immediately available to attend in such circumstances. EES training equipped staff to respond to a deteriorating or collapsed patient in a setting where a doctor may not be immediately on site, which reflects the operational reality of a community mental health inpatient environment that is distinct from an acute hospital ward. The Trust

recognises, however, that the deviation from the letter of NG10 para 1.4.4 was not explicitly documented or formally risk-assessed, and this is addressed further below.

204. EPUT has undertaken a thorough review of its records to determine whether any clinical risk assessment or formal justification was recorded at the time versions 10 to 13.1 of the CPR Procedure were adopted, in respect of the conclusion that BLS training was the appropriate standard. EPUT has been unable to locate any such clinical risk assessment or recorded justification for that specific conclusion. EPUT is therefore required to clearly state, as it does, that no such risk assessment or justification can be identified. The staff members involved in producing the CPR Procedure interpreting NG10 are no longer available or employed by the Trust to consult determine why the amendment to the policy was made.

205. Notwithstanding the reference to BLS in the NG10 commentary in versions 10 to 13.1 of the CPR Procedure, EPUT's position is that EES-trained staff were available on its wards during this period. Specifically, EPUT's CPR Procedure has, throughout the Relevant Period, required that an appropriately trained member of staff be present or immediately contactable during any resuscitation event. Registered nursing staff on EPUT's inpatient mental health wards have since September 2022 been required to hold ILS training as part of their mandatory training requirements.

206. EPUT has been unable to locate any documented assessment of increased clinical risk arising specifically from the reference to BLS training during the period when versions 10 to 13.1 of the CPR Procedure were in use. EPUT is therefore required to clearly state that no such risk assessment can be located. The Trust notes, however, that the practical consequence of the misinterpretation was limited in its effect because: (i) the misinterpretation related to the characterisation of the applicable training standard in the context of restrictive interventions, rather than a wholesale failure to provide for trained staff; and (ii) as noted above, appropriately trained registered nursing staff were in practice expected to be available on wards.

207. EPUT has carefully considered whether all versions of its CPR Procedure up to and including version 13 deviated from paragraph 1.4.4 of NG10 in the two respects identified by the Inquiry: namely, (a) the absence of a requirement for immediate life support staff to be immediately available; and (b) the absence of a requirement for a doctor trained to use resuscitation equipment to be immediately available to attend.

208. In relation to (a), EPUT's CPR Procedure has, across successive versions, required that an appropriately trained member of staff be present or available.

However, EPUT acknowledges that the Procedure did not, in express terms, replicate the requirement in NG10 para 1.4.4 that such a person be “immediately” available. To the extent that “immediately” connotes something more stringent than the Procedure provided, EPUT accepts that there was a deviation in those terms.

209. In relation to (b), EPUT accepts that its CPR Procedure did not, across the versions identified, require a doctor trained to use resuscitation equipment to be immediately available to attend. EPUT notes that this aspect of NG10 para 1.4.4 is particularly challenging in the context of a community mental health inpatient setting, where, unlike in an acute hospital, a doctor is not routinely present on the ward. EPUT's model of care relies upon on-call medical cover rather than the immediate on-ward presence of a doctor. The Trust's position is that the requirement for a doctor to be "immediately available to attend" was never fully replicable in its operational context, and that, accordingly, the reference to NG10 in the CPR Procedure was not intended to incorporate this requirement as an operational standard. However, EPUT acknowledges that this distinction was not explicitly articulated in the Procedure, nor was a formal documented risk assessment or clinical justification produced to record the departure and assess its clinical implications.

210. It should be noted, moreover, that NG10's primary subject matter is the management of violence and aggression, not resuscitation. The requirement at paragraph 1.4.4 is specifically addressed to settings where restrictive interventions may be used, and the spirit of that requirement, that appropriately trained staff be available to respond to any adverse physical consequence of a restrictive intervention, has been met since September 2022 by EPUT's requirement for ILS-trained staff to be available.

211. The staff members involved in producing the CPR Procedure interpreting NG10 are no longer available or employed by the Trust to consult determine why the amendment to the policy was made.

212. The Procedure was approved by the Clinical Governance and Quality Subcommittee. The consultation process included Trust wide Operational Teams, the Compliance & Risk Team, Workforce & Training, Pharmacy and the Physical Health Group. There is no record of the specific rationale for the deviations from NG10 para 1.4.4 that EPUT is able to locate, nor is there any record of the deviations having been specifically identified, considered and authorised as deliberate departures from national guidance.

213. EPUT has reviewed its records and is unable to locate any documented clinical risk assessment or justification recorded for any deviation.

Current CPR Policy - Continued Deviation

214. Calling the duty doctor forms part of the cascade of actions taught in EPUT's ILS training. Within the ILS course, staff are instructed to initiate the emergency response chain at the earliest possible stage of a resuscitation event, which includes alerting the on-call duty doctor without delay whilst resuscitation is being commenced. Staff are taught that the duty doctor call should be made as one of the immediate concurrent steps, not deferred until the resuscitation attempt is already underway, and that the call should be made by a designated team member so as not to interrupt the delivery of CPR by other staff present.

215. Duty doctors are expected to attend a resuscitation event as a matter of urgency upon being notified. The policy requires the doctor to be summoned "at the earliest opportunity" but does not prescribe a response time standard for the doctor's attendance. It should be noted that the duty doctor is typically covering multiple wards across the site (or potentially across sites) on an on-call basis and is not always physically present on any individual ward. The practical consequence is that the time for a duty doctor to attend a resuscitation event will vary depending on where the doctor is when called. EPUT's model of care therefore requires that ILS-trained registered nursing staff are capable of managing the resuscitation response independently until the duty doctor arrives, and EPUT's training provision reflects this operational reality.

216. EPUT accepts that the current CPR Policy (sV 3.0) does not replicate, in terms, the requirement set out at paragraph 1.4.4 of NICE Guideline NG10 that a doctor trained to use resuscitation equipment be "immediately available to attend." As set out in response to Question 47 above, the CPR Policy requires that a doctor be summoned "at the earliest opportunity," which is not co-extensive with the requirement in NG10 para 1.4.4 for a doctor to be "immediately available to attend." To that extent, EPUT accepts that a deviation from the letter of NG10 para 1.4.4 continues to exist.

217. The deviation continues to exist for the following reasons:

- First, as noted in response to Question 47 above, NICE Guideline NG10 is a guideline concerned with the short-term management of violence and aggression, not a resuscitation guideline per se. Paragraph 1.4.4 of NG10 addresses staffing requirements in settings where restrictive interventions may be used, with the specific concern being the risk of physical harm arising from

restraint. EPUT's CPR Policy addresses the management of actual resuscitation events across its inpatient mental health settings, and it has not been EPUT's view that NG10 was intended to set the operational standard for CPR response in that context.

- Second, and more fundamentally, the operational model of EPUT's community mental health inpatient services does not permit a doctor to be physically present on each ward or "immediately available" in the sense that this may be achievable in an acute hospital setting. EPUT operates on an on-call model whereby a duty doctor covers a number of wards. Physical immediate attendance by a doctor at every resuscitation event is not, therefore, operationally achievable within EPUT's model of care, and any policy that purported to require this would not reflect operational reality.

- Third, EPUT's position is that compliance with the spirit of NG10 para 1.4.4 has been maintained by ensuring that ILS-trained registered nursing staff are expected to be immediately available on its wards. ILS training equips nurses to manage a resuscitation event, until the arrival of an emergency responder. This provides a meaningful and clinically appropriate safeguard in the context of a mental health inpatient setting.

218. In relation to approval: the current CPR Policy (sV 3.0) was approved by the Clinical Governance and Quality Subcommittee. For the reasons mentioned above EPUT did not feel that it was necessary for a clinical risk assessment to be conducted.

219. EPUT notes that, to the extent the deviation in the current policy reflects a considered and explicit recognition that the NG10 para 1.4.4 requirement for a doctor to be immediately available is not operationally replicable in a mental health inpatient on-call model.

PART 8: SPECIAL CIRCUMSTANCES

220. By reference to the current BLS and ILS course materials, the elements of training that cover the following special circumstances and the skills taught in respect of each are set out below. Where a special circumstance is not covered, this is stated.

Circumstance	Training	Content
Hanging and/or asphyxiation by ligature	Ligature Training, ILS and Simulation Exercises	Reversible causes of cardiac arrest, hypoxia
Choking and/or airway obstruction	BLS, ILS and Simulation Exercises	
Overdose	ILS	Reversible causes of cardiac arrest
Medication errors as may occur in rapid tranquillisation	Annual nurse mandatory training. CG52 provides guidance on medicines, monitoring, cardio-respiratory risks and annual CPR retraining requirements.	Covers medication incidents, reversible causes, error reporting, pharmacological management of acutely disturbed behaviour, monitoring requirements, rapid tranquillisation risks, respiratory depression and use of flumazenil.
Administration of electro-convulsive therapy	Not covered in BLS or ILS. Specialised training would be provided	
Serious self-harm by cutting	ILS	Discussion of reversible causes of cardiac arrest
Burns	Not covered in BLS or ILS. More appropriately covered in First Aid Training	
Falls from height	May be referenced in BLS/ILS Generally covered in Advanced Trauma Life Support (ATLS)	Discussion of Airway Management
Drowning	Not covered in BLS or ILS	
Headbanging	ILS	Reduced level of consciousness

		assessment and A-E assessment approach
Physical Restraint	Not covered. Addressed in TASI training	
Electrolyte abnormalities from eating disorders or malnutrition	ILS	Discussion of reversible causes of cardiac arrest
Sepsis	Signposted in ILS	Discussion of reversible causes of cardiac arrest
Seizures	ILS	Covered through A-E assessment approach
Diabetes	ILS	Covered through A-E assessment approach, including checking blood glucose levels

221. Reflecting on EPUT's package of training, EPUT's position on whether it currently provides adequate training to all staff who may be monitoring or observing patients (including Staff HCAs, Bank HCAs and Agency HCAs) to recognise deterioration and intervene in sufficient time to prevent cardiac arrest in each of the special circumstances listed above, is seen to be adequate in terms of recognition and escalation of ongoing deterioration, coupled with the use of the NEWS2 tool. Competences the Care Certificate provide HCAs with basic understanding and knowledge required, to recognise a deteriorating patient. HCAs are not expected to intervene as this is covered within RCUK ILS training.

222. Where improvements are considered necessary, these are: enhancements of the care certificate (or a separate module), in order for HCAs to be able to undertake a basic ABCDE assessment of a deteriorating patient, with escalation using the SBAR tool.

PART 9: SIMULATIONS, CPR DRILLS AND SCENARIO TRAINING

223. In respect of medical emergency simulations, CPR drills and scenario training: the changes made in practice as a result of policy changes are the removal of the facilitation of CPR events by the Workforce Development and Training Department (CPR Procedure v15.2 para.9.4) as this function is no longer undertaken by the team. The updated wording in CPR Policy v3.0 para.12.4 reflects this change.

224. The reference to regular simulation training, multidisciplinary emergency scenarios and mock cardiac arrest drills are all references to the same activity although over time they have been referred to in each of the iterations identified in that paragraph. The references are legacy definitions of the same training.

225. The CPR drills in Exhibit AS06-012 are synonymous with simulations under para 9.4 of v15.2.

226. EPUT confirms that there was no such delay to formally updating policy requirements to reflect three monthly drills/simulation. The April 2026 policy clarified the responsibility placed on Ward Managers, Matrons or Service Managers for each inpatient setting to ensure those drills took place.

227. For the purposes of the quarterly CPR drill, an inpatient setting refers to a medical care environment where a patient is formally admitted to a hospital or facility and stays overnight for continuous monitoring and treatment.

228. Paragraph 12.4 of the Policy for Adult and Paediatric Cardiopulmonary Resuscitation (CPR) document dated March 2026 states" The Ward Manager, Matron or Service Manager/Clinical lead for each inpatient setting, will be responsible for ensuring that medical emergency simulations are undertaken every three months in the clinical environment. Each inpatient setting must record when a medical emergency simulation is facilitated, using the approved 'Medical Emergency Simulation Practice Report' document". The Practice Nurse Educators (PNE's) who are assigned to the inpatient and/or the Resus/ Physical Health Link Practitioners often facilitate or oversee the medical emergency simulations. This requirement is also documented within the EPUT Internal Safety Alert (INT GEN 25 006 – SWARM early learning (Resus) dated 23 June 2025.

229. It is recommended that medical emergency simulations are conducted on an unannounced basis, in order to provide a more realistic outcome. However, both announced and unannounced approaches are acceptable, for example if the focus of the training is on a particular part of the response that may be more appropriately dealt

with as an announced simulation/workshop. The importance of regularly facilitating medical emergency simulations is emphasised during life support refresher sessions. It is widely acknowledged that there may never be an ideal time to conduct them. Notwithstanding this there are significant risks associated with not practising both the technical and non-technical skills required for the resuscitation of a patient, and the benefits of regular practice far outweigh any short term operational inconvenience.

230. All staff members, regardless of their role or employment status are required to attend, whilst recognising that the inpatient facility needs to remain safe. There is no written requirement as to how many medical emergency simulations each staff member must attend on an annual basis.

231. The facilitating team monitor and assess the medical emergency simulation as it is delivered. The Medical Emergency Practice Report document is used to record the medical emergency simulation and can be completed contemporaneously.

232. The Workforce Development and Training Department are not involved in all CPR simulations but this does not preclude them from attending planned simulations. Simulations which are shared with the Head of Deteriorating Patient Pathways and Head of Clinical Transformation, are reviewed and feedback is provided on the emergency simulation practice report document. Having reviewed the Medical Emergency Simulation Practice Reports which have been sent, it is apparent that teams are facilitating the medical emergency simulations at various times during the day/night and at weekends, to involve as many different staff as possible.

233. To date, and as far as the Head of Deteriorating Patient Pathways and Resuscitation Training Officer is aware, whilst there is an immediate opportunity to change existing practice, as a result of the learning conversation following each medical emergency simulation, there have not been any specific Trust wide changes to practice, policy or procedure, which have taken place as a direct result of a medical emergency simulation. Noting however, that key learning identified within or following an emergency simulation is immediately shared with the team and discussed at the relevant care group meetings, to identify areas of improvement and opportunities for learning.

234. Paragraph 48 of Dr Suresh's Twelfth Statement refers to a scenario-based competency assessment as part of BLS training. The assessor for that training is a member of the Workforce Training Team (a BLS Instructor). The training includes

scenario assessments which contain a practical element in which resuscitation events are 'acted out' with independent demonstration of a skill required by the candidate.

PART 10: AVAILABILITY OF ILS-TRAINED STAFF

235. EPUT acknowledges that the Inquiry does not consider that the CPR Policy sV3.0 clearly sets out who is required to stay with a patient requiring resuscitation. Appendix 6 of the CPR Policy describes the responsibilities of staff attending a resuscitation event and sets out the associated technical and non technical skills expected of those staff.

236. EPUT cannot accept the proposition, as stated, that it is common for HCAs to be left alone with patients during resuscitation events without qualification. However, EPUT acknowledges that there have been instances in which HCAs have been present with a patient during parts of a resuscitation event without an ILS-trained registered nurse or doctor remaining alongside them.

237. EPUT's primary mitigation for this risk is the requirement that every registered nurse working within an inpatient setting receives ILS training. The intention of this requirement is to ensure that, on any shift, there will be at least one ILS-trained registered nurse present on the ward who is able to attend and lead the resuscitation attempt. In addition, medical staff on rotation may be trained to RCUK ILS or ALS level, which provides a further potential source of advanced clinical support during a resuscitation event.

PART 11: STAFF

Resuscitation Practitioners and Link Practitioners

238. Group supervision for all clinical bank workers takes place ever eight weeks via video call by a nominated member of clinical staff. Sessions are held monthly across Brockfield, Rochford, Basildon, West Essex, Colchester, and Chelmsford. The

supervision tracker is updated by the bank team once the register has been received. Managers are also available to bank staff for one to one support.

239. Further details of the two dedicated resuscitation practitioners referred to at paragraph 31 of Ann Sheridan's Sixth Statement, including their appointment dates and locations, are as follows: Nicholas Archer (May 2022 with a base listed as The Lodge) and Douglas Smale (January 2023 with a base listed as Rivendell).

240. The Resus and Physical Health Link Practitioners referred to at paragraph 64 of Dr Suresh's Twelfth Statement, took up their additional and voluntary roles in September 2023, with the volunteer physical health Link Practitioners taking up their additional and voluntary roles in November 2025.

241. Their skills are relevant to their role i.e. basic life support training for HCAs; the 'Standardising the Approach to Training and Facilitation' workshop was offered to all Link Practitioners, ward managers and matrons, and delivered to staff who confirmed their attendance.

242. EPUT's assessment of the required number of Resus Link and Physical Health Link Practitioners per ward/unit was two, currently there are 115 active Link Practitioners although this number fluctuates as staff leave and join. The frequency with which each role runs training sessions for the wards is dependent on the Link Practitioner, those sessions are monitored by the ward manager or matron and the purpose, attendees and outcomes of Resus Link meetings are to enable us to share key learning and important updates and to facilitate those Link Practitioners who can attend to ask questions.

Required Skills Mix

243. The required skills mix in terms of BLS and ILS trained staff/temporary workers, and the number of patients, for each of the Linden Centre Wards, the St Aubyn Centre, and each of the Broomfield Mental Health Hospital Wards, is as follows:

Linden Centre

Ward	ILS/BLS Staff total	Ratio per shift	Bed numbers (Max patients)
Galleywood	15 out 17 registered trained in ILS. 1 staff new and 1 on long term sick.	Min of 2 registered per shift trained ILS	18

	12 out 13 BLS one staff not trained as on maternity leave for HCA		
Finchingfield	16 out 17 registered trained in ILS. 1 new starter. 10 Out of 14 BLS one staff off long term, 2 staff need to complete training	Min of 2 registered per shift trained ILS	17
Christopher Unit	16 out of 21 registered trained 4 new starters and 1 staff booked onto ILS training . BLS 100% staff trained 12 HCA in total	Min of 2 registered per shift trained ILS	10
Rainbow Mother and Baby Unit	9 out of 10 registered staff trained in ILS. 1 has expired and booked to attend in September 2026. 11 out of 13 unregistered staff trained in BLS. 1 expired as is on maternity leave and other is new starter who joined 2 weeks ago	Routinely 2 ILS and 2 BLS on days 1 ILS and 2 BLS on nights	6

St Aubyn Centre

Ward	ILS/BLS Staff	Ratio per shift	Bed numbers (Max patients)
Longview	11 trained	Minimum of 1 per shift	12
Larkwood	13 trained	Minimum of 1 per shift	10

Broomfield Mental Health Hospital Wards

Ward	ILS/BLS Staff	Ratio per shift	Bed numbers (Max patients)
Topaz	ILS 13 Registered Nurses trained BLS 10 staff trained. 2 on long term sick	Min of 2 registered per shift trained ILS	17
Ruby	ILS 16 Registered Nurses trained BLS 100% trained HCA substantive staff	Min of 2 registered per shift trained ILS	17

Standalone Unit	ILS/BLS Staff	Ratio per shift	Bed numbers (Max patients)
Edward House	ILS 16 Registered Nurses trained. 1 nurse's training has expired but booked to attend. 94% team compliance rate BLS 20 staff trained. 95% team compliance	Required ILS ratio: 4 registered nurses on LD and 4 registered nurses on LN shifts Required BLS ratio: 5 HCAs/Associate Practitioners on LD and 3 on LNs	20

	rate. 1 Activity Coordinator's training has expired but they are leaving the service imminently.		

PART 12: RESUSCITATION EXPERTS

244. Prior to the appointment of Nicholas Archer to the role of Head of Deteriorating Patient Pathway and Resuscitation Training Officer, the Trust did not have a dedicated in-house resuscitation lead or specialist resuscitation function. Resuscitation expertise was instead distributed through a variety of existing internal clinical resource and external providers including:

a. Registered nurses, who held resuscitation training competencies and provided day-to-day resuscitation support within the clinical environment;

b. Medical staff and doctors, who contributed resuscitation expertise as part of their broader clinical responsibilities;

c. 999 emergency services, who provided pre-hospital resuscitation expertise and response capability where required;

d. BTUH, who provided external resuscitation training and expertise to the Trust following the merger; and

e. Other external training providers, who delivered resuscitation training programmes to Trust staff in the absence of a dedicated internal resuscitation lead.

245. In the period following the merger and prior to Nicholas Archer's appointment, there was therefore no single, centralised point of resuscitation leadership or oversight within the Trust.

246. The Head of Deteriorating Patient Pathways and Resuscitation Training Officer are dedicated posts and whilst separate in relation to their areas of responsibility, are intrinsically linked, as appropriate recognition and management of a deteriorating

patient, may prevent the patient going into cardiac arrest. Having responsibility for both roles provides a unique opportunity to advise on and inform change in both areas of practice.

247. Nick Archer is the Trust's Resuscitation Officer ("RO"). The Head of Deteriorating Patient Pathway and Resuscitation Training Officer is not expected to respond to and participate in emergency incidents on every ward; this is impossible given the geographical spread of the wards.

248. The Trust RO is RCUK ALS qualified and is also a RCUK ALS instructor. The RO has completed a TALK Foundation supporting clinical debrief instructor course and gained RCUK Generic Instructor Course (GIC) full instructor status in 2025. The RO has a PGCert in Medical and Healthcare Education.

249. The Trust's RO leads on the development and implementation of strategies to ensure the safe and appropriate management of the deteriorating patient. This includes sepsis management, the use of NEWS2 as an early warning tool, and the development of clinical patient pathways and associated medical equipment to support, monitor, prevent and manage clinical deterioration throughout the Trust. The RO oversees resuscitation training provision and additionally reviews the effectiveness of care processes to identify examples of good practice and areas for improvement, contributing to the Trust's culture of learning.

250. Daily, the RO reviews relevant Datix incident reports and provide help, advice and support to operational staff as required, in relation to physical health and resuscitation matters. The RO will carry out reviews of allocated Policies and Clinical Guidelines, review CCTV and Lio footage as part of patient safety investigations. The RO will facilitate life support and physical health refresher sessions for staff. In terms of governance, the RO chairs the monthly Harm Free Care Group and feeds into the bi-monthly combined Resuscitation and Deteriorating Patient and Medical Devices Group meetings, as well as other forums including the Falls Group, Learning Oversight Sub Committee, Learning Collaborative Partnership meeting and Learning from Deaths Oversight group. Following the creation of the Physical Health Faculty and the subsequent in-house delivery of RCUK ILS, the RO will regularly deliver RCUK ILS as part of the faculty.

251. The RO undertakes formal supervision sessions with their Line Manager monthly, where possible, in addition to an annual appraisal. These supervision sessions provide a structured opportunity to discuss workload, ongoing projects,

professional development and any concerns or challenges arising within their areas of responsibility. In addition to these formal sessions, there are opportunities for regular informal catchups and ongoing communication with their Line Manager, ensuring that any emerging issues or priorities can be addressed in a timely manner.

PART 13: BUDGET

252. The Trust does not hold a single identified budget line specifically for resuscitation training or per staff member. It cannot extrapolate the number of hours spent on resuscitation training per staff member. However, all resus activity, including BLS delivery, is funded through the central training budget, and BLS is delivered in-house by Band 5 trainers via the Trust's Training establishment. For ILS, the Trust's year-on-year expenditure shows that this funding was consistently being utilised as training activity increased, with spend rising as set out in the table below.

253. The table also illustrates Earlier Healthcare Training Ltd spend across 2018 and 2019 to support training delivery of Enhanced Emergency Skills. The figures collectively show funds being used to deliver and expand resuscitation training across the Trust.

Amount spent on A to E and Healthline	
Year	A to E Spend
2023 (April 22 - March 23)	£18,480.00
2024 (April 23 - March 24)	£102,300.00
2025 (April 24 - March 25)	£124,268.64
2026 (April 25 - March 26)	£133,200.00
2027 (April 26 - July 26)	£39,900.00
Total	£418,148.64
	Healthline Spe
2018 (April 17 - March 18)	£39,990.00
2019 (April 18 - March 19)	£63,344.00
Total	£103,334.00

254. EPUT's Resuscitation Officers are not ward based.

255. Financial support for the Resuscitation Service is provided through the Trust's wider education, training and workforce development budgets. Whilst EPUT does not maintain a separately identified budget line or dedicated resuscitation cost centre, resuscitation related expenditure is funded and managed within the Trust's established training governance and financial planning frameworks. All resuscitation training expenditure is recorded within broader training budget codes, as confirmed by Finance colleagues. Defined financial support is provided in the following ways:

i. Funded training programmes: The Trust funds the delivery of Immediate Life Support (ILS) and Basic Life Support (BLS) training, together with the associated staff time, training resources and operational support necessary to maintain compliance with mandatory training requirements and to sustain emergency response capability across inpatient services.

ii. Staffing resource: During 2026, the Trust approved a business case for dedicated ILS training posts (Resuscitation Officers), representing a direct investment in resuscitation infrastructure and providing additional resource to support the delivery of resuscitation training and the wider resuscitation function across the organisation.

iii. Prioritised expenditure: Resuscitation related expenditure is prioritised within the Trust's training and workforce budgets to ensure ongoing staff competency and compliance with resuscitation standards.

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

PART 14: PARTNERSHIPS

257. The Head of Deteriorating Patient Pathways and Resuscitation Training Officer worked in conjunction with the East of England Ambulance service to design the calling (9)999 document in a medical emergency document. In addition, the Head of Deteriorating Patient Pathways and Resuscitation Training Officer and Head of Clinical

Transformation have participated in multidisciplinary team meetings with acute colleagues, in relation to advice and management of an EPUT patient who may require input from the acute Trust in relation to discharge Trust including a joint onward plan to manage to mental and physical health needs.

PART 15: LEARNING FROM PAST INCIDENTS

258. EPUT notes the Inquiry's categorisation of the incidents identified in Question 68. EPUT does not consider that the categorisation adopted in Question 68 fully reflects the circumstances of, or distinctions between, the individual cases relied upon by the Inquiry.

259. While there are common themes arising from some of the incidents identified, there are also material differences in the ascertainable circumstances of the individual cases, the findings reached by the relevant investigations, the contributory factors identified, and the learning arising from those events. Accordingly, EPUT does not accept all aspects of the categorisation or underlying premise of Question 68.

260. A fuller response, addressing both the similarities and distinctions between the cases relied upon by the Inquiry, will be of greater assistance to the Inquiry in understanding the extent to which particular themes can properly be said to have persisted over time.

261. The Trust has reviewed the cases identified in Question 68 by reference to available investigation reports, inquest materials and other relevant records. In doing so, it has considered whether the documents support characterising a particular issue as a recurring failing and whether the cases identified disclose the same underlying problem.

262. Where the same or a materially similar issue arose in more than one case, the Trust has addressed the action taken following the earlier incident, the arrangements for monitoring implementation and, so far as the documents permit, the reasons why a later issue nevertheless arose. Where the evidence does not permit a firm conclusion, that limitation is identified. Certain broader factors are relevant across

more than one category, including the fact that primarily CPR is used when a person's heart, or breathing has already stopped. It is a treatment that tries to restart the heart and breathing, but success depends on many factors.

263. Other factors include the relative infrequency of resuscitation events in mental health inpatient settings, variation in local arrangements, workforce turnover and use of temporary staff, and limitations in central oversight arrangements at the relevant times.

264. Before turning to those cases where the Inquiry has identified alleged failings, it is relevant to observe at the outset that the Trust's learning from incidents has not been confined to identifying failings. There are also examples demonstrating areas of effective practice and the benefits of improvements implemented over time. For example, in the case of CP, the PSII found no direct contributory factors arising from the Trust's care and concluded that staff recognised and escalated his acute deterioration appropriately, in accordance with NEWS2 processes and Trust policy. The investigation found that emergency equipment was available and had been appropriately checked, that staff involved were up to date with mandatory and Immediate Life Support training, and that the ward team responded promptly and competently when CP suffered a cardiac arrest.

265. The report specifically concluded that CPR processes were followed effectively, that no barriers were identified, and that the resuscitation response successfully achieved return of spontaneous circulation prior to transfer to the acute hospital. The investigator further noted the positive impact of the Trust's sustained investment in physical healthcare training, deteriorating patient pathways, NEWS2 implementation and resuscitation preparedness. While areas for further improvement were identified, particularly around integrated working and discharge planning, the investigation provides evidence that the Trust's efforts to strengthen physical healthcare systems, staff training and emergency response arrangements have, in some cases, resulted in the delivery of care that met expected standards during a rapidly evolving medical emergency. The improvements in this respect were recognised by paramedics and the coroner at inquest.

266. The Trust will now turn to the illustrative cases as set out in Q68.

(a) Failures to call an ambulance / 999 urgently, or at all; repeated absence of the "Calling (9)999 in a Medical Emergency" poster

267. The illustrative cases identified disclose a range of distinct issues relating to the summoning of and communication with the emergency services, including the need to dial an additional "9" to obtain an outside line, telephone availability and location, the need for a member of staff to leave the patient to make a call, facilitating ambulance access to the site, and the adequacy of information provided to emergency services. The Trust addresses each case in turn.

268. Bethany Lilley (DOD 16.01.19). The Trust accepts that this case concerns delay in calling an ambulance. Emergency assistance was summoned promptly through the Crash Team and the on-call doctor, but an ambulance was not called at the outset or in parallel. The issue was therefore one of sequencing, rather than a failure to summon emergency assistance at all.

269. The Trust's internal investigation concluded that the Registered Nurse ought to have remained with Bethany and asked another member of staff to call the Crash Team and then an ambulance immediately. It recommended that the Basildon Mental Health Unit CPR Policy be reviewed to consider expressly requiring an ambulance to be called urgently in every life-threatening situation, with further face-to-face training if required. The subsequent action plan recorded that resuscitation training would remain in place supported by additional CPR drills, although those drills experienced some disruption during the COVID-19 pandemic. In addition, the Trust's policy was amended to expressly include the requirement to call the emergency services through (9)999.

270. The available case summary does not record a finding that the "Calling 9(999) in a Medical Emergency" poster was absent from the ward or that any absence contributed to the delay. The inquest did not identify delay in calling an ambulance as having made a more than minimal contribution to Bethany Lilley's death.

271. Elise Sebastian (DOD 19.04.21). The PSII identified that the first member of staff who attempted to call the emergency services did not know that it was necessary to dial the prefix "9" before dialling 999. The initial call therefore did not connect. A second member of staff completed the call, which was received by the ambulance

service at 18:43 — approximately four minutes after Elise was found. The inquest jury did not identify the delay in connecting the emergency call as a cause of, or contributor to, Elise Sebastian's death. The PSII recommended that staff knowledge of the prefix be strengthened and the requirement to call the on-call doctor at the same time as the emergency services. The resulting action plan recorded improved signage, inclusion of the requirement within staff induction and signs placed on telephones reminding staff to add the "9" prefix. The Trust's available material does not establish that the "Calling 9(999) in a Medical Emergency" poster was absent from the ward at the time. The investigation highlighted in the limited sense that the initial call failed to connect due to staff uncertainty about the telephone system but did not establish a repeated failure to display the prescribed poster.

272. Michael Nolan (DOD 10.07.22). The Trust does not consider Michael Nolan's case to demonstrate a failure to call an ambulance urgently or at all. Michael Nolan was found collapsed and not breathing at approximately 07:39. The rapid alarm was activated, chest compressions commenced at approximately 07:41 and the ambulance call was assigned at 07:43. The ambulance crew arrived on site at 07:47. The difficulty identified by the PSII concerned the means by which staff communicated with ambulance control after contact had been established. The ward landline could not be moved to Michael Nolan's side, requiring a member of staff to leave the resuscitation scene to make the call and preventing real-time updates to ambulance control. The available material does not identify delay in contacting 999 or the absence of the "Calling 9(999) in a Medical Emergency" poster as contributing factors.

273. Sophie Alderman (DOD 19.08.22). The Trust accepts this has relevance to Question 68(a). The PSII identified the timing of the ambulance call as one aspect of an emergency response that varied in its timeliness and adherence to guidance. It did not establish a failure to recognise that an ambulance was required, or a failure to call one at all. The call was made whilst staff were simultaneously removing the ligature, moving Sophie, obtaining resuscitation equipment and commencing chest compressions. The available material does not establish that the "Calling 9(999) in a Medical Emergency" poster was absent or that its absence contributed to the interval before the call.

274. The more specific systems issue identified by the PSII and AAR was that a member of the nursing team had to leave the resuscitation scene to use the fixed ward

telephone. As a result, the nurse could not remain at Sophie Alderman's side or provide the dispatcher with a contemporaneous account from the scene. The learning identified was therefore the need for a mobile or DECT telephone that could be used during an emergency at the patient's side.

275. An immediate safety action was subsequently approved to provide an alternative means of external communication, such as a Digital Enhanced Cordless Telecom ("DECT") telephone. The action plan records that the telephone was ordered and that the action was implemented on 17 January 2023.

276. Carol Taylor (DOD 21.11.23). Carol Taylor was found unresponsive in the early hours of 21 November 2023. Staff entered her room at 03:10, attempted to establish whether she had a pulse at approximately 03:12, brought the emergency equipment at 03:15 and commenced CPR at 03:16. The emergency call was made at 03:15 but did not connect until 03:18. Paramedics attended and took over the resuscitation at approximately 03:38. The After Action Review records that the ward cordless telephone did not connect and that a member of staff used a personal mobile telephone to call the emergency services. It identified learning concerning the use of the ward cordless telephone and the requirement to dial the additional prefix "9" for an external call. The subsequent Safety Action Plan included provision for the "Calling (9)999 in a Medical Emergency" poster to be displayed in nursing offices across inpatient wards. Neither the PSII nor the After Action Review expressly found that the prescribed poster was absent from Roding Ward at the time of Carol Taylor's death.

277. The Trust acknowledges that the above demonstrates recurring risks within the system for contacting and communicating with emergency services and the investigations identified a range of responsive measures, including clearer guidance on emergency-call procedures, improved signage and prompts, provision of more suitable telephone equipment and incorporation of emergency-call arrangements into training.

(b) Lack of availability of cordless or mobile phones on EPUT wards

278. The Trust accepts that the illustrative cases generated learning concerning communication during medical emergencies. The evidence does not however, establish that each case arose from the absence of a portable telephone or involved

the same underlying systems issue. The matters identified ranged from staff knowledge of ward telephone systems to the ability to contact emergency services from the patient's side to the maintenance of effective communication during resuscitation.

279. Elise Sebastian (DOD 19.04.21). The Trust does not consider Elise Sebastian's case to be a clear example of the absence of cordless or mobile telephones on a ward. The learning identified concerned staff knowledge of the telephone system, improved signage and reminders, and reinforcement of the correct emergency-calling procedure. The available material does not identify the absence of a cordless, mobile or DECT telephone as a principal systems issue or as the focus of the subsequent recommendations.

280. Michael Nolan (DOD 10.07.22). The issue identified following Michael Nolan's death was not primarily one of staff knowledge of telephone procedures. The PSII identified that the fixed ward telephone could not be taken to Michael Nolan's side. As a consequence, a member of staff was required to leave the resuscitation scene to communicate with ambulance control, and was unable to provide real-time updates whilst remaining involved in the immediate response. The learning arising from the investigation included the introduction of a dedicated portable means of communication for use during emergencies.

281. Sophie Alderman (DOD 19.08.22). An Immediate Safety Action following Sophie Alderman's death was subsequently approved to provide an alternative means of external communication, including a DECT telephone or similar solution, and the action plan records that this was implemented.

282. The Trust notes that Michael Nolan died approximately five weeks before Sophie Alderman. To the extent that both investigations identified learning concerning communication arrangements, the Trust considers that caution is required before inferring that learning arising from Michael Nolan's investigation had not been implemented or had proved ineffective. Investigation findings, recommendations and remedial actions may not yet have been finalised, disseminated and embedded across services at the time of the later incident.

283. The Trust considers that the illustrative cases do not establish an uninterrupted repetition of an identical failing across all three cases. Current evidence indicates that wards now have access to mobile or cordless communication devices to support emergency escalation. The introduction of medical emergency simulations, resuscitation drills and Resus Link Practitioners provides additional opportunities to test communication arrangements as part of emergency response exercises.

(c) Persistent failures in the ability of staff to deliver oxygen

284. The Trust accepts all three illustrative cases generated learning concerning oxygen administration during emergency responses. The nature and context of the issues however differed, including the timing of oxygen delivery, operation of oxygen cylinders, staff familiarity with oxygen equipment, oxygen flow rates and wider aspects of airway management and resuscitation.

285. Jason Standing (DOD 5.01.22). The Safety Action Plan expressly referred to "issues relating to the non-delivery of oxygen" and identified a need to strengthen staff competence in oxygen administration through enhanced resuscitation training.

286. The CPR timeline records that cardiopulmonary resuscitation commenced at 06:30:59 and that bag-mask-valve ventilation and oxygen were subsequently applied at 06:38:48. The investigation also identified delays in recognition of collapse, delays in application of the AED and shortcomings in CPR technique. The PSII did not conclude that the oxygen issue caused or materially contributed to Jason Standing's death, but that does not diminish the significance of the learning identified.

287. Michael Nolan (DOD 10.07.22). The PSII and subsequent addendum identified a number of significant issues concerning oxygen administration during the emergency response, including difficulties operating oxygen equipment, delays in obtaining a usable oxygen source and the delivery of oxygen at an inappropriate flow rate.

288. During the resuscitation attempt, the emergency oxygen mask could not immediately be located, and staff were unable to operate the CD oxygen cylinder available on the ward. An alternative oxygen source had to be obtained before oxygen could be administered effectively. The addendum report clarified that approximately eight minutes elapsed between the attempted use of the initial oxygen cylinder and the

arrival of a replacement source. The resulting learning concerned equipment familiarity, practical competence and the correct administration of oxygen during resuscitation.

289. Carol Taylor (DOD 21.11.23). During the resuscitation attempt, staff attached an oxygen cylinder which had not been made operational, and consequently oxygen was not flowing. The issue identified was not the absence of oxygen equipment but the failure to operate available equipment correctly. This led to refresher training, a Trust-wide safety alert relating to oxygen cylinder flow risks and further actions concerning emergency equipment preparedness. The PSII did not identify the oxygen issue as having caused or materially contributed to Carol Taylor's death.

290. The Trust considers that caution is required before concluding that these cases demonstrate the persistence of a single unchanged failing. Michael Nolan and Carol Taylor both died before the Jason Standing PSII was completed and its final recommendations approved. The cases demonstrate that oxygen delivery remained an area requiring improvement, but the chronology and differing circumstances do not support a straightforward conclusion that the same failing continued notwithstanding implementation of the recommendation set out following Jason Standing's death.

(d) Problems with the use of other emergency equipment and/or need for further training on such equipment

291. The Trust accepts that several of the illustrative cases generated learning concerning emergency response procedures, use of resuscitation equipment and staff preparedness for medical emergencies however was unable to identify a single recurring defect in emergency equipment. The issues identified are addressed by reference to each case in turn.

292. Bethany Lilley (DOD 16.01.19). The RCA identified learning relating to staff use of emergency resuscitation equipment and associated training needs. The investigation found that, whilst CPR was commenced following Bethany's discovery, no attempt was made to secure an airway or administer oxygen until the arrival of the Crash Team. The RCA concluded that airway management and oxygen administration should have been prioritised at an earlier stage in accordance with the Trust's Cardio Pulmonary Resuscitation Policy (CLP14).

293. The RCA did not identify any defect or failure in the emergency equipment itself. Rather, it identified a need for further staff training in the use of airway adjuncts, oxygen administration and resuscitation procedures. Reflecting those findings, the investigation recommended further training in resuscitation and airway management, and the subsequent action plan included additional CPR training and practical exercises. Accordingly, the case is more accurately characterised as one concerning staff competence and training in the use of emergency equipment than equipment failure.

294. Madison Naylor (DOD 27.09.19). The RCA identified a number of equipment-related issues. These included the fact that the electrical surgical aspirator was not appropriately charged, there was no electrical supply available to the sockets in Madison's room and routine equipment checks did not extend to the suction apparatus. The investigation also found that some healthcare assistants were unfamiliar with all of the equipment contained within the emergency grab bag. The resulting recommendations included review of the use and checking of suction equipment, provision of training where portable suction devices were used, improved staff familiarity with emergency grab-bag equipment and reinforcement of nursing responsibilities during emergency responses.

295. Stephen Neville (DOD 18.12.21). Following Stephen's discovery, staff obtained ligature cutters and the resuscitation grab bag, called 999, commenced CPR and utilised a defibrillator. The available material does not identify any failure of emergency equipment, malfunction of equipment or inability to operate emergency equipment during the emergency response. The principal findings of the subsequent investigations concerned observation arrangements, ligature-risk management, staffing and training oversight.

296. The resulting learning included enhanced oversight of resuscitation training, implementation of ILS training requirements, the introduction of resuscitation champions and the use of resuscitation drills and debriefing processes. Stephen Neville's investigation provided support for the need for stronger training governance and competency assurance, but did not demonstrate problems with emergency equipment or the inability of staff to operate it.

297. Morgan-Rose Hart (DOD 12.07.22). Following Morgan-Rose's discovery, staff promptly commenced CPR, administered oxygen, utilised an oropharyngeal airway and undertook a coordinated resuscitation response pending the arrival of the ambulance service. The PSII included a review by the Head of Deteriorating Patient Pathways and Resuscitation Training, identifying good practice, including the prompt commencement of CPR, timely administration of oxygen and use of an airway adjunct. It also identified opportunities for improvement, namely the time taken to obtain and apply defibrillation pads, the timing of the first rhythm check and consideration of earlier insertion of an i-Gel airway. The learning arising from the case related principally to refinement and optimisation of the resuscitation response rather than a failure of emergency equipment or inability to operate that equipment.

298. Sophie Alderman (DOD 19.08.22). The PSII identified learning concerning the conduct of the resuscitation response following Sophie being found in cardiac arrest, including the timing of chest compressions, oxygen administration and attachment of defibrillator pads. The investigation identified opportunities to strengthen practical preparedness for cardiac arrest events and recommended more regular scenario-based training in the management of such emergencies. However, the equipment required for the resuscitation attempt was available and was used and all staff involved were up to date with their Basic Life Support training. The investigation focused on the organisation, coordination and timeliness of the response once Sophie had been found.

299. The PSII acknowledged that cardiac arrests are encountered only infrequently within mental health inpatient settings and that staff had limited practical experience of managing such events.

300. The Trust consider the cases do not demonstrate the persistence of a single recurring problem with emergency equipment. Rather, the issues identified were varied and included staff competence and training in the use of resuscitation equipment (Bethany Lilley), equipment maintenance and assurance (Madison Naylor), training oversight and competency assurance (Stephen Neville), optimisation of an otherwise effective resuscitation response (Morgan-Rose Hart) and preparedness for infrequent but time-critical cardiac arrest events (Sophie Alderman).

301. The recurring theme is more accurately characterised as the need to strengthen resuscitation capability, practical familiarity with emergency procedures and preparedness for low-frequency medical emergencies. In particular, the learning identified across the cases concerned airway management, oxygen administration, use of emergency equipment during resuscitation, equipment assurance processes, practical emergency-response skills and the maintenance of competence for events that occur relatively infrequently in mental health inpatient settings. The Trust subsequently introduced a more comprehensive programme including ILS training, quarterly medical emergency simulations, Resus Link Practitioners, grab bag training, deteriorating patient training, and regular refresher exercises.

(e) Need to check and audit emergency equipment

302. The Trust has reviewed the investigations relating to Sharon Langley and Michael Woods. Whilst both cases generated learning concerning patient safety, emergency response and equipment assurance, neither investigation identified deficiencies in routine emergency equipment checking or audit arrangements as a root cause of, or contributory factor to the death.

303. Sharon Langley (DOD 10.08.19). The Action Plan and associated ward governance records included measures relating to equipment assurance and recorded that equipment was subject to regular checks. The same records also referred to ECG equipment, associated training and maintenance arrangements. However, the investigation did not identify failures in emergency-equipment checking or auditing as a root cause or contributory factor in Sharon Langley's death.

304. Michael John Woods (DOD 26.12.20). The investigation examined the circumstances of Mr Woods' admission, the risks associated with the provision of a profiling bed, the management of those risks and the quality of the subsequent emergency response.

305. In relation to the emergency response, the PSII identified learning concerning the deployment and use of emergency equipment, including delays in bringing the emergency grab bag to the scene. These findings led to recommendations concerning resuscitation training, CPR drills, human factors and emergency-response

preparedness. Deficiencies in routine equipment checking or audit arrangements as a cause or contributory factor were not identified as root causes.

(f) Problems with identifying deteriorating patients and escalation processes

306. The illustrative cases identified by the Inquiry do not all relate to the same type of deterioration or escalation issue. Some cases concern emergency response and resuscitation following a patient being found unresponsive; others concern the management and escalation of known psychiatric risks; one case concerns the recognition and management of physical health deterioration. Each is addressed in turn.

307. Sharon Langley (DOD 10.08.19). The principal findings concerned environmental safety, patient supervision, emergency response, human factors and resuscitation procedures following Sharon being found unresponsive. On the morning of 10 August 2019, Sharon's presentation was recorded as normal with no apparent risks identified. Whilst the RCA identified delays in summoning assistance and escalating the emergency response once Sharon had been discovered, these findings related to the management of an acute emergency rather than the identification and escalation of clinical deterioration.

308. Madison Naylor (DOD 27.09.19). The RCA records that Madison's significant risks were well known throughout her admission. Madison had a documented history of repeated self-harm, suicidal ideation and frequent ligature incidents which staff were aware of. The investigation did not identify a failure to recognise a deteriorating patient in the conventional clinical sense in that there were no findings that staff failed to recognise physiological deterioration or failed to escalate abnormal clinical observations. It also identified evidence suggesting that some staff may have become inured to the frequency of Madison's ligaturing behaviour. Shortly before the fatal incident, staff discovered and removed a ligature. Whilst equipment was being obtained to undertake physical observations, Madison was left unsupervised for a period. When staff returned, she was found unresponsive following a further ligature incident. The RCA identified as a root cause that, due to conflicting staff demands, Madison had been left alone in her room for too long unsupervised.

309. Elise Sebastian (DOD 19.04.21). The PSII found that staff recognised the increasing risk presentation and sought to escalate the response through enhanced observation requirements.

310. The evidence demonstrates that the clinical team had recognised Elise's significant ligature risk and had implemented a clear observation regime, comprising Level 2 observations in communal areas and Level 3 constant eyesight observations in her bedroom and other isolated settings. The concern arising from the incident is that the requirement for Level 3 observation does not appear to have been effectively implemented when Elise returned from the communal area to her bedroom. Several staff members subsequently indicated that they believed Elise remained in the communal area and were unaware that she had been permitted to return to her room. The central finding was that the escalated measures were not implemented consistently. Despite the requirement for continuous observation in isolated areas, Elise was able to access her bedroom alone and remain there unsupervised.

311. Sophie Alderman (DOD 19.08.22). The Trust's records indicate that Sophie had shown signs of improvement in the weeks before her death, leading to a documented reduction in observation levels, and that staff engaged with her shortly before the incident without identifying an intention to self-harm. The principal learning arising from the case concerned observations, use of Oxevision, emergency response arrangements and resuscitation preparedness, rather than shortcomings in processes for recognising and escalating deterioration.

312. Carol Taylor (DOD 21.11.23). The investigation recognised a prolonged decline in Carol's physical condition during her admission, including substantial weight loss, episodes of dehydration, acute kidney injury, reduced mobility, falls and oedema. The PSII examined whether those factors ought to have have prompted reassessment of her VTE risk and whether escalation of physical-health concerns was required as her condition changed over time. The PSII did not conclude that staff failed to identify an active pulmonary embolism or ignored recognised signs of VTE. The investigation found that Carol did not demonstrate clinical signs of VTE prior to her death and that no calf pain, significant swelling or other recognised indicators had been identified. The learning identified was directed towards the reassessment of risk factors and escalation of physical-health risks, particularly where reduced mobility, dehydration or the use of antipsychotic medication may alter a patient's VTE risk profile.

313. The Trust subsequently introduced NEWS2 training, deteriorating patient pathways, physical health competency programmes, non-contact physical observation technology, structured assessment tools, Physical Health Link Practitioners and enhanced physical health governance.

(g) Problems with post-incident audits and use of Cardiac Arrest Event / audit forms / Resuscitation Event Forms

314. The Trust accepts that each of the cases identified by the Inquiry contains learning relevant to post-incident recording, audit or review processes but notes that the investigations did not identify the same issue in each case. Rather, the cases concerned different aspects of post-incident documentation and organisational learning.

315. Madison Naylor (DOD 27.09.19). The RCA identified shortcomings in post-incident documentation and recording following the events of 27 September 2019. In particular, that there was no contemporaneous record of the events surrounding Madison's collapse and subsequent resuscitation attempt. The investigation concluded that staff misunderstood instructions to secure the clinical record following Madison's death and had not reverted to paper documentation when electronic recording became unavailable. The resulting recommendations included reminding staff of the importance of maintaining contemporaneous records and advising staff to revert to paper documentation where electronic records are secured.

316. Elise Sebastian (DOD 19.04.21). The investigation found that no Resuscitation Event Form was completed following the incident and recorded that ward management and responding staff were unaware of any requirement to complete such a form. The PSII observed that the Resuscitation Event Form served a broader purpose than retrospective audit alone, and could operate as both an audit tool and an aide-mémoire during resuscitation events by assisting staff to record key actions, timings, processes and equipment use.

317. As a result, Recommendation 9 specifically required that Cardiac Arrest Event forms (known also as Resuscitation Event Forms) be stored alongside resuscitation equipment as a prompt to ensure completion following every resuscitation event, in

accordance with Trust policy. The associated action plan required the forms thereafter to be kept with the grab bag and incorporated into Datix reporting arrangements.

318. Jason Standing (DOD 05.01.22). The principal learning identified by the PSII concerned wider record-keeping failures rather than the completion of Cardiac Arrest Audit Forms or Resuscitation Event Forms in isolation. The PSII concluded a lack of contemporaneous and patient-centred record keeping, necessitating review and immediate change.

319. Whilst all three cases are capable of informing the Inquiry's consideration of post-incident audit and documentation processes, the Trust does not consider that they demonstrate a single recurring failing in relation to Cardiac Arrest Audit Forms or Resuscitation Event Forms. Rather, they reveal distinct learning relating to (i) contemporaneous post-incident documentation, (ii) the completion and accessibility of dedicated resuscitation audit forms, and (iii) broader clinical record-keeping standards and governance.

(h) Problems with calling the on-call doctor

320. The Trust accepts that each of the cases identified by the Inquiry contains learning relating to medical escalation during emergency situations. However, the investigations did not identify a single, common failure.

321. Elise Sebastian (DOD 19.04.21). The PSII did not identify any deficiency in the availability of the on-call medical service itself, nor any failure on the part of the on-call doctor once contacted. The on-call doctor attended approximately seven minutes after being contacted. Recommendation 6 required the service to strengthen staff knowledge of two specific matters: first, the need to dial "9" before calling 999 to obtain an outside line, and secondly, the requirement to call the on-call doctor at the same time as emergency services. The associated action plan provided for improved signage, staff induction measures and visible reminders adjacent to ward telephones.

322. Marion Michel (DOD 04.03.22). The PSII identified a delay in the attendance of the duty doctor following the emergency response on 4 March 2022. However, unlike cases where the issue concerned a failure to contact the on-call doctor, the investigation found the delay arose because it was unclear to the duty doctor whether

the incident had been communicated as a medical emergency or a psychiatric emergency. The PSII did not identify a deficiency in the availability or responsiveness of the duty doctor once the nature of the emergency was understood. Nor did the investigation conclude that earlier attendance would have altered the outcome in Marion's case, although it observed that delays of this nature could be significant in other circumstances.

323. The PSII recommended a review of the protocol for rapid responses to emergency incidents, with a particular focus on the distinction between medical and psychiatric emergencies. The resulting Immediate Safety Action amended the emergency response protocol so that duty doctors are required to attend all emergencies, thereby removing the scope for ambiguity as to whether a doctor should be summoned.

324. Michael Nolan (DOD 10.07.22). The PSII identified that the on-call doctor was not informed of Michael's cardiac arrest until after the resuscitation attempt had concluded. As a result, there was no medically qualified doctor present during the emergency response and the doctor's expertise was not available to support the resuscitation attempt.

325. The PSII expressly records that no staff member contacted the doctor because they were all either involved in, or affected by, the cardiac arrest itself. The investigations identified system factors which contributed to the omission. The After Action Review recorded that the resident doctor did not form part of the existing emergency escalation pathway and that there was no established facility within Kelvedon Ward for contacting the resident doctor during a medical emergency.

326. The resulting recommendations focused upon strengthening emergency communication processes. The After Action Review recommended the introduction of a reliable method by which resident doctors could be contacted during medical emergencies, including consideration of pagers and improved communication systems. Subsequent actions included the provision of communication devices and revised arrangements for managing medical emergencies.

327. The findings do not demonstrate a single recurring failure in relation to calling the on-call doctor. However, the Trust acknowledges that the persistence of issues in

this area arose because emergency responses were often focused on immediate resuscitation activity and local processes did not consistently emphasise the requirement for parallel escalation to medical staff. The Trust's response included revised signage, emergency posters, induction changes and reinforcement within emergency response training. Staff are now specifically reminded to contact both emergency services and the on-call doctor when a medical emergency occurs.

(i) Problems communicating with emergency services

328. The cases relied upon by the Inquiry involve materially different issues. Michelle Morton's case concerned disputed evidence regarding ambulance access to the patient; Elise Sebastian's case identified direct communication difficulties involving address information and contact with emergency services; and Jason Standing's case was principally concerned with clinical observation, deterioration and resuscitation rather than communication with emergency services.

329. Michelle Morton (DOD 08.12.19). The issue of communicating with emergency services, whilst a feature of this case, was not a central focus of the RCA and did not result in any specific recommendation. The investigation recorded concerns raised by the attending ambulance crew that, although they arrived promptly at the Lakes Unit, they experienced difficulties reaching Michelle because of multiple access points, locked doors and address information communicated through the dispatch system.

330. However, ward staff disputed that any material delay had occurred and stated that access was provided promptly. The investigators were unable to resolve the issue conclusively because relevant CCTV footage and precise timings were unavailable. Accordingly, whilst the case contains some disputed evidence of difficulties encountered by ambulance crews in accessing the patient, it is more accurately characterised as a case concerning environmental safety, observation arrangements and ligature-risk management than one principally concerned with communication or handover arrangements with emergency services.

331. Elise Sebastian (DOD 19.04.21). The PSII identified a number of communication issues during the emergency response, including confusion regarding the correct address and postcode of the St Aubyn Centre, difficulties experienced by

the ambulance crew in locating the unit and inaccuracies in information communicated during the emergency call.

332. The investigation also concluded that communication with emergency services would have been enhanced had staff been able to maintain contact with ambulance control from the patient's side using a portable telephone. Recommendation 8 required the Trust to correct address information and liaise with the ambulance service to ensure that accurate location details were held on relevant systems. The action plan records that those steps were subsequently taken.

333. Jason Standing (DOD 05.01.22). The PSII did not identify failures in communicating with emergency services, provision of address information, facilitating ambulance access or handover to responding paramedics. The principal findings concerned observation practices, physical-health monitoring, record keeping, clinical handovers between care teams, delayed recognition of deterioration and the conduct of the resuscitation response.

334. The investigations into Michelle Morton's and Elise Sebastian's deaths identified issues concerning communicating with emergency services, albeit to different degrees. Of those cases, the clearest findings arise from Elise Sebastian, where the PSII identified specific shortcomings relating to address information, ambulance access and communication with emergency services. By contrast, the issue in Michelle Morton's case was limited to disputed evidence concerning site access and did not give rise to any root cause, care and service delivery problem or recommendation.

335. The Trust does not consider that these investigations demonstrate a recurring or systemic problem in communicating with emergency services. Rather, they identify different issues arising in different circumstances. Jason Standing's case, although it involved communication and handover issues between clinical teams, did not identify deficiencies in communication with emergency services. The principal learning arising from this category therefore concerns site information, access arrangements and emergency communication processes rather than a single persistent failing across all three cases.

336. The below table sets out a summary of the Trust's position in respect of the issues identified and the current measures in place addressing those issues.

Failing identified	Why the failing persisted	Trust's response	Current position
Failures to call 999 urgently or at all; repeated absence of the "Calling (9)999" poster	Learning implemented locally rather than Trust wide; staff turnover and temporary staffing meant local actions did not embed consistently	Trust wide "Calling (9)999 in a Medical Emergency" process; standardised posters; inclusion in training; prompts in equipment; safety alerts and learning events	Standardised Trust wide process in place
Lack of cordless or mobile phones on wards	Absence of Trust wide telephony standard; provision sat with local operational and estates arrangements; local solutions did not address system-wide risk	Portable and mobile devices introduced; local surveys undertaken; guidance amended to encourage calling from patient's side; Resus Link Practitioners test communications in drills	Current evidence indicates wards now have access to cordless/mobile devices
Persistent failures in ability to deliver oxygen	Oxygen administration infrequent in mental health settings; limited real-life exposure despite training; episodic training without continuous skills maintenance	Head of Deteriorating Patient Pathways appointed; ILS training introduced; Resus Link Practitioners established; oxygen training videos; reinforced training on flow rates	Continuous skills maintenance and simulation-based learning implemented

Problems with use of other emergency equipment and need for further training	Infrequent real-life cardiac arrest exposure; local variation in drills; workforce turnover; reliance on BLS rather than enhanced training; historical emphasis on equipment availability over proficiency	ILS training; quarterly medical emergency simulations; Resus Link Practitioners; grab bag training; deteriorating patient training; aide-mémoires; refresher exercises	Comprehensive programme in place
Need to check and audit emergency equipment	Early investigations focused on individual ward corrections; assurance arrangements not sufficiently standardised or subject to secondary validation	Structured audit programmes; Resus Link Practitioners; enhanced equipment checking processes; simulation programmes; Trust wide governance oversight	Greater governance oversight in place through Trust wide committees
Problems identifying deteriorating patients and escalation processes	Challenge of recognising physical deterioration in mental health settings; variability in physical health competencies; NEWS2 not required Trust wide until June 2022 despite national deadline of March	NEWS2 training; deteriorating patient pathways; physical health competency programmes; non-contact physical observation guidance; structured assessment tools; Physical Health Link Practitioners	Enhanced physical health governance in place

	2019; inconsistent use of structured escalation tools		
Problems with post-incident audits and use of cardiac arrest event forms	Completion of resuscitation documentation relied on local practice and individual teams; learning not captured consistently across the organisation	Resuscitation Event Forms incorporated into grab bags; inclusion within Datix; discussion during training; oversight through physical health governance	Physical health governance structures in place
Problems calling the on-call doctor	Emergency responses focused on immediate resuscitation; local processes did not consistently emphasise parallel escalation to medical staff	Revised signage; emergency posters; induction changes; reinforcement in emergency response training	Staff now specifically reminded to contact both emergency services and on-call doctor
Problems communicating with emergency services (address information, ward access, handovers)	Complexity of mental health sites; variation in local knowledge; inconsistent use of structured handover tools; absence of Trust wide communication aid	"Calling (9)999 in a Medical Emergency" guidance; corrected ambulance service and website location information; communication prompts in training; SBAR approaches; prompts on meeting ambulance crews	Consistent guidance, training and assurance arrangements across inpatient services

Cross-Case Learning and Governance

337. Ann Sheridan chairs the Emerging Incident Review Group (“EIRG”): In her absence a suitably qualified deputy will attend. The Terms of Reference are exhibited at (KS.AS-017).

338. The EIRG is intentionally designed as a forum for early identification, discussion and dissemination of learning, rather than a formal action monitoring group.

339. Learning identified through the EIRG is cascaded through the Trust's established governance and professional leadership structures. The group comprises representatives from Care Units, Patient Safety, Quality & Safety, the Lessons Team and key corporate functions, responsible for sharing relevant learning and actions within their respective areas. Where learning identifies the need for local improvement, the responsibility for considering, implementing and monitoring any resulting actions sits with the relevant operational, clinical and governance leads, through existing management, quality improvement and governance processes.

340. Immediate safety actions are allocated to appropriate leads for implementation, supported by an action log maintained by the Patient Safety Incident Management Team. Learning and themes are disseminated through weekly reports to the Executive Team and quarterly reporting to the Quality of Care Group and Quality Committee.

Michael Nolan

341. Michael Nolan died on 10 July 2022 whilst an inpatient on Kelvedon Ward at Basildon Mental Health Unit. His death was the subject of a Patient Safety Incident Investigation ("PSII") conducted under the Trust's Patient Safety Incident Response Framework ("PSIRF"). The Inquiry’s question arises as to why his case was not presented to the Trust's Learning Oversight Subcommittee ("LOSC") until March 2025.

342. The Trust addresses two preliminary points at the outset:

i. Michael Nolan's case was in fact first presented to the LOSC in May 2024.

ii. The interval between Micheal Nolan's death and the initial LOSC presentation is explained by a sequence of procedural steps, each of which required completion before the matter could advance to the next stage.

343. Commissioning of the investigation team – the investigation required the identifying staff with the requisite skills and capacity to undertake the roles of Lead

Review Lead ("LRL") and Doctor Subject Matter Expert ("SME"). This involves working with operational leadership to identify an appropriate staff member, a process that recognisably takes time as managers will likely approach several staff to identify a suitable candidate.

344. In parallel to this process, an After Action Review (“AAR”) was held on 4 August 2022 and approved on 6 September 2022, in order to capture the immediate learning from the incident.

345. Factual accuracy process - the factual accuracy process for preparing the report for approval ran from 28 November 2022 to 24 January 2023. This process involved the draft report being sent to the staff involved, the care unit leadership, and other key staff for review. A two month factual accuracy period is not typical, and the Trust accepts that this was a longer period than would ordinarily have been expected.

346. First Executive Approval Group review – the draft report was presented to the Trust's Executive Approval Group ("EAG") on 24 January 2023. The EAG, acting in its capacity as a line of assurance, requested additional information and detail before it could approve the report, resulting in a delay whilst the report was amended. The report was returned to the EAG on 6 March 2023 and approved the same day. Learning was shared with the teams involved in the incident on 10 March 2023, and the family received a copy of the report on 17 March 2023.

347. CQC queries – the report was shared with the CQC on 21 April 2023. On 11 May 2023 the CQC raised queries which were subsequently referred to the LRL. The LRL indicated that they were still awaiting the family's response to the report and were therefore uncertain whether it was finalised.

348. Coroner's request for further information – the coroner requested additional information on 17 July 2023 for additional information relating to the entries of 'nil' for observations. The response culminated in the production of an addendum to the PSII report, including a correction of the times recorded in the original report as against those shown in CCTV footage. An explanation was requested by the PSIM team to explain why the addendum and changes had been made, as the central team had not been made aware of these developments.

349. Second EAG approval – the cumulative queries raised by the CQC and the Coroner necessitated the addendum being presented to the EAG for approval. The

addendum was approved by the EAG on 3 August 2023. The report was subsequently shared with the family on 12 September 2023

350. First Presentation to LOSC – 29 May 2024 – the report was first presented to the LOSC on 29 May 2024 once the full investigative and approval process was complete and the Safety Action Plan was finally signed off in February 2024.

351. Second Appearance at LOSC - 26 March 2025 – the incident reappeared before the LOSC in March 2025 by way of an assurance and update demonstrating how learning from the incident had been embedded in practice. This second appearance before LOSC was accordingly a distinct and separate exercise from the initial presentation in May 2024. Its purpose was to provide the committee with assurance that the learning identified had been properly embedded at ward level - a function entirely consistent with the LOSC's oversight role.

Learning material

352. The learning material relating to emergency response and resuscitation distributed to staff between 24 June 2025 and the date of this request (11 August 2026) are exhibited (KS.AS01-018)

PART 16: DEATHS OCCURRING AFTER THE RELEVANT PERIOD

[I/S] (died [I/S] April 2025)

353. The Trust attaches the SWARM Huddle report dated [I/S] April 2025 and the Patient Safety Incident Investigation Report dated [I/S] April 2025 as (KS.AS01-019 and KS.AS01-020).

354. Ms **[I/S]** was reviewed by the on call Doctor during the morning of [I/S] April 2025. At the time of that review, there were no clinical indicators of imminent deterioration. Vital signs, observations, and blood tests were taken, and because of the clinical assessment, Ms **[I/S]** s observation level was appropriately increased to Level 2. The clinical working hypothesis at that stage included a query urinary tract infection and a possible gallbladder issue, with blood results awaited. Based on the clinical picture available to staff at the time of the morning review, there was no medical or clinical basis upon which to summon emergency services.

355. The change in Ms **[I/S]** s presentation, from being active on the ward to remaining in her room, was a potential indicator of deterioration that could have

triggered a heightened clinical and engagement response, including a prompt physical review of Ms [I/S] in her room.

356. The 2 minute delay between Ms [I/S] being observed on the floor via the Oxevision monitoring system and staff entering the room. Ms [I/S] was observed lying on the floor. Upon seeing this, a student nurse went to the room and looked in through the door before returning to obtain further nursing staff. EPUT's policies and expected standards of care, require staff to enter the room.

357. EPUT has not been able to obtain a fully clear account from the staff involved as to the precise reasons for the 8 minute delay before calling 999, and it is right to be transparent with the Inquiry about that limitation. From the information available, including review of the CCTV footage, the Trust understands that several factors contributed to the delay in calling 999.

358. Upon entering the room, staff found Ms [I/S] lying on the floor positioned against a profiling bed. Due to her weight and the physical constraints of the room, staff experienced significant difficulty in repositioning her to assess her condition. The ambulance was ultimately called on instruction from the on-call Doctor. 999 should have been called immediately upon finding Ms [I/S] unresponsive on the floor, without waiting to fully assess her condition. Not doing so was against the Trust's policy and procedures.

359. It is recognised that human error cannot be entirely eliminated, particularly in the context of medical emergency situations, which are inherently high-pressure and emotionally demanding. Such conditions present significant challenges to staff at all levels, and it would be unrealistic to expect that errors will never occur.

360. A further compounding factor is the infrequency with which many staff members are exposed to medical emergency scenarios in the course of their day-to-day duties. Limited exposure of this nature can adversely affect the ability of staff to respond effectively.

361. Central to the effective management of a medical emergency, including cardiac arrest, is the role of the team leader. This role is afforded considerable emphasis within the Immediate Life Support (ILS) training programme delivered by the Resuscitation Council UK (RCUK). The Resuscitation Council UK has stated that: "a team leader provides guidance, direction and instruction to the team members to enable successful completion of their stated objective."

362. The importance of effective team leadership in such circumstances cannot therefore be overstated, and the adequacy of training, preparation and support provided to those expected to fulfil this role is a matter of significant relevance.

363. From the evidence available, including CCTV footage reviewed as part of the Patient Safety Incident Investigation, the primary reason for the 11-minute delay before CPR and AED use and the 12-minute delay before chest compressions appears to have been the difficulty staff experienced in accessing Ms [I/S] 's chest in order to commence compressions, arising from her position on the floor against the profiling bed and the physical challenges associated with her size as a bariatric patient. Staff were also subject to the considerable stress of the emergency.

364. Equipment difficulties that arose during the emergency response. There were two distinct issues identified:

365. AED pads not adhering: The AED pads did not adhere effectively. This was at least in part due to Ms [I/S] 's skin being wet. Ms [I/S] was a bariatric patient and the standard equipment available was not well suited to her body habitus.

366. CPR on specialist mattresses and bariatric patients: The profiling bed created difficulties in terms of both positioning Ms [I/S] for CPR and in transferring her. The Trust notes that Resuscitation Council UK guidance, which is reviewed every four years, addresses the question of whether to move a patient from a specialist mattress to the floor to facilitate chest compressions. The Trust has identified as a specific area of learning that staff would benefit from bespoke practical training on managing resuscitation in these circumstances, including scenarios involving bariatric patients and specialist mattresses.

367. The Trust's expectation is that learning from previous incidents is actively disseminated to all staff and embedded in practice. Learning is shared through several methods, including the EIRG, Care Unit Incident Review, Team Business meetings, Care Unit Quality and Safety meetings and the Learning Collaborative Partnership, which produces communications that are fed into the Learning Oversight Committee. Learning is also discussed within individual supervision and can occur informally in manager or peer discussions.

368. However, EPUT accepts the existence of learning dissemination mechanisms alone does not provide assurance that learning has been fully understood, retained, translated into practice, or recalled effectively during an emergency situation.

369. The Trust has established several mechanisms to support the communication and embedding of learning. These include the Learning Collaborative Partnership (LCP), Learning Oversight Sub-Committee (LOSC), Safety and Learning Command Calls (SALC), Safety Learning Alerts, Lessons Briefings, the monthly Lessons Identified Newsletter, 5 Key Messages communications, Learning Matters sessions, and the EPUT Culture of Learning intranet resources. Learning is also reviewed routinely at team meetings, safety huddles, handovers, multidisciplinary meetings, supervision sessions and through the Local Lessons Log process on Datix.

370. The Trust's expectation is that learning identified from incidents, investigations, complaints, patient feedback, audits and national inquiries is not only disseminated but actively embedded into day-to-day practice through its EPUT Culture of Learning ("ECOL") framework. ECOL is founded on the principle that of personal accountability and that the active identification, sharing and application of lessons forms part of normal business activity across all levels of the organisation.

371. The Trust is reviewing the effectiveness of existing ECOL processes relating specifically to the communication, assurance and embedding of patient safety learning. This includes consideration of how learning from resuscitation incidents is cascaded, how understanding and implementation is tested locally, the role of ward and service leadership in reinforcing critical safety messages, and the adequacy of governance arrangements for assuring that important lessons have become embedded in practice rather than simply communicated.

372. The first member of staff to attend Ms **[I/S]** 's room was a student nurse, who conducted an initial visual check from the doorway before seeking assistance. Thereafter, a combination of substantive registered nurses (Staff Nurses), unregistered staff (Staff HCAs), and medical staff attended. All substantive staff who attended were employed by the Trust and should have completed mandatory life support training in accordance with their role.

373. Checking for a pulse before calling 999 and commencing CPR in these circumstances was not compliant with Trust policy, procedures, or training. The expected response upon finding an unresponsive patient who is not breathing is to immediately summon emergency services and commence CPR. This did not happen in this case.

374. The application of a blood pressure cuff before summoning emergency services was not compliant with Trust policy, procedures, or training.

375. The Trust's understanding, based on the available information including the CCTV footage, is that staff entered Ms [I/S] 's room at approximately 15:52, at which point a call for help was raised. The precise moment at which any formal alarm was activated is not clearly recorded in the contemporaneous documentation. The CCTV footage appears to show an alarm light flashing.

376. On the evidence available, there is no record of a staff member physically entering Ms [I/S] 's room during the Level 2 observation period between 11:29 and 15:08.

377. On the question of whether staff chose not to enter the room because Ms [I/S] appeared to be sleeping, EPUT is clear that no clinical risk assessment was undertaken or recorded to support any such decision. The Trust's expectation is that, even if a patient is believed to be asleep, Level 2 observations require a staff member to physically enter the room to check on the patient's wellbeing. That did not occur in this case.

378. The observations conducted between 11:29 and 15:08, were inadequate and fell below the standard required for Level 2 observations.

379. The principal concern identified in the PSII was not the need for additional medical emergency simulation training, but rather the need to ensure consistent compliance with the existing requirement. The CPR Policy has, for many years, required that medical emergency simulations are facilitated at least three times a year and more recently every three months in each inpatient setting. It is the consistent delivery of simulations at the required frequency that will generate examples of good practice and identify key learning through the structured learning conversations that follow each exercise. That learning must then be discussed at a local level within teams and escalated to Care Group meetings, where it can be shared more widely across the organisation. This was the issue that was raised in the PSII.

380. Initial training accompanied the roll out of NEWS2. It is continuously reinforced and addressed through the ILS training, emergency simulation training and the Life Support Refresher sessions. The proposal to make NEWS2 training "essential for role" referred to at page 35 of the PSII report was a recommendation made by the head of deteriorating patient pathways and resuscitation officer following Ms [I/S] 's death

which has been taken through the Trust's governance process and is due to be ratified imminently. The training will be an external NHS national programme and completed by all staff working within an inpatient setting.

381. Staff are reminded of the importance of ensuring continuity of care during any transition between staff members. Between observations staff are expected to have a brief word with the incoming staff member where there are any noted concerns - for example, a passing comment such as "keep an eye on patient X" or drawing attention to a change in behaviour. Where concerns are more significant, a safety huddle can be arranged to allow for a more focused discussion. The expectation is simply that relevant concerns are communicated, however informally, so that the incoming staff member is appropriately sighted.

[I/S] (died [I/S] June 2025)

382. The SWARM Huddle and MDTR reports are exhibited at (KS.AS01-021 and KS.AS01-022).

383. EPUT notes that Question 78 proceeds on the basis that the matters identified in connection with [I/S]'s death represented the persistence of failings identified in the earlier cases referred to in Question 68. EPUT does not presently accept that all of the matters identified in Question 78 can appropriately be characterised in that way.

384. EPUT accepts that a number of the issues identified following [I/S]'s death shared features with themes arising from some of the cases addressed in response to Question 68. However, for the reasons set out in that response, EPUT does not accept that the earlier cases demonstrate a single unchanged failing persisting over time. Rather, the Trust's review identified a number of related but distinct issues concerning emergency communications, oxygen administration, airway management, equipment familiarity, leadership during resuscitation and preparedness for infrequent medical emergencies.

385. In EPUT's view, any assessment of the significance of the findings arising from [I/S]s death requires careful consideration of the specific factual circumstances of that case, the conclusions reached by the relevant review processes, and the extent to which meaningful comparisons can properly be drawn with earlier incidents referred to in question 68.

386. The SWARM review following L [I/S] s death identified difficulties in a number of those areas. The Trust considers that the recurrence of similar themes demonstrates that the measures then in place had not secured consistently effective emergency-response practice at ward level. In particular, the SWARM identified that CPR simulation exercises had not been undertaken for some time, notwithstanding that such exercises would have provided opportunities to practise use of the emergency telephone and radio systems, airway management, oxygen equipment, grab-bag familiarity, leadership and role allocation. Accordingly, EPUT considers that the principal explanation for the recurrence of these issues was not the persistence of a single unchanged defect, but insufficient assurance that organisational learning had been translated into consistent local practice.

a. *Failure to use the cordless phone to contact emergency services and unfamiliarity with the system to transfer calls between phones.*

387. The SWARM recorded that a cordless telephone was available but was not utilised. The ILS-trained nurse (who was not regular ward staff) made the emergency call from the nearest office rather than from the office containing the cordless device, and staff were unfamiliar with the process for transferring the call to the cordless unit. As a result, information was relayed between the office and the resuscitation scene rather than emergency control speaking directly to staff attending to [I/S]

388. As explained in response to Question 68, the earlier cases disclosed a range of different communication-related issues, including staff knowledge of telephone systems, portable communication devices, emergency escalation pathways and communication with emergency services. The [I/S] incident demonstrates that practical difficulties in emergency communications remained capable of arising notwithstanding earlier learning in this area.

b. *Failure to use radio to call a medical emergency*

389. The evidence indicates that a radio was used to call for assistance. The concern identified by the SWARM was that the emergency call was made on the internal ward channel rather than the external channel by which sister wards and the matron's office would ordinarily have been alerted.

390. The Trust therefore does not consider this to be a case of a failure to use the radio system. Rather, it concerned the effective use of that system during a medical emergency. Consistent with the analysis in response to Question 68, this reflects a practical communications issue rather than an absence of communications equipment.

c. Use of the wrong channel to call a medical emergency

391. This issue overlaps substantially with paragraph (b). The SWARM recorded that the radio emergency call appears to have been transmitted on the internal channel, with the result that other wards did not hear it.

392. The immediate cause was therefore not a lack of radios but uncertainty regarding the correct communications pathway during a medical emergency. The Trust considers that this reflects the broader theme identified in response to Question 68 concerning emergency communication arrangements and preparedness for emergency situations.

d. Management of airways and availability of emergency equipment including i-gels, contributed to by the unavailability of ILS trained staff

393. The SWARM identified difficulties establishing and maintaining an airway during the resuscitation attempt. Staff were unable to locate the smaller size i-Gel, a nasopharyngeal airway was not used, and staff reported difficulties managing the airway during CPR. The SWARM also identified that the ILS-trained nurse was occupied with emergency communications and that staff perceived a lack of leadership during the incident.

394. As set out in response to Question 68, the Trust does not consider that the earlier cases demonstrate a recurring defect in emergency equipment itself. Rather, the recurring theme is practical familiarity with emergency procedures, emergency equipment and preparedness for infrequent but time critical medical emergencies. The equipment required for airway management was available, but staff experienced difficulties locating, identifying and deploying it effectively in the circumstances. **[I/S]** **[I/S]**'s case is therefore consistent with the broader theme identified in Question 68,

namely that practical emergency preparedness required further strengthening notwithstanding previous learning initiatives.

e. Confusion over how to use equipment relating to the provision of oxygen (oxygen masks)

395. The SWARM identified confusion regarding the type of oxygen mask that should be used, recording that a therapeutic mask was used rather than a reservoir mask.

396. As explained in response to Question 68, previous cases generated learning concerning oxygen administration, equipment familiarity and practical competence during resuscitation. However, those cases did not disclose a single unchanged failing. Rather, they involved differing issues concerning oxygen delivery, oxygen flow rates, operation of cylinders and familiarity with equipment. **[I/S]**'s case similarly concerned practical familiarity with oxygen equipment during an emergency situation rather than the absence of oxygen equipment itself.

397. The Trust considers that this issue reflects the broader theme identified in Question 68, namely the need to maintain competence and familiarity with emergency equipment used relatively infrequently in mental health inpatient settings.

f. ILS trained staff were not available due to having left the patient to call emergency services

398. The SWARM recorded that the ILS-trained nurse made the emergency call from a fixed office telephone and consequently remained involved in communications with emergency control and the relay of information between the office and the resuscitation scene. This reduced the immediate availability of ILS-trained staff during the resuscitation attempt.

399. The Trust does not consider this issue arose because ILS-trained staff were unavailable generally. Rather, it arose because emergency communication arrangements required an ILS-trained nurse to undertake communications activity which removed that individual from the immediate scene. The issue is therefore closely connected with the communications difficulties addressed at questions 78 (a) to (c)

above. The Trust considers that improved emergency communication arrangements and regular simulation exercises would have reduced this risk.

g. Lack of leadership of CPR

400. The SWARM recorded staff concerns regarding leadership during the resuscitation attempt and recommended CPR simulation exercises to strengthen leadership and role allocation. It also recorded that HCAs responded with BLS training but were not ILS trained. The issue arose in the context of the principal ILS trained nurse being occupied with emergency communications, reducing leadership capacity at the bedside.

401. As identified in response to Question 68, a recurring theme across a number of investigations was preparedness for infrequent emergency events and maintenance of practical resuscitation capability. The Trust considers that the absence of a clearly identified resuscitation leader, together with the reduced availability of the ILS-trained nurse, contributed to the difficulties encountered during airway management, equipment use and coordination of the response.

402. The Trust accepts that effective emergency response requires more than completion of BLS or ILS training. It also requires opportunities to rehearse leadership, communication and role allocation under realistic conditions. The lack of regular simulation exercises reduced those opportunities.

h. Lack of familiarity with the contents of the grab bag and inability to identify equipment

403. The SWARM recorded difficulties identifying equipment within the emergency grab bag. It noted that when the bag was emptied, a number of items had similar plain packaging which made it difficult for staff to differentiate between equipment. This affected identification of the correct oxygen mask, the appropriate size i-gel and the nasopharyngeal airway. The issue was not that the equipment was absent. Rather, staff experienced difficulty identifying and deploying the correct equipment during a time-critical emergency.

404. The Trust accepts that routine checking of emergency equipment cannot alone assure familiarity with its contents. Wider staff involvement in grab-bag checks could provide a more effective means of maintaining familiarity with equipment used infrequently in practice.

i. Lack of attendance of all staff involved in the resuscitation at the debrief

405. The SWARM recorded that a debrief took place after the incident but that the doctors involved in the response did not attend. The doctors instead received a telephone check-in from their supervisor.

406. The Trust accepts that a multidisciplinary debrief is generally preferable because it allows all staff involved in an incident to contribute to the identification of learning and provides a shared understanding of events. The SWARM accordingly recommended further consideration of the debrief process. The Trust acknowledges this requires taking into account the availability and working patterns of all staff who were involved in the event to participate. The Trust has a duty to remain mindful of any impact that an immediate debrief may have on a staff member which revisits potentially traumatic circumstances.

j. Problems relating to the induction of different types of staff

407. The SWARM identified differences between the local induction received by ward-based staff and that received by doctors. Although doctors had received relevant professional training, they were not equally familiar with the location and contents of the grab bag and aspects of the ward's emergency-response arrangements.

408. The Trust accepts that emergency preparedness should not vary according to professional group and that all staff who may be required to respond to a medical emergency should receive local familiarisation with ward-specific equipment and emergency procedures. The SWARM therefore recommended review of induction arrangements to ensure that all members of the multidisciplinary team received appropriate orientation to local emergency systems and equipment.

409. **[I/S]**'s case demonstrates the recurrence of a number of broad themes previously identified in some of the investigations considered at Question 68. Ultimately, EPUT considers the issues concern the translation of organisational learning into consistently effective practice at ward level.

410. The Trust's assessment is that the principal factor underpinning the recurrence of these issues was insufficient assurance that emergency-response learning remained embedded in day-to-day practice. In particular, the SWARM review identified that ward-based CPR simulation exercises had not been undertaken for some time, notwithstanding that such exercises would have tested many of the matters identified following [I/S]'s death. EPUT accepts that its arrangements for assuring the delivery and oversight of those exercises were insufficient and that stronger assurance mechanisms should have been in place prior to the incident.

411. Discussions around the issues discussed above take place with wider regional groups and at Integrated Care Board ("ICB") level. EPUT uses these discussions as an opportunity to share learning from incidents and learn from other Trusts, organisations and care providers to identify thematic learning. This had led to an opportunity for one of EPUT's senior nurses to lead on physical health at a regional level to progress discussions with the Provider Collaborative.

412. SWARM is designed to start as soon as possible after a patient safety incident occurs. The Trust uses swarm-based huddles to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened, how it happened and decide what needs to be done to reduce risk enabling insight and reflection to be quickly sought and generate prompt learning.

413. MDTR is a broader, multi-disciplinary process which happens later and examines the incident across professions and pathways to deepen learning and systemic change. Specific Terms of Reference can be drafted. The Head of Deteriorating Patient Pathways did not attend the MDTR however the Head of Clinical Transformations was in attendance and who works closely with the Head of Deteriorating Patient Pathways.

414. The MDTR was commissioned following the SWARM huddle to answer 6 specific questions. The two reports should therefore be read in conjunction with one other; the MDTR does not cover the issues within the SWARM. The phrasing of "no tools or technology issues identified in this incident" is accepted by EPUT as incorrect and should read as "no tools and technology issues noted within this MDTR review". This does not preclude the fact that tools and technology were dealt with a SWARM.

415. On review of the SWARM huddle, MDTR and the Initial Incident Datix the Trust does not believe that two Healthcare Assistants were first on scene and undertaking CPR without ILS supervision.

416. The Trust has located evidence of unplanned CPR drills being conducted in March and September 2024, however cannot locate any documentation determining whether any CPR drills were delivered on Willow Ward between September 2024 and February 2026. This has been explored with staff on the ward who cited acuity levels, the availability of Rapid Response staff who are based on other wards and who are required to contribute to drills, and the ability to undertake drills whilst ensuring a safe operational ward which cares for patients with high level needs.

417. A gap in monitoring was identified, whereby not all wards were forwarding the requisite completed reports to the Head of Deteriorating Patients and Resuscitation Training Officer. This gap has since been remedied through the introduction of the Tendable Audit referred to below, which now forms part of the ward audit process and ensures that compliance with the emergency simulation drill requirement is systematically captured and monitored.

418. EPUT does not tolerate non-compliance with the requirement to carry out emergency simulation drills. To strengthen oversight and accountability in this regard, the Trust has introduced a Tendable Audit question requiring wards to confirm, as part of the ward audit process, whether an emergency simulation has been undertaken within the preceding three-month period. Where a ward indicates that no such simulation has taken place, the Head of Deteriorating Patients and Resuscitation Training Officer will engage with the relevant ward to ascertain the reasons for non-compliance and to facilitate the completion of the required exercises.

[I/S]

419. EPUT is unable to disclose the PSII report relating to **[I/S]** at this stage. The agreed submission date for the report was 9 June 2026, but the report did not meet that deadline. The PSII report is currently going through further review and checks. EPUT commits to disclosing the report to the Inquiry as soon as it is complete and the report has been finalised.

PART 17: INTERIM RECOMMENDATIONS

420. EPUT's view on what needs to improve in relation to deteriorating patients, emergency response and resuscitation in order to improve outcomes for patients at EPUT and nationwide, in the context of the Inquiry's interim recommendations hearing, is as follows:

421. EPUT provides community health, mental health and learning disability services for a population of approximately 3.2 million people in a variety of settings ranging from inpatient wards to the patient's own home. In the event of a cardiac arrest in any setting, all EPUT staff must be able to recognise and respond appropriately to maximise the patient's chances of survival.

422. EPUT recognises that the delivery of effective emergency care for deteriorating patients within a mental health inpatient setting presents challenges that are materially different from those arising in an acute hospital environment. EPUT sets out, constructively and candidly, the areas in which improvement is needed both within EPUT specifically and across the mental health inpatient sector nationally. It is intended to assist the Inquiry in understanding the structural and operational context in which those challenges arise, and to propose realistic, evidence-based actions aligned with national guidance.

Early Recognition of Deterioration and Resuscitation Response

National Guidance

423. The National Confidential Enquiry into Patient Outcome and Death report “A Picture of Health?”, the most comprehensive national review of physical healthcare in mental health inpatient settings, recommended that on admission to a mental health inpatient setting, a physical health assessment (including baseline observations) should start within 4 hours, in line with the Royal College of Psychiatrists' Standards for Inpatient Mental Health Services (2019).

424. NICE NG94 (Acutely ill adults in hospital: recognising and responding to deterioration, 2007, updated 2020) provides the principal national framework for recognising deterioration. Whilst NICE NG94 was designed primarily for acute hospital settings, NHS England has consistently stated that its principles, including structured observation, track-and-trigger systems such as NEWS2, and defined escalation pathways, apply equally in mental health inpatient settings. Key recommendations include:

a. Physiological observations should be monitored and recorded at the time of admission or initial assessment.
b. A clear monitoring plan must be in place for every patient.
c. Any patient whose NEWS2 score is elevated must trigger a graded response.
d. NHSE/I Patient Safety Alert, "Resources to support staff to deliver basic medical care in mental health inpatient settings", specifically identified the risk of staff in mental health settings not having the skills or confidence to respond to medical emergencies and required providers to:
e. Ensure that all staff in mental health inpatient settings are trained in immediate life support (ILS) or basic life support (BLS).
f. Have a documented process for summoning emergency assistance.
g. Audit compliance with medical emergency response arrangements.

Current Practice

425. EPUT has policies and procedures in place that embed the recommendations made in the above guidance and reports. For example, in EPUT's mental health and learning disability settings, baseline clinical observations are to be recorded within 4 hours of admission and a NEWS2 chart completed. NEWS2 are to be recorded every 24 hours for the first 72 hours of admission unless more frequently recommended by the admitting doctor. If baseline clinical observations are considered by the multidisciplinary team to be within normal range after 72 hours, observations must be recorded as a minimum once daily for patients on older people's wards, and every 7 days for patients on all other wards until discharged (CG87 – Clinical Guidelines on the use of NEWS2 Exhibit MK2-028)).

426. Mental health inpatient units are designed and staffed to care primarily for patients experiencing acute mental illness. Unlike patients on acute medical or surgical wards, patients admitted to mental health wards are typically ambulatory and are not, as a matter of routine, subject to continuous physiological monitoring of the kind that would be standard in an acute hospital setting, such as continuous cardiac monitoring, automated blood pressure monitoring, or pulse oximetry. The clinical focus of the ward environment is on mental health presentation rather than physical health surveillance.

427. A patient who is showing early signs of cardiovascular instability may not be identified as quickly in a mental health inpatient setting as they would be in an acute

hospital, where continuous monitoring and regular clinical observations by staff with acute medical training are the norm.

428. The particular challenges that arise in the mental health inpatient setting include that patients may lack capacity, refuse assessment, or become agitated or aggressive during an emergency response, and this may have an impact on the delivery of timely and effective resuscitation. The non-contact physical observations tool must be used when it is not possible to record a service user's physical health parameters, for example, because the service user refuses to have their vital signs recorded or following rapid tranquilisation.

429. The existence of this tool demonstrates that EPUT has recognised and adapted to the challenge of patient refusal; however, the clinical implications of repeated non-contact observations, and the thresholds at which a refusal to be assessed should itself trigger escalation, require greater clarity and embedding in training. EPUT recognises that improvements include the production of structured guidance for staff on how to manage the intersection of mental health presentation and physical deterioration risk, including when to involve medical staff despite a patient's refusal.

430. Mental health inpatient units are frequently located in buildings that are physically separate from the main acute hospital, either on the same broader site or on an entirely different site. Unlike patients admitted to acute hospital wards, patients on mental health wards cannot, as a matter of routine, access the crash teams and specialist resuscitation resources that are immediately available within an acute hospital setting. This structural difference is not the result of any failing on the part of any individual Trust but is an inherent feature of the way in which mental health inpatient services are organised and delivered across the NHS.

Areas for Improvement – EPUT

431. In terms of seeking emergency help to patient quickly and effectively, improvements could include;

a. Mapping all inpatient sites against response time estimates for ambulance arrival, to quantify the isolation gap at each site;

b. Ensure that 999 call protocols are displayed prominently and that staff are trained in their use, including the provision of precise location information to the Ambulance Service;

c. Ensure a nominated individual is always available to direct ambulances arriving on site and escort emergency service personnel to the scene.

Areas for Improvement - National Recommendations

432. A recurring theme across the issues identified above is the absence of national standards calibrated specifically to the mental health inpatient setting. NICE NG94 does not address the specific challenges of mental health settings e.g., patients who may be unwilling to have observations taken, lack of on-site medical cover, and distance from acute hospital facilities. RCUK guidelines do not specifically address the unique configuration of mental health wards, including locked wards, wards without resident medical staff overnight, or learning disability settings where patients may have anatomical or behavioural factors affecting resuscitation. There is no national minimum staffing standard specifying how many staff trained to ILS/ALS level must be present on a mental health inpatient ward at any given time.

433. EPUT submits that national improvement in this area requires:

a. A single, dedicated national standard for resuscitation and deteriorating patient management in mental health inpatient settings, replacing the current patchwork of guidance from multiple bodies;
b. Clearer requirements for physical health monitoring frequencies that are differentiated according to patient risk profile, not merely inpatient status;
c. Scenario-specific training guidance addressing each of the six specified circumstances within a mental health inpatient context;
d. Minimum standards for escalation pathway design where mental health units are not co-located with acute crash team facilities; and
e. A national reporting mechanism for resuscitation events in mental health settings, analogous to acute hospital reporting, to enable system-wide learning.
f. A single national standard specifying minimum NEWS2 trigger thresholds specifically calibrated for mental health and learning disability inpatient settings, as distinct from acute hospital settings.

Resuscitation Training Standards

National Guidance

434. RCUK 2021 Guidelines are the primary national standard for resuscitation. They apply to all clinical settings and require:

a. All clinical staff to be trained in basic life support (BLS) at minimum, with a proportion trained to ILS or ALS level.
b. Resuscitation equipment (defibrillators, airway equipment, emergency drugs) to be available, maintained, and regularly checked.

435. RCUK Quality Standards for Mental Health Inpatient Care (Published May 2014; Last Updated May 2020) apply to settings that deliver mental healthcare, referring predominantly to mental health inpatient units that provide care for adults of all ages, adolescents, and children. It requires:

a. Every organisation must have an identified board member who is responsible for resuscitation services,
b. That there is defined financial support for the resuscitation service structure,
c. Every organisation must have at least one person, (a resuscitation officer (RO), resuscitation lead, resuscitation services manager, or equivalent), who is responsible for co-ordinating the teaching and training of staff in resuscitation.
d. All healthcare staff must undergo resuscitation training at induction and at regular intervals thereafter to maintain knowledge and skills. Training must be to a level appropriate for the staff member's expected clinical responsibilities.
e. Clinical staff in each mental health inpatient facility should receive regular update training in physical health skills in addition to ILS, in response to an assessment of need undertaken by each organisation.
f. The organisation must ensure that the resuscitation team or designated responding staff are activated within 30 seconds of the call for help. A daily test call is recommended as a minimum. Responses to test calls must be monitored and any failure must be followed up and remedied immediately.
g. Organisations must have policies and procedures in place for resuscitation in special circumstances, including blood loss due to trauma, suffocation, application of a ligature to the neck and hanging, self-harm, seclusion, and rapid tranquilisation.

436. NCEPOD 2022 specifically highlighted resuscitation-related concerns in mental health settings:

a. Several patients who suffered cardiac arrest or severe physical deterioration did not receive timely and effective resuscitation.
b. Case reviewers noted that delays in calling 999 contributed to poor outcomes in a number of cases.

437. NCEPOD recommended that all mental health inpatient staff should receive annual resuscitation training appropriate to their role, and that AEDs (automated external defibrillators) should be accessible on all inpatient wards within defined response times.

a. NHSE Prompt 2019 Patient Safety Alert required Trusts to confirm that:
b. Staff competencies in BLS/ILS are maintained.
c. Defibrillators are available and staff know how to use them.
d. DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions are appropriately documented and communicated.

438. National guidance from NICE, the CQC and the Resuscitation Council UK has, over time, increasingly recognised the need for ILS-level training in settings where restrictive interventions are used.

Current Practice

439. Within EPUT the technical and non-technical skills relating to CPR training (both BLS and ILS) are assessed during mandatory face-to-face annual life support training. The Ward Manager, Matron or Service Manager/Clinical Lead for each inpatient setting is responsible for ensuring that medical emergency simulations are undertaken every three months in the clinical environment, and each inpatient setting must record when a medical emergency simulation is facilitated using the approved Medical Emergency Simulation Practice Report document (KS12-021 – CLP14 CPR Policy).

440. Mental health inpatient staff are primarily trained in the assessment and management of mental illness and have materially less frequent exposure to medical emergencies than colleagues working in acute hospital settings. Staff working in mental health services consistently face challenges in maintaining resuscitation

competency and confidence given the relatively low frequency with which they encounter cardiac arrests and other life-threatening emergencies.

Areas for Improvement - EPUT

441. Annual training and quarterly simulations are necessary and meet the standard set by the RCUK but may not be sufficient in a mental health inpatient setting which can include; ligature, choking, overdose, serious self-harm by cutting, drowning, and head banging, each requires a different pre-resuscitation sequence before standard CPR can be commenced. For example, a ligature requires cutting and airway management before chest compressions; an overdose may require Naloxone administration; and a patient found in water requires removal from the hazard before any resuscitation. Simulation exercises should be designed to rehearse these specific scenarios, not generic cardiac arrest algorithms alone. Clinical staff should also receive regular training in physical health skills

442. EPUT recognises that improvements would include:

a. Ensuring that at least one simulation per year per ward specifically rehearses a scenario relevant to each of the six specified circumstances;
b. Audit simulation records to confirm they are being completed quarterly as required, and identify wards where compliance is deficient;

Areas for Improvement - National Recommendations

443. There is currently no unified national standard specifying the precise training requirements for mental health inpatient nursing staff in relation to the six specified circumstances. National bodies should issue clear, setting-specific guidance addressing scenario-based training requirements for mental health inpatient staff, distinguishing these from the standards appropriate for acute hospital staff and community-based staff.

444. No mental health-specific resuscitation guidance exists addressing the specific challenges of resuscitating patients in mental health settings, including:

a. Patients on high-dose antipsychotics (which carry a risk of QTc prolongation and sudden cardiac death).
b. Patients with learning disabilities who may have complex airway or cardiac anatomy.
c. The impact of restraint-related incidents on resuscitation scenarios.

d. Locked ward environments and their impact on AED/equipment access times.

Incident Review and Learning

Current Practice

445. The Head of Deteriorating Patient Pathway and Resuscitation Training Officer will review resuscitation event report forms and will provide support for staff by attending SWARM huddles or debriefs and delivering subsequent refresher training if required.

446. The Associate Director and Medical Director are responsible for taking appropriate action from audit results, acting upon any lessons learnt from the root cause analysis and disseminating those lessons.

Areas for Improvement - EPUT

447. EPUTs framework for post-event learning is sound in policy terms (CPR Policy (CLP14, sV 3.0) and the CPR Procedure (CLPG14A, v 15.2)). The challenge lies in consistent implementation and meaningful dissemination. EPUT recognises that it can improve by:

a. Improving the process by which Datix and Patient Safety findings outcomes are disseminated to frontline ward staff, with documented evidence that learning has been received and understood;
b. Ensuring that the annual report of resuscitation events and patient outcomes, as required by the policy, is produced, reviewed at the appropriate governance group, and that its findings are acted upon.

448. EPUT is committed to continuous improvement in its response to deteriorating patients and in the delivery of resuscitation within its inpatient settings. The challenges identified in this statement are real, but they are not unique to EPUT - they are structural features of the way in which mental health inpatient care is organised and delivered nationally. Addressing them effectively requires both local action to improve training consistency, escalation protocols and post-event learning and national leadership, to provide clear, setting-specific guidance that reflects the material differences between mental health inpatient and acute hospital environments.

STATEMENT OF TRUTH

The facts stated in this witness statement are true to the best of my knowledge and belief.

Name: Dr Kallur Suresh

Signed: [I/S]

Dated: 09/09/2026

Name: Ann Sheridan

Signed: [I/S]

Dated: 09/09/2026

Appendix One

Subject Matter Experts/Contributors to Dr Suresh's Thirteenth Witness Statement and Ann Sheridan's Sixth Witness Statement

Name of SME/Contributor	Job Title
[I/S]	Service Manager
	Head of Compliance and Emergency Planning
	Operational Service Manager, Adult Acute Inpatient Services and PICU (South West), MH Urgent Care Dept and Neuromodulation Service Trustwide
	Functional Lessons Analyst & Head of Shared Learning
	Training Manager
Gill Brice	Director of Education Learning and Development
Harbens Kaur	Associate Director of Legal Services
[I/S]	Quality Governance Lead
	Service Manager for Children and Adolescent Mental Health Services and Service Manager
	Service Manager Specialist Services
Lucy Beach	Director of Safety
[I/S]	Interim Operational Service Manager, NE
	Operational Service Manager, North West Essex Mental Health Urgent Care and Inpatient Services

Name of SME/Contributor	Job Title
Nick Archer	Head of Deteriorating Patient Pathways and Resuscitation Training Officer
[I/S]	Clinical Advisor & Patient Safety Specialist
Natasha Dominque	Deputy Director, Quality & Safety – Inpatient and Urgent Care
[I/S]	Service manager (Inpatient and Emergency services, Mid and South)

Subject Matter Experts/Contributors to Rule 9 (149b) Statement

Name of SME / Contributor	Job Title
[I/S]	Consultant Psychiatrist | Deputy Director of Medical Education
Allison Dossiter	Director Chief Pharmacist (Community Delivery)
[I/S]	Patient Safety Lead - Inpatient and Urgent Care
Angela Wade	Director of Nursing, Director of Infection Prevention and Control
Anna Davis	Associate Director of Specialist Services
[I/S]	Clinical Lead for Safety and Family Liaison Officer's Patient Safety Specialist
	Service Manager
Cindy Weaver	Associate Director of Mental Health Inpatient and Urgent Care Services
[I/S]	Head of Compliance and Emergency Planning
	Head of Operational HR
	Functional Lessons Analyst & Head of Shared Learning
	Head of Clinical Transformation

Name of SME / Contributor	Job Title
Gemma Wood	Training Manager
Gill Brice	Director of Education Learning and Development
Joanne Fordham	Medical Education Manager
Kellie Miles	Temporary Staffing Manager
Kelly Gibbs	Associate Director People – Resourcing
Lidia Woods	Clinical Manager
Lizzy Wells	Executive Chief Operating Officer
Louise Borton	Matron
Louise Rose	Quality Governance Lead
Louise Summers	Service Manager for Children and Adolescent Mental Health Services and Service Manager
Lucy Beach	Director of Safety
Martin Mizen	Senior Director of Estates and Facilities
Matthew Ling	Director of Pharmacy and Accountable Officer for Controlled Drugs
Nick Archer	Head of Deteriorating Patient Pathways and Resuscitation Training Officer
Nicola Armstrong	Clinical Advisor & Patient Safety Specialist
Nicola Greenhalgh	Deputy Chief Pharmacist, Inpatient, Specialist and Secure Services Interim Medicines Safety Officer
Nicola Jones	Director of Risk and Compliance
Nicky Reeves	Head of Organisational Development
Phil Stevens	Senior Datix Manager
Sarah Pemberton	HEALTH AND SAFETY & VIOLENCE AND ABUSE PREVENTION & REDUCTION MANAGER and LIGATURE CO-ORDINATOR
Tara Merrell	Service manager (Inpatient and Emergency services, Mid and South)
Tendai Ruwona	Associate Director of Mental Health Inpatient and Urgent Care Services
Tsitsi Adiukwu	Senior Clinical Advisor EPUT Inquiry Team
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