

Explanatory Note in relation to Scope

The Explanatory Note does not form part of these Terms of Reference but indicates how the Chair is minded to interpret them.

In relation to the Inquiry's scope:

Dates: 1 January 2000 to 31 December 2023.

Location: Investigations will focus on the Trust(s) which provide NHS mental health inpatient care in Essex. These include the Essex Partnership University Foundation NHS Trust (EPUT) and the North-East London Foundation Trust (NELFT) and their predecessor organisations, where relevant, which provided care in Essex during the relevant time period. The Chair may make national recommendations as she considers appropriate. To do so, she may seek evidence from individuals, organisations or from Trusts who are either involved in the provision of mental health care in other areas or have evidence which may be relevant to the issues which the Inquiry is investigating.

Inquiry's definition of inpatient death:

- (a) those who died on an NHS mental health inpatient unit or in receipt of NHS funded inpatient care within the independent sector (whether detained under section or informally). Units to be included are:
 - adult mental health units
 - psychiatric intensive care units (PICU)
 - CAMHS units (acute and PICU)
 - mental health assessment units
 - mother and baby mental health units
 - older adult mental health units
 - eating disorder units
 - forensic/secure units
- (b) those who died while on leave from any of the above units, including supervised leave
- (c) those who died while absent without leave or having absconded from any of the above units, within 3 months of going absent without leave or absconding
- (d) those who died during or within 3 months of transfer from any of the above units, including transfer to a physical health setting or to an out of area mental health service
- (e) those who died whilst awaiting an assessment under the Mental Health Act
- (f) those who died whilst waiting for a bed in a mental health inpatient unit within 3 months of a clinical assessment of need

(g) those who died within 3 months of any mental health assessment provided by the Trust(s) where the decision was not to admit as an inpatient (this includes but is not limited to any death following a review in A&E, or an assessment under section 135 and 136 of the Mental Health Act)

(h) those who died within 3 months of discharge from any of the above units

Further points to note:

As well as hearing from the families of those who have died, the Chair will hear from others, including patients and former patients, and their families.

In undertaking her investigations into mental health inpatient deaths the Chair will consider as appropriate the particular circumstances which may be relevant to those individuals who have died. This may include (but is not limited to) neurodiversity, learning disabilities, dementia, co-existing physical health issues, drug and alcohol addiction, and other social and economic factors.

The Chair is minded to identify a sample of cases, representative of the issues, that will be investigated in detail in order to draw wider conclusions.

The Inquiry will investigate deaths which took place between 1 January 2000 and 31 December 2023. However, there may be limits to the level of investigation into deaths which took place within the early period of this timeframe. This is because relevant information and data may not be available to the Inquiry in some circumstances.

The Chair may investigate or obtain additional evidence in respect of any issue which she considers relevant and important to an understanding of the provision of mental health inpatient care or which may be a factor in mental health inpatient deaths. This may include, but is not necessarily limited to, the actions of other bodies and their interactions with the Trust(s), including the relevant Integrated Care Board(s) and predecessor organisations.