PART 2 – EXPERT REPORT FOR THE LAMPARD INQUIRY

15 SEPTEMBER 2026

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1 BACKGROUND AND MY INSTRUCTIONS

1.1 My medical degree is from Emmanuel College, Cambridge University, and the University of Cambridge School of Clinical Medicine (1990). My bachelor's degree is in Medical Sciences and Pharmacology (1988). I am registered with a licence to practise, and on the Specialist Register of the General Medical Council (number 3467499). I am a Fellow of the Royal College of Anaesthetists, the College of Intensive Care Medicine and the Royal College of Physicians. I have been a Consultant at Southmead Hospital, Bristol NHS Foundation Trust since 1999 and work full time providing anaesthesia and caring for critically ill or injured adults. Southmead Hospital has a 48-bedded intensive care unit and is one of the busiest in the UK. I am a national and international expert in cardiac arrest treatments, guidelines and outcomes.

1.2 As stated in my Part 1 report, I am not a psychiatrist so have not commented on specific psychiatric diagnoses and mental health issues as these fall outside my expertise – the focus of my opinion relates to resuscitation and physical health issues.

1.3 I have been instructed by The Lampard Inquiry to assist with regard to the emergency response and resuscitation on mental health wards. I note that the inquiry has already had a written statement and oral evidence from the Resuscitation Council UK (RCUK)[1]. I am a former President of the RCUK (2009-2012), and I am currently a member of the Executive Committee. I helped develop the RCUK Immediate Life Support (ILS) course from its inception in 2000[2], and chaired the RCUK ILS Subcommittee up to 2016. Since 2016, I have chaired the RCUK Advanced Life Support (ALS) Subcommittee. Both the ILS and ALS Subcommittee roles have included developing the course content, training

[1] https://www.resus.org.uk/ [accessed 20 August 2026].
[2] Soar J, Perkins GD, Harris S, Nolan J. The immediate life support course. Resuscitation. 2003 Apr;57(1):21-6.

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materials and regulations. RCUK is a charity and all my RCUK roles have been in a voluntary capacity. I am providing this report in a personal capacity and the opinions expressed are my own. I have provided expert reports as an independent expert for solicitors and Inquests concerning deaths in mental health inpatient settings.

1.4 This is Part 2 of my Report. In Part 1 I provided an expert opinion concerning 'Clinical information about cardiac arrest and cardiopulmonary resuscitation (CPR) in special circumstances that are relevant to mental health wards'. For Part 2, my letter of instruction asks me to provide an opinion on the following:

a. 'The extent to which the following current Essex Partnership University NHS Foundation Trust ("EPUT")'s policies, procedures and training (both trust-wide and any local arrangements for specific units) comply with RCUK Guidelines and Quality Standards, NICE Guidance and any other relevant national standards:
    i. CLP14 CPR Policy sV 3.0 dated April 2026;
    ii. HR21 Induction and Mandatory Training Policy sV 3.0 dated January 2026;
    iii. CG87: Clinical Guidelines on the Use of National Early Warning Scoring System (NEWS2) sV1 dated March 2025;
    iv. Basic Life Support Training Lesson Plan and Basic Life Support Summary & Competencies. Please note that the Inquiry is providing you with two versions of the Basic Life Support Training because EPUT updated its lesson plan in August 2026;
    v. In-house non-mandatory refresher training;
    vi. Immediate Life Support Training.
b. In answering [that] question, please:
    i. set out the national standards applicable to training in mental health inpatient settings from April 2017 to date; explain the clinical and practical significance of the distinction between Basic Life Support training, Immediate Life Support training and Advanced Life Support training and assess EPUT's current training provision as against current national standards;
    ii. provide your opinion on the extent to which EPUT's current policies and procedures adequately address the special circumstances addressed in your Part 1 Report;

iii. Clearly identify any areas where you consider there may be an ongoing patient safety risk.'

1.5 In addition to the above, I have been provided with further documents to comment on:

a. Mr Nick Archer's witness statement. Mr Archer is EPUT's Head of Deteriorating Patient Pathway and Resuscitation Training Officer [STAF028088].
b. RM05 Therapeutic and Safe Interventions and De-escalation (TASID) Policy, sV 3.0, 12 November 2025 [EPUT024967].
c. CG52 Clinical Guidelines for the Pharmacological Management of Acutely Disturbed Behaviour, sV 1.1 [EPUT023438].
d. Twelfth statement of Dr Kallur Suresh and exhibits [EPUT023406].
e. NHS England's statement to the Inquiry and 13 exhibits.

1.6 I will first set out the relevant guidelines, standards and available training courses – much of the background information is already in my Part 1 report. I will then review each document against those standards.

1.7 Importantly, for all healthcare organisations, including EPUT, it is the translation and implementation of the policy and procedure documents into the delivery of safe and effective patient care that matters – all organisations will have a large number of policy and procedure documents and those concerning resuscitation and emergency care will only make up a small proportion of these. The systems in place for implementation are key. In general:

a. System focused and engineered interventions work best such as engineering out ligature points or other risks so that incidents cannot occur, as these do not rely on a conscious effort by staff to implement.
b. Standardisation and simplification of structures and processes will also help mitigate risk; for example having the same types and brands of equipment in every clinical area helps standardise the training needed for staff and makes it easier for staff to work between different areas in an organisation. When procedures and policies and the systems to implement them work well, staff are more likely to follow them.
c. Use of checklists and prompts such as the 'SBAR' handover tool or well-designed validated checklists help mitigate risks and harm. SBAR stands for Situation, Background, Assessment, Recommendation – it is a standardised structured

communication tool widely used in the NHS, to ensure clear, concise, and safe handovers of patient information between staff.

d. Asking staff to be more vigilant, work harder, or be careful, or interventions relying on memory are the least effective and most prone to failure, especially at busier or more stressful times.

2 GUIDELINES, STANDARDS AND TRAINING COURSES

Guidelines

2.1 Resuscitation Council UK (RCUK) guidelines are updated every 5 years – the relevant guideline years for the Inquiry are 2000, 2005, 2010, 2015 and 2021 (the guidelines launch was put back a year by the pandemic). The most recent guidelines are from 2025 and are the guidelines currently available on the RCUK website[3]. From 2017, the relevant guidelines were the 2015, 2021, and 2025 RCUK guidelines. I have been involved in writing RCUK guidelines since 2005.

2.2 RCUK guidelines follow the European Resuscitation Council (ERC) guidelines that are launched on the same 5-year cycle and are followed in most European countries and some outside Europe. There are some local UK modifications but these are relatively small and have got fewer over time. The scientific basis for the guidelines comes from the International Liaison Committee on Resuscitation (ILCOR)[4], a global organisation that generates Consensus on Science and Treatment Recommendations (CoSTRs) using internationally recognised evidence evaluation and guideline writing processes. ILCOR CoSTRs are used by the ERC and other organisations, e.g., American Heart Association, and resuscitation guidelines are similar globally on core issues such as how to recognise cardiac arrest, start CPR, use an AED, and give oxygen. I have had lead roles in the ERC and ILCOR outputs for adult resuscitation starting with the 2005 guidelines.

a. The guidelines aim to cover all types of patient groups (newborn, children, adults) and potential rescuers – lay people, those with a duty to respond in non-clinical roles (e.g., first aiders, lifeguards), and those in clinical roles.

[3] https://www.resus.org.uk/professional-library/2025-resuscitation-guidelines [accessed 26 August 2026]
[4] https://www.ilcor.org/ [accessed 26 August 2026].

2.3 Key tools for assessment, identifying patients at risk of physical deterioration and escalation of treatment are early warning scoring systems based on clinical assessment and vital sign measurement. These help frontline staff identify patients who are physically unwell, and escalate treatments based on a predetermined response. These scoring systems were designed based on data from acute hospital medical and surgical patients, but have been also implemented in other care settings including mental healthcare settings:

a. For adults, the National Early Warning Score (NEWS) is recommended for these purposes – NEWS was launched by the Royal College of Physicians in 2012, and updated as NEWS2 in 2017[5]. Each measured vital sign (pulse, blood pressure, respiratory rate, oxygen saturation level, need for oxygen, consciousness, temperature) is given a score from 0 to 3 based on how far it is from the normal range, and these numbers are added together for a total score. The total score determines the escalation in care required (e.g., increased frequency of vital sign measurement, review by a doctor, calling an ambulance or resuscitation team). The NEWS and NEWS2 systems were derived from acute hospital inpatient vital sign data and were first used by acute hospitals. It was adopted more widely only after studies showed that it performed well outside acute hospitals – I am not sure exactly when mental health settings started using the NEWS score. It is likely that this was after 2017 – an NHS England document on sepsis guidance and implementation advice for adults published in September 2017[6] includes [point 7] 'NEWS is recommended for use in hospitals including mental health hospitals and in ambulance services and in prison healthcare.' There was also a patient safety alert from NHS England and NHS Improvement in April 2018[7] that stated the aim that all acute trusts and ambulance trusts caring for adult patients 'fully adopt NEWS2 for adult patients by March 2019'. This alert did not mention mental health trusts.

b. The equivalent for children is the Paediatric Early Warning System – I do not treat children in my current day to day clinical work and am less familiar with these. The current PEWS system was launched in 2023 – the Charts and links are available through NHS England[8] – PEWS is more complex than NEWS as normal vital sign

[5] https://www.rcp.ac.uk/resources/national-early-warning-score-news-2/ [accessed 26 August 2026].
[6] https://www.england.nhs.uk/wp-content/uploads/2017/09/sepsis-guidance-implementation-advice-for-adults.pdf [accessed 11 September 2026].
[7] https://www.england.nhs.uk/wp-content/uploads/2019/12/Patient_Safety_Alert_-_adoption_of_NEWS2.pdf [accessed 11 September 2026].
[8] https://www.england.nhs.uk/get-involved/cyp/pews/ [accessed 13 September 2026].

values change as children grow from babies to infants, to children and teenagers and this requires separate scoring charts for 0-11months, 1-4 years, 5-12 years and 13 years and over.

c. The NEWS and PEWS systems are taught on Resuscitation Council UK courses for adults and children respectively.

2.4 Relevant guidelines from NICE (National Institute for Health and Care Excellence) include:

a. CG50 – Acutely ill adults in hospital: recognising and responding to deterioration[9] – this was published in 2007 but had a minor update in 2019 to include NEWS 2. The text in this document is specific for acute hospitals patients but much of the guidance can be extrapolated to other care settings including mental health – NHS England has recently (2024) launched the PIER approach which 'will enable the effective management of acute physical deterioration in health and care and will apply to all conditions, clinical settings and specialities'[10]. PIER stands for:

   i. Prevention: planning ahead of any episode of deterioration to stop what is preventable, considering indicators of risk and patient choice.

   ii. Identification: tools and methods to identify when deterioration is occurring in a standardised way – this includes the use of tools such as NEWS2 and PEWS.

   iii. Escalation: timely escalation of care when deterioration has been identified using standardised communication tools.

   iv. Response: timely, appropriate and effective response to escalation of the deteriorating patient/person.

b. NG10, Violence and aggression: short-term management in mental health, health and community settings (Published 28 May 2015)[11]. This replaced NICE CG25, Violence, The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (February 2005). Of note the 2005 guidance specifically stated the RCUK Immediate Life Support Course (ILS) course, whereas the 2015 NICE guidance used the generic term 'immediate life support' as

[9] https://www.nice.org.uk/guidance/cg50 [accessed 26 August 2026].
[10] https://www.england.nhs.uk/patient-safety/managing-acute-physical-deterioration-through-the-prevention-identification-escalation-response-pier-approach/ [accessed 23 August 2026].
[11] https://www.nice.org.uk/guidance/NG10 [accessed 26 August 2026].

opposed to the RCUK ILS course – this change implies that the precise training required in this document can be determined locally.

2.5 The Care Quality Commission produced 'Brief guide: Immediate Life Support training for services that may use restrictive interventions' in March 2020[12]. This aims to clarify training requirements for staff and align them with the RCUK Quality Standard with regards basic and immediate life support training:

a. This guidance from CQC is again not explicit that this must be an RCUK ILS course, only that it must be in line with the RCUK guidelines and standards. The RCUK standards do however refer specifically to the RCUK ILS course.

b. The CQC guidance states: 'All clinically trained staff (doctors, registered nurses), who deliver or are involved in rapid tranquilisation, physical restraint and seclusion are trained in ILS. Training compliance, policy and rotas should ensure 24/7 access to ILS trained staff' – the main difference with the RCUK standard is that RCUK does not specify that ILS training is only for doctors and registered staff. In addition, the NICE NG10 guidance also does not stipulate that only registered staff should be trained in ILS.

c. Importantly, CQC registration is a legal requirement for any health or social care provider in England including mental health providers. Services are rated based on CQC inspections and ongoing monitoring – this means that this CQC brief guide should carry significant weight in local decision making. The CQC position does mean that mental health organisations do not have a driver to train non-registered staff in ILS. The CQC does emphasise the need for 24/7 availability of ILS-trained staff.

Standards

2.6 Resuscitation Council UK Quality Standards: Mental health inpatient care[13] (Published May 2014; last updated May 2020) is the current standard produced by RCUK to support resuscitation activities in mental health inpatient settings. I have addressed the contents of this document in my Part 1 report.

[12] https://www.cqc.org.uk/system/files?file=20200325_briefguide-LifeSupportTraining.pdf [accessed 26 August 2026].
[13] https://www.resus.org.uk/library/quality-standards-cpr/mental-health-inpatient-care [accessed 26 August 2026].

2.7 The Royal College of Psychiatrists has produced Core standards for mental health inpatient services[14] – the most recent version is the 5th Edition, 2026:

a. Standard 16.17 is listed as a Type 1 Standard. Type 1 Standards are essential standards. A failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These Type 1 standards also include the fundamentals of care, including the provision of evidence-based care and treatment. Standard 16.17 states 'Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.' The reference given is the RCUK Quality Standards document referred to above – of note is that RCUK document does not make a specific recommendation for frequency of checks as long as the equipment is always available for use when needed.

b. Standard 18.4 – (Type 1) states: 'There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an urgent situation.' In my opinion this guidance does mean that immediate access to a doctor in an emergency may not be possible. In addition, the recommended time for a doctor to attend does in effect mean that doctor could be on another site or at home.

c. Standard 21.1b – (Type 1) states: 'Physical health assessment and management, including management of the physically deteriorating patient. Guidance: This could include training in understanding physical health problems, undertaking physical observations, using early warning scores (e.g., NEWS2), identification and management of the medically deteriorating patient and basic life support'. The Immediate Life Support course or equivalent training is not mentioned, and the RCUK Quality Standard is not referred to.

2.8 As mentioned already, the Care Quality Commission (CQC) has produced 'Brief guide: Immediate Life Support training for services that may use restrictive interventions' in March 2020[15]. This aimed to clarify the existing RCUK standard and NG10. As explained earlier in this report, however, it goes further, in that it identifies only doctors and registered nurses as requiring ILS training. The CQC guidance also states 24/7 access to ILS-trained staff but in my opinion falls short by not stating that this access needs to be

[14] https://www.rcpsych.ac.uk/improving-care/ccqi/resources/core-standards-project [accessed 26 August 2026].
[15] https://www.cqc.org.uk/system/files?file=20200325_briefguide-LifeSupportTraining.pdf [accessed 26 August 2026].

immediate, i.e., arriving at the patient within about the first minute after the call for help.

2.9 The CQC document does include two issues that are different to the RCUK standards:

a. It recommends 'Emergency equipment is immediately available (within three minutes if shared between wards), including basic life support equipment (e.g., automated external defibrillator, self-inflating bag mask devices or mouth-to-mask devices)' – the RCUK standards document defines immediate as 'available for use within the first minutes of cardiorespiratory arrest (i.e., at the start of the resuscitation)' and does not mention sharing equipment between wards, as irrespective of whether it is shared or not the time for availability should be the same. In addition, the RCUK standards document state that if the patient is in cardiac arrest with a shockable rhythm, the shock should be given within 3 minutes, i.e., to achieve this target, the defibrillator and staff would need to arrive much earlier than 3 minutes, be attached to the patient and the heart rhythm analysed.

b. The CQC states that equipment is maintained and checked at least weekly – this is not in the RCUK standards, but is in the Royal College of Psychiatrists standards documents. The RCUK standards leave this issue to be determined locally as long as the equipment is always available when it is needed.

2.10 An area of contention has always been whether the 'ILS' training has to be the RCUK ILS course or an equivalent course developed locally or by a private training provider – in the past, although I am less familiar with the situation now, it was not uncommon for RCUK to get queries about ILS training or asking for an RCUK ILS certificate when they had done local or private ILS-equivalent training.

2.11 There has been a move in guidance from national organisations such as NICE, CQC, GMC (General Medical Council) and NHS England not to specify a specific training course from an organisation such as the RCUK and use more generic terms – the RCUK has commented on this issue in 2011[16] and 2023[17]. In my opinion one driver is to save on cost and training time – RCUK courses are tightly regulated with regards to who can

[16] https://www.resus.org.uk/sites/default/files/2020-05/RC%28UK%29_Courses-VS-EquivalentLocalTraining.pdf [accessed 26 August 2026].
[17] https://www.resus.org.uk/about-us/news-and-events/rcuk-position-statement-alternative-resuscitation-courses [accessed 26 August 2026].

teach them, the training materials and assessments required to get a certificate. Over the past 25 years the duration of the face-to-face training component of the RCUK courses has decreased. The RCUK ALS course was originally a 3-day course, then a 2-day course, and there is now an eALS course that has an e-learning component followed by a 1 day of face-to-face hands on training and assessments. The RCUK ILS course is a 1-day course but there is now an eILS course that has an e-leaning component followed by half a day of face-to-face hands-on training and assessments. The significant drivers for these changes have been the cost of running the courses, and a lack of staff or instructor time either to attend or deliver the training.

2.12 Resuscitation training falls under 'mandatory training' for all NHS staff and this includes mental health inpatient settings – resuscitation training therefore competes with a large and growing list of training clinical staff have to do and repeat as part of their daily work (e.g., fire, cybersecurity, information governance, manual handling, infection control, safeguarding, health and safety, Oliver McGowan training, mental health and capacity, conflict resolution) with little time set aside for this and until recently often not portable between NHS organisations[18]. Mandatory annual training for many NHS staff will consist of a short (less than 30 minutes) online module in basic life support and use of an AED with an annual update. Staff in clinical roles that require a higher level of resuscitation training will do additional training including RCUK courses. I will address this further in the next section on resuscitation training courses below.

Resuscitation Training and Courses

2.13 Mandatory training in resuscitation is defined in the Core Skills Training Framework (CSTF), authored and maintained by Skills for Health[19], a charity that has developed e-learning courses for mandatory training in a wide range of subject areas and commissioned by UK health services and NHS England to maintain the framework:

a. According to the website the framework 'was first developed in 2013 and has become widely recognised as the trusted standard for statutory and mandatory training in the health sector. It helps guide and standardise the focus and the delivery of key statutory and mandatory training skills. It was developed in

[18] https://www.england.nhs.uk/long-read/action-needed-to-save-up-to-200000-days-of-staff-time-following-changes-to-statutory-and-mandatory-training/ [accessed 20 August 2026].
[19] https://www.skillsforhealth.org.uk/ [accessed 20 August 2026].

collaboration with employers, industry leading experts and professional bodies, such as the Resuscitation Council and the Infection Prevention Society.'

b. There are two versions of the CSTF[20]:
    i. UK Core Skills Training Framework – Statutory/Mandatory Subject Guide (Version 1.6.2) – version 1 was launched in 2013. RCUK was consulted during 2012, when I was RCUK Chair (the role is now described as President), but has only co-badged the more recent frameworks – I do not know exactly when.
    ii. Core Skills Training Framework (England) Statutory/Mandatory Subject Guide Version: CSTF (England) v1.1, June 2021. For NHS Trusts in England – this is the current version and co-badged by the RCUK.
c. The main differences are that the older 2013 UK version has a 'proposed' frequency of refresher training or assessment and 'Suggested' standards whereas the newer 2021 NHS England document uses the firmer term 'Required' frequency, and has dropped the term suggested for the training requirements.
d. Both versions have defined resuscitation training as Levels 1, 2, 3. Specifically, both documents set minimum training standards, supported by RCUK, structured across three levels: Level 1 (basic awareness – recognising cardiorespiratory arrest, summoning help, starting chest compressions, locating and operating an AED, and aimed at non-clinical staff); Level 2 (Level 1 plus Basic Life Support, split into Adult, Newborn, and Paediatric for clinical staff based on setting), and Level 3 (Level 2 plus Immediate Life Support, for registered healthcare professionals expected to participate in a resuscitation team, including those administering rapid tranquillisation or sedation). 'At levels 2 and 3, practical instruction, i.e., 'hands-on' simulation training and assessment is recommended for clinical staff'. Refresher training is required annually at all three levels in both documents. This document again only requires that Level 3 training is for registered staff – this means that following this framework in a mental health inpatient setting would only require registered nurses to be trained to ILS level. This and the guidance from the CQC would in my opinion be a valid justification for this as long as there is 24/7 immediate availability of an ILS registered nurse staff when an emergency occurs. This would need to be reflected in staffing rotas and the ability to ensure cover remains adequate to enable staff breaks. In addition this document does not

[20] https://www.skillsforhealth.org.uk/integrated-solutions/core-skills-training-framework/ [accessed 28 August 2026].

mention the need for ILS training for physical restraint – this is probably an oversight in my opinion.

e. The documents do not recommend any specific course and state 'Where a staff member or learner can demonstrate the required level of current knowledge, understanding and practice through robust pre-assessment, including where relevant practical assessment, this can be used as evidence that knowledge and skills have been maintained, and the staff member may not need to undertake refresher training.' In my opinion, for staff working in settings where cardiac arrest is infrequent, it is very difficult to maintain skills and knowledge, such that in my opinion most staff will need refresher training to maintain the required level.

2.14 I will cover the training provided by the RCUK below, some of these issues have been touched on in the RCUK statement and evidence to the Inquiry, and Part 1 of my report.

2.15 RCUK does not currently offer basic life support (BLS) training courses – the RCUK quality standards document sets out the minimal levels of training required for clinical and non-clinical staff in mental health settings:

a. Firstly clinical staff covers both non-registered and registered staff who care for patients in a clinical setting. As stated in my Part 1 report, in mental health settings there has been a move towards a larger proportion of staff being non-registered support staff[21]. Non-registered staff include healthcare assistants (HCAs).

b. Most organisations provide in-house training and updates to their staff using their own employed trainer or a trainer from another provider.

c. The trainers should have clinical experience, in my opinion, above the level of the individuals they are training, and tailor the training for the setting where the staff work, including how to call for help, ensure help is coming and where the emergency equipment is.

d. Basic life support training should cover recognition of cardiac arrest and signs of life, calling for help, starting chest compressions, safe use of an AED, the recovery position, and recognising and starting treatment for choking.

[21] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-workforce [accessed 11 September 2026].

e. The training should include specifically how to call for help, and get the emergency equipment in the clinical area where staff are working – having standardised systems and equipment across an organisation makes this easier.

f. Basic life support is taught to both clinical and non-clinical staff. The main difference between clinical and non-clinical staff is that clinical staff are taught rescue breathing using a bag-mask device, and often taught how to use suction.

g. In my opinion, the clinical staff who are most likely to respond immediately to a patient with a life threatening emergency require a higher level of training than provided in BLS training – see below. In my opinion that level is ILS, and it can include non-registered staff such as healthcare assistants.

2.16 Immediate life support (ILS) training builds on the basic skills above:

a. Specifically the RCUK ILS course bridges the gap between basic life support training and the RCUK Advanced Life Support Course. I have addressed the gap in my part 1 report – to put it simply the basic training is too basic, and the advanced training, too advanced for many staff for their clinical role. The RCUK ILS course includes everything taught on BLS course and some skills taught on an ALS course.

b. The RCUK ILS course is a one-day face-to-face course. There is an e-ILS course which consists of a half-day of e-learning and a half-day face-to-face hands-on component - both courses cover the same hands-on skills. ILS was launched in 2002[22] and is now the RCUK's most popular course with about 150,000 people trained per year. ILS was designed for clinical staff to recognise and treat acutely ill patients before cardiac arrest using an ABCDE approach, and start treatments if cardiac arrest occurred including chest compressions, airway and breathing interventions (bag-mask ventilation, i-gel insertion) and defibrillation, and depending on the setting and staff, giving adrenaline and fluids and other specific treatments. These interventions, when delivered early give the best chance of survival and a good recovery, or buy time whilst waiting for help from advanced life support providers to arrive. In my opinion HCAs who are already involved in patient care such as checking vital signs and doing clinical assessments would be able to successfully complete an ILS course. Some skills such as giving drugs and fluids may be outside the scope of practice of non-registered staff, but these are not core skills on the ILS course.

[22] Soar J, Perkins GD, Harris S, Nolan J. The immediate life support course. Resuscitation. 2003 Apr;57(1):21-6.

c. The RCUK ILS course has allowed instructors to adapt the course scenarios to the setting in which the instructors were teaching and to tailor teaching to the staff group – the programme also includes a targeted training session. I note that the RCUK evidence to the Inquiry mentions that mental health-specific ILS course materials and simulation scenarios were introduced in about 2019, with updates since then.

d. RCUK ILS courses were only initially allowed in NHS, private hospital or university settings, but over time much of the training outside acute settings was provided by external instructors or organisations. More recently, after I completed my tenure as the RCUK ILS Subcommittee chair in 2016, RCUK has allowed private training companies to set up as course centres. I do not know the precise date for this change. This change means that there is greater availability of the RCUK ILS course. There is still non-RCUK 'ILS' training available in the UK, including standalone non-RCUK 'ILS' e-learning modules. The RCUK ILS course requires hands-on skills and team skills, and I am uncertain if these are replicated similarly on non-RCUK 'equivalent' courses.

e. In my opinion the RCUK ILS course is the minimum requirement for staff who deliver or are involved in rapid tranquillisation, physical restraint and seclusion – as mentioned already there are differences between what different organisations state:

    i. The RCUK Quality Standards (2020) do not specify staff roles (nurse, doctor, healthcare assistant etc) for who should be trained in the RCUK ILS course.

    ii. NICE NG10 (2015) states 'Staff trained in immediate life support and a doctor trained to use resuscitation equipment' such that the training required for doctors is ambiguous, and does not specifically state it has to be an RCUK ILS course.

    iii. The CQC Brief guide on ILS training (2020) states 'All clinically trained staff (doctors, registered nurses), who deliver or are involved in rapid tranquilisation, physical restraint and seclusion are trained in ILS.' – this guidance does not include non-registered staff such as HCAs, and only implies it has to be the RCUK ILS course.

    iv. The Core Skills Training Framework (CSTF) lists ILS training as Level 3 for registered staff, and does not specify it has to be the RCUK course.

v. The Royal College of Psychiatrists Core Standards only provide guidance on basic life support level training as part of caring for the medically deteriorating patient and are silent on the subject of ILS-level training.

f. My opinion is that registered doctors and nurses should be trained to ILS level, and that ILS training is also suitable for staff in non-registered clinical roles (e.g., HCAs) – this would be the case in settings where HCAs make up the majority of immediate responders to an emergency and a trained registered staff member cannot be guaranteed to attend immediately 24/7.

2.17 RCUK Advanced Life Support (ALS) training covers all the issues covered in BLS and ILS, and additional knowledge of care before, during and after cardiac arrest and primarily aimed at those leading a resuscitation team, or frequently working in settings where resuscitation takes place – the RCUK Quality Standards do state Members of mental health resuscitation teams that have specific involvement in resuscitation, particularly team leaders, require a level of training beyond that provided by local ROs [resuscitation officers]. These people should be encouraged and supported to attend nationally recognised courses, such as the Advanced Life Support (ALS) course.' Team leaders refers to staff who would be leading the resuscitation attempt prior to an ambulance crew or hospital resuscitation team arriving. This recommendation would be difficult to meet in most mental health settings and the person most likely to have an RCUK ALS provider qualification would be a clinical lead for resuscitation who has acquired this whilst working in a post in an acute hospital setting. I also note that Dr Suresh in his statement (number 12) [EPUT023406] dated 21 May 2026 states that EPUT have not provided ALS training, and that some resident doctors may have acquired ALS training in roles prior to joining EPUT.

NHS England's statement to the Inquiry regarding resuscitation training

2.18 Before I review the EPUT policies I will briefly comment on the NHS England's submission to the Inquiry.

2.19 I should say at the outset that I hold an ongoing voluntary role on the Executive Committee of the Resuscitation Council UK. RCUK has been involved in discussions on this topic and at various points over the past year I have been in discussions or commented on proposals from NHS England. I note one of the issues raised by the

proposed changes is a loss of income for the RCUK. I have not had a significant role in the RCUK's work with NHS England on this issue, and the final proposals are new to me.

2.20 I have been provided with the statement of Mr Thomas Simons of NHS England dated 28 August 2026 [NHSE028083] and 13 exhibits. These describe a national programme replacing the Core Skills Training Framework with a new competency-based framework that awaits ministerial approval. New competency assessments and learning content are to follow by April 2027. I have commented on the proposals briefly below.

2.21 The new framework moves from completion of training to demonstration of competence, assessed by situational judgement tests rather than attendance, with everyone required to demonstrate competence once every three years by passing those assessments. The competencies required of all staff are to summon help, to start cardiopulmonary resuscitation on an adult in any environment, and to place and use an automated external defibrillator. Further competencies are additional and tied to defined audiences: managing airways and breathing is for 'staff in a high-risk area or community setting without a cardiac arrest team' (this could include mental health inpatient settings), and using the ALS algorithms is for 'a staff member in high-risk areas'; and responding to self-harm incidents that potentially lead to cardiac arrest is for 'mental health staff, paramedic and accident and emergency staff'.

2.22 Positive aspects include: a competency for responding to self-harm incidents that may lead to cardiac arrest, directed at mental health staff; training regarding ligature; a deteriorating patient competency extending to healthcare support workers as well as registered staff; and proposals to work with the Resuscitation Council UK on the National Cardiac Arrest Audit, to standardise equipment including defibrillators, and to provide 24/7 skills laboratories with automated competency recording, which would address skill decay between assessments.

2.23 I also agree with the use of the hierarchy of intervention effectiveness and with its premise that training is the least effective intervention available and systems based and engineered solutions work best. The issue is that with less weight placed on training, the higher-order intervention system interventions must be put in place.

2.24 The Gateway 1 guidance describes mandatory training as 'the minimum for keeping everyone safe', with anything further determined locally. My concern is that the basic level for most staff including in mental health settings is probably set lower than at present.

2.25 The competencies required of all staff are built around chest compressions and a defibrillator and aimed primarily at primary cardiac arrest – these will only make up a small proportion of cardiac arrests in mental health inpatient settings.

2.26 It appears that mental health inpatient wards may be designated for additional training in airway management because there is no access to a cardiac arrest team.

2.27 It is not clear how the new framework will address guidance such as the need for ILS-trained staff for settings using tranquillisation or restraint.

2.28 I am sure the recommendations in these documents will need clarification as much of the training appears to be through e-learning interventions with the majority of staff receiving either a 15 or 60 minute module and judgement tests as opposed to hands on training. There is a gap between basic and advanced training that a course such as ILS may continue to fill to ensure staff are trained to the local needs. In addition, most staff will only require 3 yearly refresher training. For staff who rarely deal with emergencies, this will be too long in my opinion.

2.29 The proposed framework is not yet published and may therefore change before launch, and how additional local training will be delivered. I suspect there will still be a role for RCUK or similar courses to fill in the gaps in this framework. NHS Trusts have been given the opportunity to feedback on the proposals and EPUT may or may not have provided feedback.

3 MY REVIEW OF EPUT POLICIES

3.1 I have only commented on those issues and sections of the guidance where I have identified specific issues to comment upon.

CLP14 CPR Policy sV 3.0 dated 17 April 2026 [EPUT023452]

3.2 Version 1.0 of this policy was 1 July 2017, with updates in November 2019 (version 3.0, there is no version 2), January 2020 (3.0 again), March 2020 (3.1), November 2022 (3.2), March 2023 (4.0, referencing Immediate Life Support, NEWS2), February 2025 (sV 1.0), and March 2026 (sV 2.0). [0002-3].

3.3 I will first provide a brief background based on the statements of Nicholas Archer [STAF028088], the lead author for this policy and Dr Suresh's evidence [EPUT023406]:

a. From EPUT's formation in April 2017 until 2020, inpatient staff received Enhanced Emergency Skills training delivered by Health Care Training Ltd, which Dr Suresh states included the content recommended by RCUK for immediate life support as well as additional training in line with Trust needs [paragraph 50].
b. From 2020 until September 2022, inpatient staff received 'grab bag training' [Suresh paragraph 50; Archer paragraphs 23 and 28].
c. RCUK ILS training was procured in July 2022 and first delivered in September 2022 [Archer paragraph 28].
d. From October 2019 until March 2023, versions 10 to 13.1 of the CPR Procedure interpreted NICE NG10 as requiring only basic life support for settings where restrictive interventions may be used [paragraphs 15 and 40]. Dr Suresh accepts at paragraph 40 that NG10 and the CQC brief guide both in fact require access to staff trained in immediate life support. The requirement was reinstated in version 15 in March 2023 [paragraph 19].
e. Dr Suresh states [paragraph 16] that the Trust's mandatory training policy continued to require immediate life support training for registered inpatient nursing staff throughout that period. Mr Archer's evidence that RCUK ILS training was only procured in July 2022 from a private company [paragraph 28].
f. The available evidence suggests there was a period of approximately two and a half years during which the staff responding to an emergency on an EPUT inpatient ward

had not completed an immediate life support course. This period falls within the COVID-19 pandemic. The pandemic caused a significant fall nationwide in the number of staff attending ILS courses in the UK due to COVID-19 restrictions causing a decrease in the number of courses offered and the ability of staff to attend courses – this is based on a published study for which I was the senior author[23]. This is not an excuse for EPUT, however.

3.4 The lead author of the policy is a Resuscitation Training Officer [0001], Nicholas Archer. The statement of Mr Archer dated 28 August 2026 [STAF028088] includes their past roles including at a matron level in an acute NHS setting, that they have been in the role since 2022, have an RCUK ALS instructor qualification and teach on the RCUK ALS and ILS courses. In my opinion the policy is led and written by an appropriate member of staff. The report includes:

a. Paragraph 36 includes 'I would not consider that ILS training is appropriate for non-registered staff, since the training requires an understanding of human anatomy and physiology, which is not a competency that can be assumed unless they have received such training elsewhere.' I disagree as the level of knowledge required does not preclude HCAs. Indeed the ILS course is already attended by staff from a wide range of backgrounds including HCAs, and non-clinical staff such as fire officers, military personal, police officers, and cabin crew. The pass rates for these groups are very good and close to 100% [this data is available in Appendix Table 1 in the study about RCUK courses above, footnote 23].

b. Mr Archer's evidence includes the Trust currently has one Resuscitation Training Officer for 52 inpatient wards, he does not attend emergencies, and the response to any medical emergency comes from and is led by the ward team [paragraphs 21 and 22]. It appears the ward team cannot be guaranteed to have an ILS-trained registered nurse immediately available 24/7. In my opinion training the healthcare assistants who will be there is the only way of meeting the standard.

c. Paragraph 74 states that 'annual training in the identification and management of the deteriorating patient is, in my view, essential. This training should be provided to both registered and non-registered staff, recognising that it is frequently the

[23] Thorne CJ, Kimani PK, Hampshire S, Hamilton-Bower I, Begum-Ali S, Benson-Clarke A, Couper K, Yeung J, Lockey A, Perkins GD, Soar J. The nationwide impact of COVID-19 on life support courses. A retrospective evaluation by Resuscitation Council UK. Resusc Plus. 2023 Mar;13:100366. Available at https://www.sciencedirect.com/science/article/pii/S2666520423000097?via%3Dihub [accessed 14 September 2026]

nonregistered staff who are tasked with undertaking physical health observations and completing the NEWS2 chart.' This aligns with my opinion that HCAs are already involved in clinical tasks including vital sign observations – ABCDE skills are addressed on the ILS course and these skills include vital sign monitoring and using the NEWS2 score.

d. Finally, Mr Archer states [paragraph 45] that he does not have the data to confirm whether each ward is carrying out the medical emergency simulations required by the CPR Policy, and [paragraph 51] that he was unaware of the lack of simulations on Willow ward and would have no visibility of a similar gap on any other ward. A specific audit question was added to the Ward Managers' audit in August 2026.

3.5 My comments on the introduction (Section 1) are:

a. The policy is generic for all trust settings that include mental health inpatient settings [1.1, 0007]. This does mean that some issues specific for inpatient settings are not always explicit.

b. The policy states that automated external defibrillators (AEDs) should be 'provided in any healthcare setting, that might reasonably expect to use them, at least once every 5 years' [1.4, 0007]. This guidance may have been used in the past for public settings to justify the cost of an AED, and was also used in RCUK guidance and the National Patient Safety Agency (NPSA) report published in November 2008 – Rapid Response Report NPSA/2008/RRR010: Resuscitation in Mental Health and Learning Disability settings. More recent guidance including the RCUK Mental health inpatient quality standards do not include this requirement.

c. Paragraphs 1.5 and 1.6 refer to NICE NG10, and the need for Resuscitation Council UK ILS training and appropriate equipment for settings using restrictive interventions, with reference to documents from the CQC, and RCUK – these specific references appear to have been added in Version 4.0 in March 2023 [0007].

3.6 My comments on the Principles (Section 2) are:

a. Paragraph 2.1 states the policy's purpose is to ensure CPR 'incorporating the current resuscitation guidelines, as published by the Resuscitation Council (UK), in 2025' [2.1, 0007–0008], and is consistent with the current guidelines cycle.

b. Paragraph 2.2 appropriately signposts, rather than duplicates, the separate DNACPR procedure (CLPG14B) [0008]. I have not been asked to review CLPG14B.

c. Paragraph 2.4 extends NEWS2 monitoring to 'Hospital at Home and Urgent Care Response teams' and applies PEWS to CAMHS and children's community services [0008].

3.7 My comments on the Duties (Section 5) are:

a. Duties cascade conventionally from Trust Board to individual staff member level [5.1–5.9, 0010–0012].
b. Paragraph 5.3 gives the Head of Deteriorating Patient Pathways and Resuscitation Training Officer responsibility for auditing cardiac arrests [0010].
c. I have not identified an equivalent duty assuring continuous (24/7) immediate availability of ILS-trained staff on each ward, of the kind identified in the CQC's Immediate Life Support guidance as a matter for 'training compliance, policy and rotas.' – this is an important gap in my opinion.
d. Paragraphs 5.8–5.9 place equipment-checks on managers and individual staff respectively [0010–0012], but do not cross-refer to any maximum time within which equipment must be accessible, e.g., immediately for a ligature cutter (see my comments on Section 9 below).

3.8 My comments on the Early Warning Scoring System (Section 6) are:

a. Paragraph 6.2's 'non-contact physical observations' tool, for use where vital signs cannot or will not be recorded including following rapid tranquillisation [0012], is an adaptation for mental health settings. In my opinion, the document should state that this non-contact method should be used in exceptional circumstances (e.g., lack of cooperation or resistance with having a hands-on assessment) in patients who appear physically unwell and deteriorating or are having restrictive interventions such as tranquillisation. This is because hands-on assessment, vital sign monitoring and use of NEWS scores will add to the no-contact assessment.
b. These additional measures will help identify and quantify deterioration and lead earlier than just looking at the person. For example a pulse oximeter will detect low oxygen levels in a patient with breathing difficulty, and help identify the need for oxygen therapy before a patient appears a blue or pale colour.

3.9 My comments on the Procedure for CPR (Section 7) are:

a. Paragraph 7.1's reference to 'intermediate life support training' [0013] is in my opinion likely to be a drafting error rather than a distinct training tier – this is probably a remnant of previous versions of the policy before the change to the RCUK ILS course.
b. Paragraph 7.1 requires staff to 'call (9)999 as soon as possible' – the additional '9' I assume is to get an outside line. This also implies that all EPUT settings now rely on an ambulance service response as opposed to a local acute hospital resuscitation team. Dr Suresh [EPUT023406, paragraphs 18, 28, 44 to 46] clarified this in his statement – there was an arrangement under which Basildon Mental Health Unit called 2222 for the acute trust's cardiac arrest team and this terminated on 31 March 2020.
c. Paragraph 7.1 requires 'safe defibrillation, as soon as possible following collapse', but does not itself state the specific 'within 3 minutes of collapse' standard set out in the RCUK Quality Standards: Mental Health Inpatient Care (2020) document. This is a core standard in the RCUK quality standards for all healthcare settings – even if the patient does not require a defibrillator shock, the AED should still be used within the target time frame in my opinion. There is no reasonable justification to depart from the RCUK quality standard in my opinion. If the organisation cannot get an AED and staff to use it to a patient within the target time, it does suggest to me there will be similar failures in delivering other immediate interventions.
d. Paragraph 7.2 requires only that the duty doctor 'is informed and they may need to contribute to the resuscitation event' [0013]. This is ambiguous in my opinion and needs clarification. In my opinion if there is a doctor on site, they should be part of the initial emergency response. I note that Mr Archer states that duty doctors would be trained to a minimum of BLS – given that these doctors may also be asked to prescribe drugs and be involved in tranquillisation as well as attend other emergencies training to ILS level would be more appropriate in my opinion.
e. Paragraph 7.6 mentions using the document in appendix 14 – Calling (9)999 in a medical emergency [R9(149)(A) – Exhibit 12]. This is kept 'in the front pocket of the resus bag or stored with the resus trolley' which in my opinion may limit accessibility and use given the guidance has to be found to be used. Placing a simpler version next to the phones used for emergency calls may be a better option. In the final box, it mentions 'if possible' to use a cordless phone so the call can be made from the patient's location. For inpatient settings this needs to have greater

emphasis so the person making the call can take the phone to the patient area and answer any questions about the patient's condition the ambulance service call handler may have.

f. Paragraph 7.11 addresses adult-BLS-only staff attending a paediatric arrest, advising use of the adult sequence they are familiar with including the paediatric modifications if possible' [0014], reflecting current 2025 RCUK guidance and, in my opinion, an appropriate inclusion given the Trust operates both adult and CAMHS services.

3.10 My comments on Provision and Maintenance of Emergency Equipment and Drugs (Section 9) are:

a. Paragraph 9.1 makes equipment provision to enable staff to carry out both basic and immediate life support in an inpatient setting [0015].

b. I have compared the adult resus bag equipment list at Appendix 9 against the Resuscitation Council UK's equipment and drug lists for adult settings. The bag matches the most 'Immediate' items – including the ligature cutter, oropharyngeal and nasopharyngeal airways, i-gel supraglottic airways (sizes 3–5), oxygen cylinder, defibrillator, and pads – however, I did not identify a stethoscope, laryngoscope, pocket mask, or clock/timer. Many clinical settings have moved away from using pocket masks. The absence of IV cannulation equipment (cannulae, tourniquets, infusion sets) is, in my opinion, more readily explicable: RCUK states these items as dependent on 'local policy and staff training' and CLP14 paragraph 9.11's ward medicines list is confined to intramuscular, buccal, and nebulised drugs, with no intravenous drugs stocked – so the omission is consistent with, rather than contrary to, the Trust's stated scope of practice, provided that scope was itself the product of a documented local risk assessment. I am uncertain if this risk assessment exists.

c. Appendix 9 only includes gloves/aprons/eye protection in a COVID-19 addendum, as opposed to being routinely available for medical emergencies.

d. Paragraph 9.2's requirement for ligature cutters with signed storage in all mental health inpatient areas addresses the ligature-related special circumstance identified in Part 1 of my report – ligature cutters should be immediately available so they can be used immediately.

e. Paragraphs 9.5–9.8's daily/weekly equipment-checking regime [0016] meets, and in respect of some equipment (e.g., Appendix 12's weekly baby/infant inventory) exceeds, RCPsych Core Standards (5th edition, 2026) Standard 16.17.

f. Paragraph 9.11's minimum ward medicines list – including midazolam (seizure), naloxone (overdose), adrenaline/glucose/glucagon (anaphylaxis/hypoglycaemia), salbutamol, aspirin, glyceryl trinitrate, rapid-acting insulin and, on mental health wards, procyclidine [0016-0017]. This appropriately addresses several special circumstances from my Part 1 report. The list also includes flumazenil 500 microgram/5ml solution for injection. Flumazenil is only given intravenously, and CG52 states at paragraph 7.3 that nursing staff are not permitted to administer medicines intravenously. There is no cannulation equipment in the resuscitation bag at Appendix 9 and no intravenous fluid on the ward stock list. In my opinion this means that the antidote to benzodiazepine-induced respiratory depression is held on the ward but cannot be given by any member of staff likely to be present when it is needed, unless a staff member competent in intravenous administration is on site.

3.11 My comments on Training requirements (Section 12) are:

a. Paragraph 12.2's mandatory annual face-to-face BLS/ILS training with assessment [0018] meets the need for annual, practically-assessed refresher training.

b. The wording in paragraph 12.3 is ambiguous on what specific training will be offered as it states, 'in accordance with the RCUK life support guidelines for both BLS and ILS'. There are no RCUK guidelines for ILS – RCUK guidelines exist for BLS and ALS, but there is an RCUK ILS course.

c. Paragraph 12.4's quarterly medical emergency simulation requirement, recorded via Appendix 16, is good practice in my opinion, if these simulations are occurring. I note that the target time on the simulation document for both a doctor and nurse to arrive in an emergency is 3 minutes – this suggests that the expectation is that non-registered healthcare professionals such as HCAs manage up to the first 3 minutes of any medical emergency. This is too long in my opinion, and the time for an ILS-trained nurse to arrive should be within about the first minute. I note that Dr Suresh in his statement [paragraph 63] says that simulations are required every four month whereas the policy says three.

d. I have not identified any reference, within this section, to rota-based assurance of a 24/7 immediately available ILS-trained nurse.

3.12 My comments on Monitoring and audit (Section 13) are:

a. This section lists source information and responsibilities that in my opinion are reasonable but does miss an important source – defibrillators store time-stamped cardiac arrest heart rhythm and resuscitation data and have software that enables review of resuscitation events. Most modern defibrillators can generate event reports that can be used as part of feedback and learning.

b. I note that the document contains two separate paragraphs both numbered 13.3 [0019] – a minor error, but one which, in a document that has passed through committee approvals and ratification, I would have expected to be caught.

c. Paragraph 13.5 states there will be an annual report of resuscitation events and outcomes – if this was in previous versions of this document, I would expect there to be at least one annual report available.

3.13 My comments on the References (Section 16) are:

a. The RCUK 2025 Guidelines were launched on 27 October 2025 such that they could not have been accessed in January 2025 as stated.

b. I note that NICE NG10, referred to in paragraph 1.5 [0007], is not included in this reference list.

3.14 My review of the appendices includes:

a. Appendices 1 to 5 are the correct and appropriate RCUK algorithms.

b. Appendix 6 [0026] refers to roles of responsibilities of staff attending a resuscitation event:

c. This does not make clear that the target is to use the AED within the first 3 minutes.

d. It states that ILS guidance should be followed for using a bag valve mask device. As stated already ILS guidance does not exist, but there is an RCUK ILS course. It does later state that BLS is started without delay and ILS is started as soon as appropriately trained staff arrive.

e. Appendix 9 (inpatient wards) and 10 (mental health and learning disability services) are equipment checklists.

f. I have commented on Appendix 9 already and this is a grab bag check list.

g. There is an inconsistency between the two oxygen-cylinder thresholds given for the same resus bag cylinder: Appendix 9 (weekly check) states the cylinder should be

replaced immediately if less than 1/2 full, while Appendix 10 (daily check) states the gauge 'should be inspected daily to ensure an adequate supply, i.e., ¾ full'.

h. Appendix 11 is a resuscitation trolley check list for inpatient settings.

i. It is not immediately clear from the appendix document which inpatient settings have a grab bag and which have a trolley or whether some have both. Section 7.1 states the trolley is available in ECT suites and community physical health inpatient settings – there are separate RCUK standards[24] and equipment lists for these settings that are not referenced in the document.

j. I note the trolley contains IV cannulation equipment (cannulae, tourniquets, infusion sets) suggesting there is capability for their use, and the capability for giving intravenous drugs.

k. The most notable gaps against the RCUK recommended list are no ligature cutter, gloves, masks, eye protection, laryngoscope, stethoscope, or intravenous fluid. The lack of intravenous fluids is a discrepancy given the trolley list includes intravenous fluid giving sets. Of note is that the policy (9.2) includes 'All mental health inpatient areas must have ligature cutters available within a designated storage location (indicated by a clearly displayed directional poster). Refer to the Trust CPG75 Ligature Risk Assessment & Management Procedure'.

l. Appendix 12– Baby / Infant Resuscitation Bag / Equipment Weekly Full Inventory Check. The Baby/Infant bag is specific to a mother-and-baby unit, and not a trust-wide item, which is a reasonable local risk-assessed decision. The items in this list are additional to items in the adult resuscitation bag, and the contents are reasonable in my opinion.

HR21 Induction and Mandatory Training Policy sV 3.0 dated 29 January 2026 [EPUT023450]

3.15 HR21 is a generic, trust-wide induction and mandatory training policy; it is not specific to resuscitation training. Its main relevance to my instructions lies in the fact that Immediate Life Support (ILS) training was added as a mandatory training requirement at version 3.0 of this policy, following the three-year review dated 29 November 2023.

3.16 The training policy as written seems to enable staff to miss mandatory training:

[24] https://www.resus.org.uk/library/quality-standards-cpr/quality-standards-community-hospitals-care [accessed 7 September 2026].

a. Paragraphs 2.5.1 and 6.5.1 record non-attendance as a DNA [did not attend] where a staff member cannot attend 'due to staffing or work-related issues within the clinical area' within two weeks of the course date [0006, 0009].
b. Paragraph 5.18 permits a manager to remove the requirement for training for staff who have not completed their training based on a risk assessment at 6-months [0009]. This does mean that some staff may not get trained in resuscitation at all – if this was being used to excuse large numbers of staff from training this would be concerning in my opinion. I am mindful that some staff may have legitimate reasons such as long-term sickness or maternity leave for failing to complete their training.

3.17 The majority of this document is appendix documents numbered 1 to 5.

3.18 Appendix 1:

a. Is a training matrix that includes TC02 (BLS) and TC20 (ILS) – the delivery method (classroom), duration (BLS – half day, ILS – one day), and a yearly update interval are in keeping with national guidance.
b. TC02 (BLS) is 'Basic Life Support (including AED)', for non-registered clinical Mental Health/Learning Disability staff, community MH and LD staff, and adult and paediatric staff (excluding scientists).
c. TC20 'Immediate Life Support', is for registered nursing staff and 'medics' in Mental Health, Learning Disability and Adult inpatient services who have a grab bag or crash trolley. I am assuming the term 'medic' is used to refer to doctors. I am not sure why this training would only be offered to those working in settings with a grab bag or resuscitation trolley (the wards are named) as opposed to the specific setting type.
d. The scope of the ILS training should in my opinion be widened to include some non-registered staff given that most staff in given shifts may be healthcare assistants who are only trained to a BLS level.
e. The document states that ILS training will be sourced externally but does not specify whether this is specifically an RCUK ILS course.
f. There is no guidance for training in resuscitation issues for non-clinical staff based on the Core Skills Training Framework (CSTF) Level 1 'basic awareness' tier for non-clinical staff (e.g., administrative, catering, security, or estates staff). If no such training exists within HR21, this is a gap in the template.

3.19 My review of appendices 2 to 4 includes:

a. Appendix 2 (Local Workplace Induction) requires resuscitation procedures to be covered as part of orientation for inpatient inductions [0005], but this is not one of the formally assessed competencies in the same document [0008].

b. Appendix 3 for Local Workplace induction for Locum/Bank/Agency staff includes only a tick box for 'Medical Emergency' with the whole induction expected to take 15-30 minutes. This puts a greater onus on permanent staff, and is problematic when a large proportion of staff are agency staff.

c. Appendix 4 ('Assessment of Competencies for Junior Doctors'), required to be completed within their first week, contains no item addressing emergencies – the document only states 'Safe management of commonly occurring conditions (urgent/non-urgent) including side effects of medication'

CG87: Clinical Guidelines of the Use of National Early Warning Scoring System (NEWS2) sV1 dated 11 March 2025 [EPUT023441]

3.20 This is version sV 1.0 dated 12 March 2025. Version 1.0 was 10 December 2018. Version 2.0 (1 June 2022) includes the move to use of NEWS2 throughout Trust, 'rather than mixture of MEWS and NEWS2 previously employed'. Version 2.1 (18 December 2023) added the UK Sepsis Trust tools.

3.21 I do not know when most English NHS mental health trusts adopted NEWS2 so cannot comment on whether EPUT was a late adopter or not.

3.22 The Contents page contains an unresolved Word field code rather than a populated table of contents [0003], and the 'Policy at a Glance Template' is a hyperlink to a document that has not been provided to me [0004].

3.23 I have identified two internal appendix cross-referencing errors, both coinciding with the version-history entry recording addition of 'appendices 2,7,14 & 15' at this same sV1.0 revision [0002]. Paragraph 7.6 refers to the 'Assessing a Critically Unwell Patient' aide memoir tool as Appendix 14 [0013], but the appendix list itself numbers this document as Appendix 13 [0029]. Paragraph 8.1 refers to the PEWS chart as Appendix 15 [8.1, 0015], but the appendix list numbers this as Appendix 14 [0030]

3.24 The sepsis-screening prompt at a NEWS2 score of 5 or more [0013] was, at the time of CG87's March 2025 review, correctly aligned with NICE NG51 and the then-current UK Sepsis Trust tools. However, NICE withdrew and replaced NG51 in November 2025 with three separate guidelines - NG253 (suspected sepsis in people aged 16 or over), NG254 (suspected sepsis in under 16s), and NG255 (suspected sepsis in pregnant or recently pregnant people). The UK Sepsis Trust has, since November 2025, issued a new suite of clinical tools[25], although there are no specific current tools for mental health settings. CG87's reference list and Appendices 4-11 therefore now reference guidance that has been superseded since CG87 was last reviewed.

3.25 On CLP14 paragraph 3.8(a): the Non-Contact Physical Observations tool [Appendix 2, EPUT026714] structures assessment around the ABCDE framework with a clear escalate/normal comparison, which is, in my opinion, clinically appropriate for use where full contact observations cannot be obtained. However, I have not identified any stated maximum duration for which non-contact observation may substitute full physiological measurement, nor a specified minimum frequency for repeating it. As stated before, this option should be the exception and usual clinical and vital sign assessments should be used, even though it can be difficult to do at times in unco-operative or unwell patients.

3.26 The document aligns with national guidance for escalating treatment based on the NEWS2 score in adults and based on guidance from the Royal College of Physicians.

3.27 The document only provides a copy of the PEWS chart for children over 13 years old, and not for younger age groups (0-11 months, 1-4 years, 5-12 years) – these are available on the NHS England website[26].

Basic Life Support Training Lesson Plan and Basic Life Support Summary & Competencies. Please note that the Inquiry is providing you with two versions of the Basic Life Support Training because EPUT updated its lesson plan in August 2026

[25] https://sepsistrust.org/healthcare-professionals/clinical-tools/ [accessed 7 September 2026].
[26] https://www.england.nhs.uk/publication/national-pews-observation-and-escalation-charts/ [accessed 8 September 2026].

3.28 The newer Basic Life Support (BLS) session plan is a 3.5-hour plan compared to the previous 3 hour plan. Both lessons include hands on training.

3.29 Both session plans cover the key issues with regards recognising cardiac arrest, starting CPR with chest compressions, and using an AED. In addition, they cover choking in adults and children.

3.30 I note that the older lesson plan [EPUT023425] includes a 10 second pulse check as part of the initial assessment of basic life support – as stated in my Part 1 report, pulse checks have been de-emphasised in guidelines for over 20 years as they are unreliable in an emergency setting, and may result in delays in starting CPR. The pulse check is not mentioned in the recent August 2026 training plan [EPUT027252].

3.31 It does not appear that two-person bag-mask ventilation is taught to staff working in in-patient settings who may have to wait for an ILS-trained person to arrive. The only rescue breath technique taught appears to be mouth-to-mouth rescue breaths using a face shield. These may be appropriate in some community settings where there is no other airway equipment available. For mental health inpatient settings, the airway and ventilation techniques of choice would be a bag-mask device or an i-gel device, and these are in the recommended equipment lists from the RCUK. Any technique that involves close proximity of rescuers to the patient's mouth is prone to cause hesitancy and delays in starting CPR, especially if there is vomit or saliva in the airway, even if a face shield is used. Adult guidelines therefore recommend starting chest compressions and adding in two rescue breaths every 30 compressions as soon as airway and breathing equipment arrives – this should arrive immediately, i.e., in about the first minute. This does mean those staff who arrive first should be taught a 2-person bag-mask technique to deliver rescue breaths.

In-house non-mandatory refresher training

3.32 The material provided under this heading is a slide presentation, 'Assessing Deteriorating Patients and BLS Algorithm', delivered by the Head of Deteriorating Patient Pathways and Resuscitation Training Officer [EPUT027256].

3.33 The slides cover the ABCDE approach, NEWS2, starting chest compressions, using an AED, using the SBAR communication tool, how to call for an ambulance tool, the resuscitation event form, and lessons identified from case reviews – this is a lecture and it is uncertain when it is used including who the target staff group is. These may be the slides mentioned for the recent August 2026 BLS training plan [EPUT027252].

3.34 There is no information in the slides on how to provide rescue breaths whilst awaiting an ILS trained provider.

Immediate Life Support Training

3.35 The documents provided under this heading are Resuscitation Council UK's own national ILS course materials – the 'Immediate Life Support Course: 1 day programme' (November 2025, Version 1) [EPUT027255] and the 'ILS Regulations' (April 2021, Version 1.4) [EPUT027257] – rather than any EPUT-authored lesson plan or session record for its own delivery of the course.

3.36 The 2021 course regulations are the version currently on the public facing RCUK website – the most up to date guidance and course materials are available to official RCUK ILS course centres through a password protected website. I am not sure if there is a more up to date version available, but if this was the case EPUT would be able to access these via the coordinator for their RCUK ILS courses.

3.37 If EPUT are teaching their staff through the actual RCUK ILS course it will follow the latest RCUK ILS course plan and regulations. They would adapt the course materials and scenarios to mental health settings.

RM05 Therapeutic and Safe Interventions and De-escalation (TASID) Policy, sV 3.0, 11 March 2025 [EPUT024967].

3.38 This policy was ratified on 12 November 2025 and expired on 1 May 2026.

3.39 RM05 governs issues which include restrictive interventions such as tranquillisation, physical restraint, and seclusion.

3.40 This cites NICE NG10 [paragraphs 1, 2.11, 12.2] but does not contains any reference to the NG10 recommendation for the need for immediate life support (ILS) trained staff. This is a concerning gap in the document in my opinion as it suggests an organisational blind spot regarding what the safe staffing requirements are.

3.41 The document does require a Band 5 'TASID-trained registered nurse' as a minimum to co-ordinate the process [paragraph 12.5] and a minimum of three physical-intervention-trained staff per shift [paragraph 23.5]. It is not clear whether TASID training includes any immediate life support content, and there is no equivalent requirement for an ILS-trained member of staff on each shift.

CG52 Clinical Guidelines for the Pharmacological Management of Acutely Disturbed Behaviour sV 1.1, 5 September 2025 [EPUT023438]

3.42 This document was approved on 5 September 2023 and expired on 5 September 2026.

3.43 Paragraph 5.5.1 requires resuscitation equipment to be 'available and easily accessible (within 3 minutes)' and lists an automatic external defibrillator, a bag valve mask, oxygen and suction. This adopts the CQC wording rather than the RCUK standard, which defines immediate as available for use within the first minutes of cardiorespiratory arrest. The equipment listed includes no airway adjuncts, no supraglottic airway device and no ligature cutter.

3.44 CG52 appears to give three different monitoring frequencies for the same clinical situation:

a. Paragraph 10.2 requires NEWS2 every 15 minutes for a minimum of one hour after intramuscular rapid tranquillisation.
b. The table at 10.5 requires observations for alertness every 5 and other vital signs every 10 minutes for the first hour.
c. The algorithms at Appendices 3 to 6 require monitoring every 10 minutes for the first hour.

3.45 My opinion is that the frequency of observations depends on the patient's condition, but should initially be every 5 minutes and increased or stepped down based on the patient's vital signs being normal or not, and risk of deterioration. For example, more than 10 minutes of physical restraint increases the patient's risk of deterioration – depending on the option taken from the guide above the patient may only get 1 or 2 sets of observations. Checking every 5 minutes would give 3 sets of observations. Some vital signs such as the pulse rate and oxygen saturation can be measured continuously with a pulse oximeter, alongside continuous observation, whereas other vital sign monitoring such as blood pressure, and counting the respiratory rate can only be done intermittently.

3.46 Paragraphs 4.4 and 17.5 still refer to Enhanced Emergency Skills lead trainers and list mandatory training as cardiopulmonary resuscitation and enhanced clinical care. The policy again does not mention the need to have an immediate life support member of staff present. According to Dr Suresh's statement this training stopped in 2020.

3.47 The 'remedial measures' table [paragraph 13] advises for a respiratory rate below 10 or oxygen saturation below 90 per cent to give oxygen and includes 'raise the legs', and to 'ventilate mechanically'. Raising the legs helps treats a low blood pressure but can make breathing worse. This is potentially dangerous advice for the breathing difficulties scenario.

4 SUMMARY

4.1 In a mental health inpatient setting, the best prospect of survival depends on identifying deterioration and intervening before cardiac arrest occurs.

4.2 Current training practice in mental health inpatient settings usually means that the earliest response to an emergency or cardiac arrest often comes from the least-trained staff. Those first responders are often non-registered staff, and they require the broadest practical skill set of anyone who will attend.

4.3 During an emergency on a mental health inpatient unit the ABCDE approach should be followed. It follows that a person trained to perform an ABCDE assessment must be immediately available on the ward, and not summoned from elsewhere. ABCDE

assessment, and the immediate interventions that follow from it, is what the Immediate Life Support course teaches.

4.4 An individual trained in immediate life support should in my opinion be available 24/7 within about the first minute after the emergency is identified – I have not identified any EPUT policy that states a maximum time within which an immediate life support trained individual must reach the patient. The only figure of this kind in the documents I have reviewed is the target of 3 minutes for a doctor and a nurse to attend, which appears on the medical emergency simulation record at Appendix 16 of CLP14. That is a target on a record form rather than a requirement in the policy itself, but it is the only indication in EPUT's documents of what the Trust regards as an acceptable time, and it implies that the first three minutes are managed by non-registered ward staff already on the ward. Stipulating three minutes is not immediate enough in my opinion.

4.5 In my opinion there is no reason why a non-registered healthcare professional working in a mental health inpatient setting, such as a healthcare assistant, could not undertake immediate life support training.

4.6 I have not identified in the EPUT's policies and procedures an express requirement for an immediate life support-trained person to be on every inpatient shift and available 24/7 to respond immediately to an emergency.

4.7 The distinction between guidance for inpatient services and its other mental health services is often difficult to follow in the EPUT policies – separating out the issues that are specific to inpatient settings may make the policy easier to follow.

4.8 I have identified the following areas where I consider there may be an ongoing patient safety risk.

a. There is no requirement in any EPUT document I have reviewed for an ILS-trained member of staff to be on every inpatient shift and available 24/7.
b. No EPUT document states a maximum time within which an immediate life support trained member of staff must reach the patient. In my opinion immediate means within about the first minute of the call for help, and the only figure in the EPUT

documents is the three-minute target on the simulation record form, is longer than that.

c. RM05 requires no ILS-trained person to be present at a restraint, despite citing NICE NG10.

d. Rescue breathing is taught in basic training only as mouth-to-mouth using a face shield. Two-person bag-mask ventilation does not appear to be taught to the clinical staff who will often be the first on scene.

e. There is no assurance that the quarterly medical emergency simulations required by CLP14 are taking place.

f. Agency staff receive a 15 to 30 minute local induction with a single tick box for 'Medical Emergency', and it appears that EPUT does not deliver its mandatory training modules to agency workers.

g. CG52 expired on 5 September 2026 and RM05 expired on 1 May 2026 and need to be updated with greater clinical input given the issues I have identified.

5 DECLARATION AND STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

[I/S]

PROFESSOR JASMEET SOAR

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15 SEPTEMBER 2026