Open letter from Dr Geraldine Strathdee, Chair of the Essex Mental Health Independent Inquiry. 12 January 2023.

I am writing to update on the progress of the Essex Mental Health Independent Inquiry.

Over the past year I have heard remarkable and sobering evidence from many families who have tragically lost their loved ones, and from people who have experienced mental health inpatient care themselves. I am enormously grateful to everyone who has spoken with our Inquiry. Their testimony has been hugely valuable to the Inquiry's work, and I know sharing this evidence has at times come at great personal cost. I have heard from parents who fought to get treatment for their child, of patients desperate for compassionate, effective clinical care, and of the unimaginable pain of losing your loved one to mental illness.

I have also been deeply moved and impressed with the practical, considered, and improvement focused recommendations I have heard throughout this evidence. These witnesses have trusted us with their heartache in order to prevent the same heartache in others.

The next stage is to hear from staff and former staff. Staff evidence is fundamental to our Inquiry: to properly investigate the deaths of mental health patients; to understand the culture, leadership, and governance at the Trusts; and so that staff can tell the Inquiry what it is like to work on the front line of mental health – and what in their view would make care better.

My team and I have worked extensively to engage staff and former staff to give evidence. As part of these efforts the Inquiry has written out to over 14,000 members of staff and former staff. We have also written to some of those involved in key cases I am investigating. We have worked to provide reassurance to staff, as well as reminding them of their duty to comply with the Inquiry under their professional codes of conduct. I am incredibly grateful to those who have come forward. However, the number of responses has been hugely disappointing.

Of the over 14,000 staff written to, we have received a small number of written comments from staff and, to date, only 11 have said they would attend an evidence session. Where we have also written directly to some of those involved in the cases of deceased patients we are investigating, 1 in 4 have responded to say they will provide evidence. This is inadequate to meet our Terms of Reference.

The Inquiry was set up as a non-statutory public Inquiry by the then Minister for Patient Safety – and I have been working to deliver the Inquiry in this form. Until now I have found the Inquiry's non-statutory status to be entirely appropriate.
However, in the event that staff engagement remains very poor, it is my view that the Inquiry will not be able to meet its Terms of Reference with a non-statutory status.

I also need to provide an update on the information provided to the Inquiry by Essex Partnership University Trust (EPUT). In March 2022, when I made a public announcement about the Inquiry's work, I had received information from EPUT related to the deaths of 1,500 people. In December 2022, I received an update on this number from EPUT, and it actually stands closer to 2,000. This is a significant increase in the number of people who have lost their lives as Mental Health patients – and the number of families who have suffered this grief. I am concerned that it has taken two years since this Inquiry was announced to be informed about these individuals' deaths by the Trust. My Inquiry will now begin the process of writing to these families to offer to meet with all of them who would like to provide evidence to the Inquiry.

I met with Minister Maria Caulfield on 15 November about my concerns regarding staff evidence and followed up in writing later that month. I have now met with the Secretary of State for Health, Steve Barclay, on 10 January, to share my concerns about the Inquiry. As an independent Chair it is my responsibility to raise matters of concern with the Minister and the Secretary of State – any decision on the Inquiry's status will be the Government's to make. I am confident that my concerns are being treated seriously. I will update my witnesses as soon as I'm in a position to do so.

These challenges will cause some time delay to the Inquiry's work, and this means we will not be publishing in spring 2023. I will provide an updated timeline as soon as I am able. The Inquiry's work will continue while we await further progress. I remain committed to getting answers for families and patients as soon as possible.

In the meantime, it is vital I am transparent about the work of the Inquiry and the reasons why I have come to this conclusion on the Inquiry's status. I owe this to everyone who has given their evidence to the Inquiry and to the many more affected by the issues I am investigating.

I took this job as Chair to this Inquiry because I am deeply passionate about ensuring mental health patients get effective, compassionate, and evidence-based clinical care. I know this cannot be achieved without the input of patients and their families. The evidence my Inquiry has received from families of those who have sadly died, and former patients will be heard. I will be in touch with my witnesses again as soon as I have a further update.

Yours sincerely

Dr Geraldine Strathdee
Chair to the Essex Mental Health Independent Inquiry