

1. Preliminaries

2. I, Louise Borton, am employed by Essex Partnership University NHS Foundation Trust (EPUT) in the role of Matron. I have held this position since February 2021.

3. Background and experience

4. My professional qualification is BSc (Hons) Nursing (Mental Health).

5. Training, competence and preparedness for medical emergencies

6. Between 2018 and the date of this request, I have undertaken a range of training relating to the recognition of deteriorating patients, emergency response and resuscitation.
7. This included e-learning training in Recognising and Managing Anaphylaxis, completed annually, and Diabetes Level 2 for Mental Health Workers, completed every three years.
8. I also undertook face-to-face training in Basic Life Support whilst awaiting my Nursing and Midwifery Council PIN, Grab Bag training every two years, Enhanced Emergency Skills training annually, Immediate Life Support training annually, and Ligature Awareness Training annually. In 2024, I completed Resus Link Practitioner training.
9. Basic Life Support and Enhanced Emergency Skills training were originally delivered by the Trust's Mandatory Training Team. Following the COVID-19 pandemic, Enhanced Emergency Skills training ceased to be delivered internally and was replaced by Immediate Life Support training, externally delivered by A to E Training & Solutions Ltd. Immediate Life Support included training on the use of the A-E assessment and was aligned with the standards of the Resuscitation Council UK.
10. Throughout my Basic Life Support, Enhanced Emergency Skills and Immediate Life Support training, I was taught that on discovering an unresponsive patient, staff should immediately shout for help, activate their pinpoint assistance alarm and, when assistance arrives, ensure that the Grab Bag is brought to the scene and that emergency services are called without delay. This should occur alongside the initial

- assessment of breathing and commencement of cardiopulmonary resuscitation (CPR) where the patient is unresponsive and has absent or abnormal breathing.
11. Enhanced Emergency Skills and Immediate Life Support training also included training in the use of Automated External Defibrillators (AEDs).
 12. Training in airway management was provided through both Enhanced Emergency Skills and Immediate Life Support courses. This included basic airway-opening techniques such as head tilt and chin lift, jaw thrust, and airway management in patients with suspected cervical spine injuries. Airway adjuncts, including oropharyngeal and nasopharyngeal airways, were also covered. Training further included the use of supraglottic airways, such as the i-gel, during CPR.
 13. The courses additionally covered oxygen therapy, including the administration of high-concentration oxygen using a non-rebreather mask, together with artificial ventilation using a bag-valve-mask.
 14. Immediate Life Support training referred to the role of resuscitation drugs, including adrenaline and amiodarone. However, it did not include training in the administration of these medications, as this would fall within Advanced Life Support training.
 15. Enhanced Emergency Skills, Immediate Life Support and Ligature Awareness Training all included scenarios relevant to mental health inpatient settings. These included self-strangulation, fixed-point ligatures and serious self-harm involving cutting.
 16. Enhanced Emergency Skills and Immediate Life Support training covered the recognition and prevention of patient deterioration and cardiac arrest, including education, monitoring, recognition, escalation, calling for help and responding appropriately. The courses addressed the assessment of airway, breathing and circulation with Immediate Life Support also including disability and exposure assessment. Competence was assessed through practical skills stations and simulated emergency scenarios.
 17. Both Enhanced Emergency Skills and Immediate Life Support training provided opportunities to practise working as part of a resuscitation team. Enhanced Emergency Skills also enabled staff to practise leading an emergency response or

- resuscitation effort. During Immediate Life Support training, the importance of leadership during emergencies was emphasised, although not all participants had the opportunity to undertake the lead role during practical scenarios.
18. The transition from Enhanced Emergency Skills to Immediate Life Support represented a substantial change in the delivery of training. Enhanced Emergency Skills was available to both qualified and unqualified staff, which in my view supported patient safety because unqualified staff may often be the first individuals to respond to incidents. In my view, the transition to Immediate Life Support training reduced the opportunity for unregistered nursing staff to develop and maintain enhanced emergency response skills. Unregistered nursing staff were limited to Basic Life Support and AED training, except where individuals undertaking the Resus Link Practitioner role were added to the appropriate Immediate Life Support training pathway.
 19. In 2020, the Trust Mandatory Training Team uploaded training resources to the EPUT YouTube channel, including Basic Life Support and Grab Bag training videos and scenario-based learning materials. An e-learning Grab Bag training package was also available. Beyond these resources, I am not aware of any Trust-wide opportunities for staff to practise emergency response skills routinely between formal training sessions.
 20. In 2023, the Interim Ward Manager for Assessment Unit - Grangewaters introduced local 30-minute practical training sessions for staff. These sessions provided staff with the opportunity to familiarise themselves with the contents and use of the Grab Bag and to practise emergency response skills learned during formal training. In my view, these sessions helped reinforce learning and provided staff with additional opportunities to maintain their confidence and competence between mandatory training sessions.
 21. I did not identify any deliberate or formal barriers preventing staff from applying their training. However, through incidents, emergency simulation and resuscitation drills and reviews, several practical and systems-related issues were identified which had the potential to affect emergency responses, including communication systems, equipment accessibility and emergency escalation arrangements.

22. When considering emergency incidents such as clinical deterioration, ligatures, choking, serious self-harm involving cutting, head-banging, drowning, overdose, medication errors during rapid tranquillisation, physical restraint-related emergencies and electrolyte imbalance associated with eating disorders, I recognise that the infrequency with which some of these events occur may affect confidence and competence in responding effectively. Unlike acute hospital settings, mental health inpatient environments generally provide fewer opportunities for staff to gain regular practical experience in managing medical emergencies.
23. Overall, I have been confident that staff, including myself, were able to recognise deteriorating patients and take appropriate action. However, I believe confidence and competence in responding to emergency incidents can be more challenging to maintain in mental health inpatient settings because such incidents occur less frequently. In addition, patients involved in emergency incidents are often well known to the staff responding, which may add an emotional dimension not always present in the acute hospital environment.
24. In my view, staff would benefit from additional practical medical emergency training sessions incorporating simulation exercises throughout the year, rather than relying solely on annual mandatory training. Such sessions should include attendance records and structured feedback to support learning and ongoing competence. I also believe that Immediate Life Support training should be mandatory for unregistered nursing staff and that consideration should be given to increasing the availability of Advanced Life Support-trained staff across inpatient services, with at least one member of staff trained to that level available on every shift.
25. In addition, I believe consideration should be given to adopting a more structured team approach to emergency responses. Where practicable, staff commencing a shift could identify those with enhanced emergency response competencies, agree who would assume the team leader role in the event of a medical emergency, and clarify potential responsibilities within the response team. In my view, this could help improve communication, leadership, role clarity and overall effectiveness during emergency incidents.

26. Historic emergency simulation and resuscitation drills

27. During my time as Matron, I arranged and participated in emergency and resuscitation scenario training exercises, commonly referred to as CPR or Grab Bag drills. These exercises involved a range of simulated medical emergencies designed to test staff responses, emergency equipment, communication systems and environmental factors.
28. Staff required to participate in these exercises included those allocated to hold the rapid response pager linked to the Pinpoint alarm system. This included both registered and unregistered staff. The On-Call Doctor was also expected to attend and participate. Where a drill was conducted on a clinical ward, staff working on that ward, including medical colleagues, would ordinarily be expected to respond and participate. Temporary staff, including bank and agency staff, would also be expected to participate if they were allocated the rapid response role at the time of the exercise.
29. Prior to the replacement of Enhanced Emergency Skills training with Immediate Life Support training, the Trust Mandatory Training Team assisted with planning and facilitating the drills. My recollection is that [redacted] [US], Mandatory Trainer, frequently led this work and provided the equipment required for the simulations, including a test Grab Bag and a Resusci Anne training torso. I do not recall wards having access to their own simulation equipment until approximately 2023. The drills did not take place during the COVID-19 pandemic.
30. The outcomes of the drills were recorded by [redacted] Mandatory Trainer using a CPR Drill Report and Audit Tool. Following completion of each exercise, a debrief was undertaken with those who had participated and immediate learning was shared. Learning was subsequently disseminated more widely through Ward Managers for discussion with clinical teams.
31. A number of learning points arose from the CPR and Grab Bag drills facilitated at Basildon Mental Health Unit by [redacted] Mandatory Trainer. The CPR and Grab Bag drills identified several recurring themes relating to emergency preparedness, emergency response systems, equipment availability, staff training and team coordination. In my view, the drills demonstrated improvement over time as learning from previous exercises was incorporated into subsequent practice.

32. A significant learning point was the importance of reliable emergency communication and alarm systems. During the drills conducted on 18 March 2022 and 1 February 2023, issues were identified with the pinpoint alarm system, including failure to activate correctly, incorrect information being displayed and delays in staff recognising the nature of the alarm. On 1 February 2023, staff ultimately used radio and verbal communication to communicate that a medical emergency was taking place. Concerns were also identified regarding the process for contacting medical staff during emergencies, as the Duty Doctor relied on being bleeped using the pager system and was not alerted through the rapid response pager linked to the Pinpoint alarm system. During the drill on 6 April 2023, it was noted that the Duty Doctors' bleep had not activated and required investigation. Following the drill, I raised the concern regarding contacting medical staff during emergencies with Dr Ashish Pathak, Consultant Psychiatrist and Clinical Tutor (South Essex), and suggested that the Duty Doctor be provided with a rapid response pager and radio.
33. The drills highlighted the need to ensure emergency equipment was immediately available and ready for use. On 18 March 2022 and 1 February 2023 there were delays in the arrival of the Grab Bag and aerosol generating procedures (AGP) personal protective equipment (PPE), with staff having to obtain PPE separately because it was not attached to the Grab Bag. Following these drills, actions were identified to ensure AGP PPE was attached to Grab Bags and included within routine checking procedures. By 6 April 2023, both the Grab Bag and AGP PPE arrived at the scene within one minute and six seconds, representing a significant improvement.
34. The ability to rapidly deploy and use the Automated External Defibrillator (AED) was another recurring learning point. Several drills identified delays in removing the AED from the Grab Bag or switching it on. Feedback repeatedly reinforced the need for staff to prioritise AED deployment immediately on arrival and to switch the device on without delay. Improvements were seen over time, with the time taken to deliver the first shock reducing from seven minutes during the March 2022 drill to three minutes and twenty seconds in December 2022 and two minutes and twenty-two seconds in April 2023.
35. The April 2022 drill identified several equipment-related learning points, including ensuring AED pads were correctly positioned, ensuring the oxygen regulator was fully opened, lubricating the i-gel airway before insertion, ensuring safe patient

- positioning and closing the airway appropriately when rolling a patient. The exercise demonstrated that although staff generally understood the emergency response process, practical drills were valuable in identifying and correcting technical aspects of equipment use.
36. Several drills highlighted issues affecting staff access and response times. During the April 2022 exercise, not all staff had the ability to move freely between wards, resulting in delays. As a result, it was identified that staff on duty should have appropriate access to clinical areas to support a timely emergency response and additional access cards were required to be ordered by wards. Whilst awaiting arrival, a system was put in place; wards would be supported by borrowing spare access cards from other wards.
 37. The drills also highlighted variation in attendance and response from different wards. In December 2022 there was little response from some clinical areas. This resulted in actions for site leadership to review why certain wards had not responded.
 38. A recurring theme was the importance of maintaining staff competence through ongoing training and regular practice. The April 2022 and February 2023 drills identified staff members who had not undertaken Grab Bag training or whose training was overdue. Recommendations were subsequently made for staff to complete additional Grab Bag theory training, update overdue training, attend Grab Bag induction sessions, attend Immediate Life Support training where invited and participate in additional practice sessions.
 39. A consistent positive finding across all drills was that, once responders and equipment arrived at the scene, communication, leadership, decision-making, situational awareness and task management were generally assessed as good or very good. The February 2023 drill specifically noted that once a nominated lead was established, the response became organised and efficient. The December 2022 drill was described as the best drill undertaken during the preceding two years, with particularly effective teamwork, communication and clinical skills being observed.
 40. The drills also reinforced the importance of allocating both clinical and non-clinical roles during an emergency. Areas identified for improvement included ensuring a member of staff was allocated to meet the ambulance, ensuring emergency services received all required information and ensuring that the Resuscitation Event Report

was completed. These responsibilities were not always allocated consistently during the earlier drills.

41. In my view, the drills demonstrated that regular simulation exercises were effective in identifying system weaknesses, reinforcing learning and contributing to improvements in emergency preparedness and response.

42. Current arrangements for medical emergency simulations

43. In respect of ongoing emergency simulation, scenario training and emergency simulation exercises are required to be facilitated every three months in accordance with the Trust's CPR Policy. The Professional Nurse Educator has been asked to increase the frequency of medical emergency simulations across Basildon Mental Health Unit to support staff competence and confidence in responding to medical emergencies.
44. There is currently no requirement within the CPR Policy, nor any formal mechanism, to record whether individual members of staff have participated in emergency simulation exercises.
45. In August 2026, an additional question was incorporated into the Tendable Ward Managers Audit: *"Has a medical emergency simulation been carried out within the last three months?"* Where no simulation had been undertaken within that period, an urgent requirement is for one to be facilitated.
46. Emergency simulations are recorded using the Medical Emergency Simulation Practice Report, contained within Appendix 16 of the CPR Policy. Completed reports are required to be shared with Nick Archer, Head of Deteriorating Patient Pathways and Resuscitation Training Officer. Simulations are facilitated and assessed by the Professional Nurse Educator and/or a Resus Link Practitioner using a range of pre-developed medical emergency scenarios. Performance is assessed against the standards set out within the Medical Emergency Simulation Practice Report.
47. To my knowledge, the CPR Policy does not specify a formal process for managing poor performance identified during simulation exercises. Where concerns were

- identified, I would expect these to be documented within the Medical Emergency Simulation Practice Report and considered through local management processes, including additional support, supervision or training where appropriate.
48. Several actions were identified following emergency simulation exercises which required changes to practice, equipment availability, communication systems and staff training.
 49. The scenarios undertaken in 2026 highlighted recurring issues relating to the recognition and escalation of medical emergencies, communication with medical staff, access to emergency equipment, leadership during emergencies and staff familiarity with local procedures.
 50. A simulation exercise undertaken on Hadleigh Unit on 29 June 2026 identified significant concerns regarding radio communications. Although staff appropriately declared a medical emergency, both the Duty Doctor and a responder from another ward reported that they were unable to clearly hear the radio transmission because of poor radio signal coverage on the ward. The Professional Nurse Educator advised that this presented a significant risk and requested that the issue be escalated to Estates and Facilities as a matter of urgency. Recommendations arising from the exercise included improving radio signal coverage on Hadleigh Unit and addressing known communication blackspots.
 51. The Hadleigh Unit exercise also identified delays in obtaining key equipment and medications. Staff recognised the deteriorating patient promptly but experienced delays obtaining suction equipment and Midazolam. Recommendations included making suction equipment more readily available and ensuring staff understood the need to bring relevant medications and equipment to medical emergencies where appropriate.
 52. The scenario further identified that staff would have benefited from clearer leadership during the emergency response. Learning from the exercise reinforced the importance of establishing a designated lead person early in the response to coordinate actions and allocate responsibilities.
 53. Following a medical emergency simulation on Assessment Unit - Grangewaters on 6 August 2026, it was identified that staff did not immediately declare a medical

- emergency on the radio despite recognising that the patient was unwell. As a result, the rapid response team was not immediately aware that a medical emergency was occurring, and there was a delay of approximately seven minutes before the doctor attended. Learning from the exercise emphasised that a medical emergency call must be made without delay whenever a patient experiences a physical health emergency. Staff were reminded of the requirement to declare a medical emergency immediately and to communicate this clearly using the radio system.
54. The same exercise identified uncertainty regarding responsibility for calling 999. Learning from the scenario reinforced the need for clear allocation of roles during emergency situations, including identifying who is responsible for contacting emergency services and ensuring that this is communicated clearly to the wider team. Staff were encouraged to verbalise key actions, such as confirming that 999 had been called and that a medical emergency had been activated.
55. The Assessment Unit - Grangewaters scenario also highlighted delays in obtaining equipment. Staff initially used the suction device contained within the Grab Bag and were unaware that motorised suction equipment was available elsewhere on the ward. Following the exercise, staff were reminded to bring all relevant emergency equipment to the scene, including the Grab Bag, suction equipment and vital signs machine. Staff were also reminded that suction machines were available on both Assessment Unit - Grangewaters and Kelvedon Ward.
56. I asked the Professional Nurse Educator to discuss the learning at the Basildon Site Safety Huddle the following morning, attended by Ward Managers, Matrons and the Service Manager so this could be disseminated to teams.
57. Because of the learning identified during the Assessment Unit - Grangewaters exercise, the Professional Nurse Educator identified the need to introduce weekly medical emergency simulation exercises on alternate wards for a one-month period, with a review planned through the Leadership Meeting to assess their effectiveness.
58. A subsequent simulation exercise on Kelvedon Ward on 13 August 2026 identified that the Duty Doctor did not respond to the scenario. Following investigation, it was established that the Duty Doctor had been unable to hear radio communications. Action was taken to remind medical staff of the importance of ensuring that radios are carried and functioning correctly whilst on duty. It was also suggested that where

radio communication is unsuccessful, staff should use the bleep system as an alternative method of contacting the doctor. The issue was additionally highlighted for handover to the night Duty Doctor.

59. Overall, the actions arising from these scenarios resulted in reinforcement of emergency escalation procedures, additional simulation training, review of communication systems, consideration of improvements to radio coverage, improved awareness of the location and use of emergency equipment, clearer role allocation during emergencies and reinforcement of expectations regarding Duty Doctors' availability and communication arrangements during medical emergencies.

60. Safety alerts, memorandums and implementation of learning

61. During my time as Ward Manager and Matron, I received, implemented and, on occasion, issued a number of memoranda and safety alerts relating to deteriorating patients, emergency response, resuscitation procedures and emergency equipment.
62. On 12 September 2019, I received safety alert reference INT 2019 022, entitled *Resus Equipment Checklist Mental Health & Learning Disability Services*. The alert followed a near-miss incident and advised that the Resuscitation Equipment Checklist had been amended to prompt staff to verify the model number of the defibrillator and ensure that replacement pads and batteries were compatible with the specific device in use. The alert highlighted that three different defibrillator models were in use across the Trust, namely Heartstart, Powerheart and Lifepak. Managers and Matrons were instructed to circulate the information to their teams and ensure that the revised checking process was followed. The alert was issued for information and did not require a formal response.
63. On 26 March 2020, I received a memorandum from [I/S] Matron, and Chloe Cawston, Service Manager, entitled *Changes to Crash Team Support at Basildon*. The memorandum advised that, from 1 April 2020, the Adult Cardiac Arrest Team provided by Basildon and Thurrock University Hospital would no longer be available to respond to emergencies at Basildon Mental Health Unit. Staff were advised that, in the event of a cardiac arrest, respiratory arrest or sudden collapse, emergency services should be contacted directly via 999 in accordance with the

- revised policy, CLPG14. Managers were instructed to ensure that all staff were made aware of the change.
64. On 14 October 2021, I received safety alert reference INT 2021 027, entitled *AED Pads for Heartstart Defibrillators*. The alert highlighted procurement difficulties affecting replacement AED pads and requested that managers ensure all defibrillators had one set of pads attached and one spare set available in accordance with Trust policy. The alert also reiterated the importance of ensuring that AED pads matched the model of defibrillator in use and outlined the reporting arrangements where equipment shortages were identified.
65. On 24 March 2022, I received a memorandum from Doreen Mhone, Service Manager, entitled *Crash Team Support at Basildon Mental Health Unit*. This memorandum reiterated that the Adult Cardiac Arrest Team provided by Basildon and Thurrock University Hospital had been withdrawn from the site in April 2020 and reminded staff that emergency services should be contacted via (9)999 in the event of a cardiac arrest, respiratory arrest or sudden collapse. Managers were asked to ensure that this information was shared with all staff within their teams.
66. On 27 May 2022, I received a memorandum from Tendai Ruwona, Associate Director (Inpatient and Emergency Services, Mid and South), entitled *Oxygen Cylinders*. This communication reminded Ward Managers that oxygen cylinders should be replaced or refilled after each use and that compliance should be monitored through routine weekly equipment checks.
67. On 8 August 2022, I received safety alert reference INT 2022 LL002, entitled *Oxygen Cylinders*, issued by [I/S], Senior Datix Manager, on behalf of Nick Archer, Head of Deteriorating Patient Pathways and Resuscitation Training Officer. The alert followed an After Action Review relating to a medical emergency on Kelvedon Ward at Basildon Mental Health Unit. It identified that staff responding to an emergency had been unable to use the oxygen cylinder contained within the Grab Bag because the cylinder had remained in the manufacturer's default OFF position. Staff were instructed to remove the grey tear ring, turn the hand wheel to the ON position, and ensure that oxygen cylinders were checked regularly and replaced when necessary. Supporting guidance, photographs, a training video and a National Patient Safety Alert were attached. The alert requested immediate action and local dissemination to all relevant staff.

68. On 3 September 2022, I received safety alert reference INT LL 2022 003, entitled *Medical Emergencies*. The alert was issued following a number of inpatient medical emergencies requiring staff to undertake CPR. It highlighted examples of good practice, learning identified from incidents and actions intended to improve outcomes for patients and staff. Matrons and Clinical Leads were required to review the alert and implement the actions contained within it.
69. On 17 November 2022, I received a memorandum from Chloe Cawston, Service Manager, entitled *Attending to Emergency/Pin Point Alarms*. This communication instructed managers to ensure that all staff responding to emergency alarms were appropriately trained in TASI and Grab Bag procedures and reiterated that Rapid Response Nurses should be fully trained before undertaking this role.
70. On 1 June 2023, I received safety alert reference INT LL 2023 002 entitled *CLPG14: Calling (9)999 in a Medical Emergency*. This alert followed reviews of a number of incidents involving physically unwell patients. A poster had been developed in collaboration with the Ambulance Service to support staff in providing complete and accurate information when contacting emergency services. Units were instructed to complete location-specific information on the poster, display copies near telephones, place copies within Grab Bags and discuss the guidance with clinical teams.
71. On 8 August 2023, I received a memorandum from Doreen Mhone, Service Manager, entitled *Safety Action Following Inpatient Death – Oxygen Administration Notification*. The memorandum repeated learning previously circulated in 2022 regarding oxygen cylinder preparation and reminded Ward Managers to ensure that staff removed the grey tear ring and turned the oxygen cylinder hand wheel to the ON position so that oxygen could be delivered immediately during cardiopulmonary resuscitation.
72. On 4 January 2024, I received safety alert reference INT LL 2024 001 entitled *Oxygen Cylinder Flow Risks: A Lethal Threat*. This alert followed a further incident review which identified that staff had again been unable to use an oxygen cylinder during a medical emergency because it had remained in the OFF position. The alert reiterated the actions previously communicated regarding the preparation and checking of oxygen cylinders prior to emergency use.

73. On 15 February 2024, I received a memorandum from Tendai Ruwona, Associate Director (Inpatient and Emergency Services, Mid and South), and Nick Archer, Head of Deteriorating Patient Pathways and Resuscitation Training Officer, entitled *Lessons Learned – Resus Event Form*. The memorandum advised that lessons from a patient safety incident had identified the need for the Resuscitation Event Form to be completed contemporaneously during all resuscitation events. The communication explained that the form could be used to support structured handovers and set out requirements relating to documentation and AED data downloads following a resuscitation event.
74. On 16 February 2024, I received a memorandum from Doreen Mhone, Service Manager, entitled *Contacting On-Call Doctors During a Medical Emergency – URGENT*. Following a Learning Response Review, it had been identified that an on-call doctor had not been contacted during a medical emergency. The memorandum strengthened local arrangements by confirming that on-call doctors would have access to both a radio and a pinpoint pager. Staff were instructed to contact the doctor by radio and identify the situation as a medical emergency. The memorandum also referred staff to the roles and responsibilities set out within the resuscitation policy.
75. On 23 May 2025, I received safety alert reference INT GEN 25 006 entitled *SWARM Early Learning (Resus)*. The alert followed a SWARM review conducted after a medical emergency on an inpatient ward. Learning identified included staff being unable to locate certain items of emergency equipment within the resuscitation bag and insufficient opportunities for staff to participate in medical emergency simulations. A number of urgent actions were issued to address these concerns.
76. On 4 December 2025, in my role as Matron, I issued a memorandum entitled *Defibrillator Check List – Compliance* to staff working within the Mental Health Urgent Care Department, Assessment Unit – Grangewaters and Clinical Site Management Team at Basildon Mental Health Unit. The memorandum reiterated the requirement for daily defibrillator checks and reminded staff of their responsibilities under the Trust CPR Procedure. Staff were instructed to ensure that all defibrillators were maintained in a rescue-ready condition, that equipment checks were completed and documented, and that all staff were familiar with the location of emergency equipment within their areas of work.

77. On 19 March 2026, I received a memorandum from Doreen Mhone, Service Manager, entitled *Location of the Electronic Suction Machines*. This communication advised staff that two electronic suction machines had been introduced at the unit to supplement the handheld suction devices contained within Grab Bags. The memorandum also confirmed that staff undertaking Immediate Life Support training would receive additional instruction in the use of the new equipment.
78. The majority of these alerts and communications were disseminated through Datix alerts, memoranda, email communications, management meetings and local team discussions. As a Ward Manager and later Matron, I was responsible for ensuring that relevant information was cascaded to staff through email communications, team meetings and ward-based discussions. Where alerts required changes to local practice, such as emergency equipment checks, oxygen cylinder preparation, procedures for contacting emergency services or Duty Doctors, these requirements were incorporated into local processes and reinforced with staff.
79. The mechanisms by which I sought assurance that staff had understood and implemented the learning contained within these communications included discussion with staff, observation of practice, emergency drills, equipment checks, incident reviews and compliance monitoring. However, in my view, the circulation of a safety alert or memorandum alone does not guarantee understanding or implementation. Effective embedding of learning requires ongoing reinforcement through training, simulation, supervision and audit.
80. Looking across the safety alerts and memoranda collectively, several recurring themes emerged. These included emergency communication processes, contacting emergency services and medical staff, oxygen cylinder readiness, defibrillator safety, emergency equipment checks, completion of resuscitation documentation and the importance of simulation-based training. A notable feature was the repeated circulation of learning relating to oxygen cylinder preparation and use between 2022 and 2024. In my view, this demonstrates that some patient safety risks required ongoing reinforcement despite previous safety communications. The fact that some of these themes recurred over several years suggests that, whilst learning was repeatedly identified and communicated, sustained assurance processes were necessary to ensure that learning was consistently embedded into practice.

81. Induction, emergency procedures and ongoing competence

82. The Trust has an Induction and Mandatory Training Policy, which includes a Local Workplace Induction process for both permanent and temporary staff. The policy states that all staff will complete the local workplace induction in accordance with procedural guidelines.
83. For permanent staff, the Local Induction Form is completed electronically. The induction includes an overview of health, safety and wellbeing and refers to emergency equipment and emergency procedures. As part of the ward tour, staff are shown the location of ligature point areas and identified hotspots, and the ligature risk assessment process specific to the ward is explained. Staff are also briefed on departmental security procedures, including the use of personal alarms, CCTV, body-worn cameras, keys and Grab Bags. Emergency responses, including clinical emergencies, psychiatric emergencies, resuscitation procedures, rapid nurse response processes and the location of first aid equipment, are covered during induction. Ligature management is also addressed, including the use of ligature cutters, awareness of the hotspot gallery and the ligature wallet.
84. For temporary staff, the Local Workplace Induction is completed using a paper-based form. This induction is required where a member of staff has not worked within the unit during the preceding four weeks, although there is no system in place to notify when this is required. The induction form is less detailed than the electronic form used for permanent staff. It includes a section specifically relating to emergency procedures, including medical emergencies and arrangements for communication, escalation and pharmacy support.
85. These local induction documents provide a formal record that induction has taken place for both permanent and temporary staff.
86. As a Ward Manager and later as a Matron, I sought to satisfy myself that staff remained familiar with emergency procedures following induction through a combination of mandatory training compliance monitoring and observation of practice.

87. At site level, monthly performance meetings are held and chaired by Doreen Mhone, Service Manager, during which mandatory training compliance and Trust Key Performance Indicators are reviewed. I regularly reviewed training compliance reports and discussed mandatory training requirements with staff during one-to-one support sessions.
88. I also relied upon ward-based discussions with staff, together with observation of staff performance during routine clinical practice and during any emergency incidents or training scenario that occurred. Where concerns were identified regarding an individual's knowledge, confidence or competence, these would be addressed through additional support, supervision, training, involvement of Human Resources and consultation with Professional Lead for Registrants. While these measures provided a degree of assurance, I recognise that maintaining competence in emergency response requires ongoing reinforcement and practical application in addition to completion of formal training requirements.

89. Adult Cardiac Arrest Team arrangements at Basildon Mental Health Unit

90. I joined Grangewaters Ward at Basildon Mental Health Unit as a Deputy Ward Manager in June 2018. At that time, a resuscitation crash trolley was available on the ward. The resuscitation crash trolley contained equipment that, to my understanding, was intended to align with the requirements of the Basildon and Thurrock University Hospital Resuscitation Service. The Resuscitation Equipment Daily Check Log Book in use on the ward had been issued by Basildon and Thurrock University Hospital and was Version 2.0 dated December 2014.
91. Following a medical emergency on Thorpe Ward on 13 August 2019, I became aware of concerns raised by a nurse who attended as part of the Cardiac Arrest Team regarding the condition and contents of the resuscitation crash trolley. As a result of those comments, I contacted the Resuscitation Service at Basildon and Thurrock University Hospital and spoke with a Resuscitation Officer.
92. During that conversation, the Resuscitation Officer advised me that, provided the resuscitation crash trolley contents complied with the checklist in use and issued by Basildon and Thurrock University Hospital, this was all that could reasonably be

- expected of staff responsible for carrying out the checks. I was also advised that updated checklists had been produced but had not yet been implemented within the Mental Health Unit. I was informed by the Resuscitation Officer that implementation of the revised checklists had been outstanding since December 2017 and that responsibility for implementation sat with the Lead Resuscitation Officer. I was further advised that the resuscitation crash trolleys at the Mental Health Unit had last been audited by Basildon and Thurrock University Hospital on 21 December 2017.
93. Following this conversation, I emailed the Lead Resuscitation Officer requesting support to implement the updated checklists and to introduce twice-yearly audits of the resuscitation crash trolleys. I do not recall any progress being made in relation to these requests before the agreement with Basildon and Thurrock University Hospital ended in March 2020.
 94. In the event of a medical emergency involving a deteriorating or unresponsive patient, the Adult Cardiac Arrest Team, commonly referred to by staff as the "Crash Team", could be called to respond.
 95. The process for summoning the Cardiac Arrest Team was to call 2222 from a Cisco telephone and notify the hospital switchboard of the location of the emergency. Switchboard would then activate the Cardiac Arrest Team by sending a pager alert advising team members of the location they were required to attend.
 96. I do not recall receiving any specific training regarding the process for calling the Cardiac Arrest Team. However, posters were displayed in ward offices setting out the procedure for contacting the team.
 97. I do not recall any drills or simulation exercises taking place that involved summoning the Cardiac Arrest Team.
 98. I am not aware of any limitations or circumstances in which the Cardiac Arrest Team could not, or should not, have been called in response to a deteriorating or unresponsive patient during the time of the agreement with Basildon and Thurrock University Hospital. I am aware of one occasion in 2022, after the retraction of the Cardiac Arrest Team in 2020, that staff on a ward called for support from the Cardiac Arrest Team during a medical emergency. I do not recall the specific details of this incident.

99. Experience of Cardiac Arrest Team attendance at medical emergencies

100. I was not involved in the deteriorating patient incident that occurred on 17 March 2019 at Basildon Mental Health Unit which resulted in the attendance of the Adult Cardiac Arrest Team from Basildon and Thurrock University Hospital.
101. At that time, I was the Ward Manager for Grangewaters Ward and was not on duty when the incident occurred.
102. I was, however, involved in other incidents where the Adult Cardiac Arrest Team was called to attend medical emergencies at Basildon Mental Health Unit.
103. Based on my experience, the Cardiac Arrest Team would usually respond within minutes of being alerted via the medical emergency pager system. My recollection is that team members would respond promptly from Basildon and Thurrock University Hospital to the Mental Health Unit, often running to the location of the emergency within minutes.
104. In the incidents in which I was involved, I do not recall any occasions on which the Cardiac Arrest Team had trouble reaching a patient once they had arrived on site. It was usual practice for staff to be deployed to the main reception area to direct the team to the location of the emergency and for staff to be positioned at access-controlled doors to facilitate rapid entry to the ward.
105. I do not recall any specific learning being shared with me because of the deteriorating patient incident that occurred on 17 March 2019. I am therefore unable to comment on whether any learning was identified or how any such learning may have been disseminated to permanent, bank or agency staff.

106. Emergency incidents, response and learning

107. In my view, the loss of direct access to the Adult Cardiac Arrest Team had the potential to increase the risks associated with managing medical emergencies within the Mental Health Unit.
108. In my experience, the Cardiac Arrest Team was an invaluable resource. Team members were trained in Advanced Life Support and were able to use the resuscitation crash trolley containing equipment and medications that were not available to staff working within the Mental Health Unit. Following the withdrawal of the service, staff were required to rely on the equipment contained within the Grab Bag and on the knowledge and skills of staff trained in Basic Life Support and Immediate Life Support. Whilst these skills are important, staff working within mental health inpatient settings generally manage acute medical emergencies less frequently than staff working in acute hospitals or specialist emergency response teams. In my view, this can affect familiarity, confidence and experience in responding to medical emergencies.
109. Following the withdrawal of the Cardiac Arrest Team, staff became reliant upon summoning the Ambulance service in the same way as any community setting. In my experience, there has often been a misconception that staff within the Mental Health Unit have access to equipment and resources equivalent to those available within an acute hospital environment. Staff were dependent upon ambulance response times and resource availability, which had the potential to result in delays in accessing advanced medical interventions.
110. I have been involved in a number of resuscitation and emergency response incidents at Basildon Mental Health Unit.
111. In January 2019, I responded to an incident on Thorpe Ward involving an unresponsive patient following a ligature incident. By the time I arrived, the Cardiac Arrest Team was in attendance and were attempting to resuscitate the patient. Sadly, the patient died on the ward.
112. In March 2019, I was involved in an incident on Grangewaters Ward involving a patient who was found unresponsive with two tightly tied ligatures. When I arrived, ward staff had already removed the ligatures and commenced emergency treatment. The Grab Bag had been brought to the scene, and the patient was receiving oxygen at 15 litres per minute. I called 2222 to summon the Cardiac Arrest Team and

ensured that the resuscitation crash trolley was available when they arrived. I am not aware of any delay in the Cardiac Arrest Team obtaining access to the ward. The Ward Doctor and Cardiac Arrest Team attended and assumed responsibility for the patient's care. It was subsequently decided that the patient required transfer to the Resuscitation Department. Due to delays in ambulance availability, the patient was transferred with support from the Cardiac Arrest Team and ward staff. I was later advised that the patient was stable, her physical observations were satisfactory, and she was awaiting blood results before being considered medically fit for return to Basildon Mental Health Unit.

113. In August 2019, I was involved in another incident on Grangewaters Ward involving a patient who had collapsed. On arrival, staff had commenced emergency treatment, including oxygen therapy at 15 litres per minute. The Cardiac Arrest Team was called and the resuscitation crash trolley brought to the scene. I am not aware of any delay in the Cardiac Arrest Team obtaining access to the ward. The patient was found to have severe hyperkalaemia and required intravenous calcium administered by the Cardiac Arrest Team. Ward staff assisted the team during the response. The patient was subsequently transferred to the acute hospital and later discharged. During this incident it was identified that the crash trolley did not contain Caresite Smallbore Y-extension sets because these items were not listed within the Resuscitation Equipment Daily Check Log Book that was in use at the time.
114. During my time on Grangewaters Ward between June 2018 and the termination of the agreement with Basildon and Thurrock University Hospital, I was involved in a number of other incidents requiring attendance by the Cardiac Arrest Team. These included a patient who was found unresponsive and required emergency treatment for a suspected opioid overdose. In that incident, the ward team supported the Cardiac Arrest Team by providing access to naloxone. I am not aware of any delay in the Cardiac Arrest Team obtaining access to the ward. The patient was transferred to the acute hospital and subsequently discharged.
115. I also responded to incidents involving a patient on the Assessment Unit with suspected cardiac concerns, a patient on Thorpe Ward experiencing catatonia who required intravenous treatment prior to transfer to hospital, and a patient who had sustained significant injuries following self-harm by cutting and required transfer for further treatment. Owing to the passage of time, I do not recall the specific details of these incidents.

116. Following the withdrawal of the Cardiac Arrest Team, I have also responded to medical emergencies involving seizures and to an incident involving a patient who had jumped from a height and required CPR.
117. On 8 August 2026, I was not on duty but was subsequently informed of an incident on Assessment Unit – Grangewaters, involving an unresponsive patient following a ligature incident. I was informed that ward staff, including nursing and medical colleagues, responded to the medical emergency call transmitted over the radio and commenced CPR. By the time I arrived, the ambulance service was in attendance and the patient's death had sadly been confirmed.
118. I do not recall debriefs routinely taking place with the Cardiac Arrest Team following incidents. However, I am aware that the Cardiac Arrest Team completed documentation when they attended the Mental Health Unit. Debriefs have taken place following emergency incidents within the Mental Health Unit and these are recorded in ward debrief books. Datix Incident Reports should also be completed following such events.
- 119. Recurring concerns regarding emergency equipment and emergency responses**
120. Looking across emergency incidents and simulation exercises, one recurring issue was that staff had trouble rapidly locating specific items within the Grab Bag during stressful and time-critical situations. In my experience, this was particularly evident in relation to high-concentration oxygen masks and equipment required for oxygen administration.
121. In September 2022, I raised concerns with Nick Archer, Head of Deteriorating Patient Pathways and Resuscitation Training Officer, regarding the organisation of equipment within Grab Bags. I provided photographs of a community midwifery emergency bag, which used a compartmentalised system that appeared to allow equipment to be identified more easily during emergency situations. Nick Archer agreed that this approach had advantages and advised that he had used a similar

- system in a previous organisation. I was subsequently asked whether I was aware of any commercially available solutions that might be suitable.
122. On 19 December 2024, following a medical emergency on a ward where staff again had trouble locating a high-concentration oxygen mask during a stressful situation, I raised the issue further and enquired whether a compartmentalised emergency bag system could be piloted within the Trust. I was advised by Nick Archer that similar systems had previously been utilised in operating department practice and critical care environments because they facilitated rapid identification of equipment. However, he explained that the Trust's current resuscitation bags contained less equipment and that alternative bag systems were significantly more expensive. He advised that he was developing a training video to support staff in becoming more familiar with the equipment contained within the Grab Bags and its use.
123. On the same date, I also raised an observation from Basildon Hospital, where a sealed high-concentration oxygen mask with tubing attached was stored on a hook adjacent to an oxygen cylinder for immediate use. I asked whether a similar arrangement could be considered or piloted within the Mental Health Unit. Nick Archer advised that he could see no objection to a sealed mask being stored separately from the Grab Bag provided that appropriate checks were undertaken to ensure that expiry dates did not lapse and that access to an oxygen cylinder was maintained. He further advised that any change to existing arrangements would require discussion through the Resuscitation and Deteriorating Patient Group.
124. To my knowledge, no such change was subsequently implemented, and high-concentration masks remain stored within the Grab Bags.
125. Whilst measures were taken to improve staff familiarity with the contents of the Grab Bags, including the development of training resources, I do not consider that the underlying concern regarding the rapid identification and retrieval of emergency equipment during stressful situations has been fully resolved. In my view, this remains a systems issue rather than a training issue alone and continues to present a potential patient safety risk. I believe further consideration should be given to whether emergency equipment could be organised in a way that allows critical items to be identified and accessed more quickly during time-critical emergencies.

126. Looking across the incidents, simulations, alerts and reviews described within this statement, my overall impression is that the most significant challenges were not deficiencies in basic resuscitation knowledge but issues relating to systems, communication, equipment accessibility, escalation processes and the practical application of learning. Whilst training is important, in my view these issues require ongoing review through simulation, audit and organisational assurance if improvements are to be sustained.

127. Statement of truth

128. I believe the content of this statement to be true

129. Louise Borton

[I/S]

130. 16/09/2026