OPENING STATEMENT OF COUNSEL TO THE INQUIRY

Chelmsford Civic Centre, 9 September 2024

Introduction and welcome

Thank you, Chair.

We will today and during the course of this hearing be addressing distressing and difficult matters. Chair, you have referred to the emotional support service that is available. It is overseen by the Inquiry's Chief Psychologist. Counsellors are present here today (I think they are wearing black lanyards), and information about further services is available on the Support Services page of the Inquiry's website, or by asking a member of the Inquiry Team (as you heard, we are wearing purple lanyards). We want all those engaging with the Inquiry to feel safe and supported.

Chair, we have lawyers here representing core participants.

- On behalf of the family, friends and patients represented by Hodge Jones & Allen, Steven Snowden KC, Dr Achas Burin, and Rebecca Henshaw-Keene;
- On behalf of INQUEST, Lillian Lewis;
- On behalf of Essex Partnership University Trust, Adam Fullwood. Chair, Eleanor Grey KC will be here on Wednesday to give their opening statement;
- On behalf of NEFLT, Valerie Charbit;
- On behalf of the three core participants, integrated care boards, Mid and South Essex, Hertfordshire and West Essex, Suffolk and North East Essex, known as ICBs, Zeenat Islam;
- On behalf of the Care Quality Commission, Jenni Richards KC;

- and on behalf of the Department of Health and Social Care, Anne Studd KC.

I am assisted at this hearing by further members of the Counsel to the Inquiry Team. They are Rachel Troup, Rebecca Harris, and Dr Tagbo Ilozue. I am grateful for all of their help.

As you have said chair, the Counsel Team works closely with the Lampard Inquiry Solicitor Team, under Catherine Turtle. The Inquiry would not be able to operate without them; and we also rely heavily on the work of the professional and experienced Secretariat Team and the Inquiry's Engagement Team, which is part of the Secretariat and with whom many families and patients may have already been in contact.

I have already referred to the Inquiry's website and I will throughout this Opening Statement be referring to other documents and information that are available on it. It is an important resource, and the Inquiry will regularly post updates on it. It is at lampardinquiry.org.uk. and it contains a wealth of material, including a series of helpful FAQs.

Background

It will be helpful to provide some background about how this inquiry came to be set up, although I do not intend to provide a comprehensive account.

Parliamentary and Health Service Ombudsman

In June 2019, Rob Behrens CBE, who was then Parliamentary and Health Service Ombudsman, published his report entitled *Missed Opportunities*,

which found that there had been a series of significant failings in the care and treatment of two vulnerable young men who died shortly after being admitted to North Essex Partnership University NHS Foundation Trust (which was subsequently subsumed into the Essex Partnership University NHS Foundation Trust).

The report considered the death in 2008 of a person referred to as **"Mr R"** and the death in November 2012 of **Matthew Leahy**. It identified multiple failings surrounding both deaths. The report also identified systemic issues at the Trust, including a failure over many years to develop the learning culture necessary to prevent similar mistakes from being repeated.

Mr Behrens noted that the families of both young men:

> ***"... suffer the ongoing injustice of knowing that their sons did not receive the standard of care they should have done. This has caused them unimaginable distress".***

He also said:

> ***"Serious failings by organisations providing mental health services can have catastrophic consequences for patients. NHS trusts must ensure timely improvements to ensure patient safety and protect patients who are at risk of taking their own life."***

Police and HSE Investigations

In 2021, Essex Partnership University NHS Foundation Trust (which I will sometimes refer to as "EPUT") faced criminal proceedings and was fined for safety failings. This was for over a period exceeding ten years, from 2004 to 2015, concerning the deaths of patients at the North Essex Partnership

University Trust. The prosecution was brought by the Health and Safety Executive and I will refer to the sentencing remarks of Mr Justice Cavanagh; that was at the Crown Court here in Chelmsford on 16 June 2021.

Some of what he said is distressing to hear. He noted that on 20th November 2020, at Chelmsford Magistrates Court, EPUT had pleaded guilty to a charge that, during the period from 1st October 2004 to 31st March 2015, it had failed, so far as was reasonably practicable, to manage the environmental risks from fixed ligature points within its inpatient mental health wards across various sites under its control in Essex, thereby exposing vulnerable patients in its care to the risk of harm by ligature. The risk of harm was that patients would end, or would attempt to end, their lives by hanging, using such ligature points as were available to them in the inpatient wards. During this period, 11 inpatients hanged themselves using ligature points, and at least one other, and probably more, tried unsuccessfully to do so.

The judge added this:

> ***"At the heart of this case are a number of interconnected failures by the Trust. In summary, these are that there was a consistent failure to comply with national standards and guidance involving ligature risks (these are sometimes referred to as "environmental" risks); failure to act in a timely manner when environmental risks were brought to the Trust's attention, and failure to act in a timely manner on recommendations made by the Trust's own internal Audits; and failure to act appropriately after serious incidents had occurred, by failing to make appropriate environmental changes to reduce suicide risks, so as to remove the environmental risks from the***

same or similar locations. These failings often persisted for a number of years and meant that dangers resulting from ligature points on wards … were not identified and dealt with."

Public pressure from campaign group

Dedicated family members, with the strong support of a number of MPs, raised awareness of these issues within Parliament. And on 16th October 2020, during a debate on deaths in mental health facilities, James Cartlidge MP spoke about the circumstances of the death of a young man named **Richard Wade** in 2015 in the Linden Centre here in Chelmsford. The debate highlighted concerns over the Care Quality Commission's handling and investigations of deaths in a mental health inpatient setting. Ed Argar MP, who was then Minister of State for Health, told the House of Commons that fellow health minister Nadine Dorries MP intended *"to commission an independent review into the serious questions raised by a series of tragic deaths of patients at the Linden Centre between 2008 and 2015."*

At around the same time, a petition created by **Matthew Leahy's mother, Melanie**, was signed by over 100,000 people calling for a statutory inquiry, to cover all Essex Mental Health services. This extraordinary effort secured a second Parliamentary debate on 30 November 2020. During this debate Nadine Dories announced that there would be an independent inquiry covering the period from 2000 to the present day. The Essex Mental Health Independent Inquiry was established by the government in April 2021 and Dr Geraldine Strathdee CBE was appointed as its Chair. This was a non-statutory inquiry.

Significant concerns were raised by some families from the outset about it being a non-statutory Inquiry and calls were made for it to have the full force and powers of a statutory Inquiry.

In November 2021, the Inquiry launched a call for evidence from families and carers of inpatients who died in Essex NHS Trusts between 2000-2020, as well as anyone with experience of mental health inpatient services across Essex during the 21-year period. In March 2022, the Inquiry put out a wider call for evidence.

In July 2022, the Inquiry's Chair issued an urgent appeal to staff to come forward to share their experiences with the Inquiry. The response to this was extremely poor.

On 12th January 2023, Dr Strathdee published an open letter setting out her belief that the Inquiry could not deliver as a non-statutory Inquiry with the current response from staff. After further efforts to engage staff, the Chair informed Steve Barclay MP, who was then Secretary of State for Health and Social Care, on 17th April that her view remained that the Inquiry could not meet its terms of reference without statutory status to compel witnesses to share evidence.

In June 2023, Steve Barclay announced the Statutory Inquiry, saying that:

> ***"Due to the challenges faced while running an independent inquiry - such as engaging former and current staff at the Essex Partnership University Trust..., and in securing evidence from the trust itself - a statutory inquiry will have legal powers to compel witnesses,***

including those former and current staff of EPUT, to give evidence."

Chair, you have already described how the Inquiry was put on a statutory footing in October 2023, that you took over from Dr Strathdee as Chair, and that it relaunched on 1st November last year as the "Lampard Inquiry".

Dispatches documentary

It is clear that serious issues with mental health care in Essex continue, and that the matters to be investigated by the Inquiry are as pressing and relevant as when it was first established.

On 10th October 2022, Channel 4 broadcast a Dispatches documentary entitled *Hospital Undercover – Are they Safe?* The programme showed footage from a year-long undercover investigation and highlighted concerning practices on various wards run by EPUT. It is a stark but important piece of reporting. It covers issues of great relevance to this Inquiry, including concerning ligatures, the use of restraint and absconding from wards.

Procedure

I turn now to discuss the Inquiry's procedure. The statutory public inquiry is a process that allows for a thorough but ultimately flexible and imaginative approach in pursuit of the truth.

I want to speak first about some of the provisions in the Inquiries Act 2005 and Inquiry Rules 2006 as they form an important part of the Inquiry's

procedure, but I do not intend to enter into an exhaustive discussion of this statutory framework.

Inquiries Act 2005

[Link to Act]

The Inquiries Act specifically says that the procedure and conduct of an inquiry are to be as the Chair directs them to be. That is section 17. It is subject to the Inquiry Rules, which I will come back to in a moment. The law therefore gives the Chair a great degree of control about how to proceed.

The Act also makes clear that the Chair:

> ***"must act with fairness and with regard also to the need to avoid any unnecessary cost".***

That is again section 17. The central requirement of fairness is as one would expect. And the Chair must adopt a proportionate approach, with efficiency and the urgency of the Inquiry's task in mind.

Section 2 of the Act states that the Chair is not to rule on (and has no power to determine) any person's civil or criminal liability. Chair, as you have said that means that the Inquiry is not a trial. The Inquiry's process is inquisitorial and the end results are its report and recommendations. It is not like a civil or criminal case. There are no sides and there is no finding of guilt or innocence.

Chair, this does not stop you from reaching strong and clear findings about the facts. On the contrary, it is your duty to do so. And it does not stop you

from going on to make robust recommendations for change. This is in part because section 2 also makes clear that the Chair is:

> ***"not to be inhibited in the discharge of [her] functions by any likelihood of liability being inferred from facts that [she] determines or recommendations that [she] makes".***

One of the requirements for the Chair's appointment is impartiality. This is addressed in section 9. The Chair and this Inquiry will be entirely independent from all of those engaging with the Inquiry and, more widely, from Government or any health body or other organisation. This is a statutory requirement and a matter of fundamental fairness. The Inquiry's findings would be undermined were we to act in any other way.

This is a public inquiry. The default position is that inquiry proceedings shall be public. Section 18 covers this. It sets out that the Chair must take such steps as she considers reasonable so that firstly, members of the public are able to attend the Inquiry in person or to view its proceedings virtually via a simultaneous transmission; and secondly, to obtain or view a record of its evidence and documents.

But the Inquiry is considering matters of great sensitivity. They involve highly personal information regarding mental health and medical matters, in relation to people who may be vulnerable. The Inquiry's Terms of Reference recognise this and include that:

> ***"Personal and sensitive information provided to the Inquiry will be appropriately handled. It will only be shared or made public as is necessary and proportionate for the Inquiry to fulfil these Terms of Reference".***

This is where section 19 comes into play. It allows the Chair to impose restrictions both on attendance at an inquiry and the disclosure or publication of evidence. In general terms, this means that in certain circumstances the Chair may hold hearings in private or hold back certain documents or provide them with redactions. Another aspect of this is that the Chair may grant individuals anonymity – allowing them to give evidence without disclosing their identities. In some cases, this might be appropriate for those who wish to assist the Inquiry but for various reasons are very apprehensive about doing so in public.

Restrictions on the disclosure of identities or other parts of evidence are imposed by making a "restriction order". Two different categories of restriction may be contained in an order. They are set out in Section 19. The first are those required by a statutory provision or rule of law. The second are those that the Chair considers *"to be conducive to the inquiry fulfilling its terms of reference or to be necessary in the public interest"*.

The system involves careful consideration and balancing of a number of relevant factors. It also requires a clearly set out, proper basis before any restriction may be made.

Chair, you have published a Note on the Inquiry's website setting out the approach you will adopt in relation to restricting the identities of patients who engage with our investigations. You have decided to apply a presumption in favour of anonymity for those who are living and are currently, or have previously been, mental health inpatients under the care of NHS Trusts in Essex.

I would now like to address the Inquiry's powers of compulsion, which most clearly set it apart from the non-statutory Inquiry. Chair, you have said that the Inquiry expects that those asked to provide documents or to come to give evidence will do so voluntarily. However, where that does not happen, the Chair has powers under section 21 by notice to require a person to give evidence and to produce documents and materials to the Inquiry. It is a criminal offence under section 35 to fail without reasonable excuse to do anything that is required by a section 21 notice. It is also a criminal offence to suppress, conceal, alter or destroy relevant evidence.

As we have heard, the importance of the matters being looked into, and the difficulties experienced by the Non-Statutory Inquiry, have made a statutory inquiry with powers necessary.

I repeat the call for those with relevant information to provide to the Inquiry, whether they are current or former staff members or others, to come forward voluntarily. By doing so and cooperating, they will rightly assist us in uncovering what happened.

We recognise that there will be dedicated and committed staff and former staff who do wish to come forward to share their experiences of mental health inpatient care in Essex and to express their concerns about what they have witnessed. They will be supported throughout by this Inquiry, including, where appropriate, through the use of restriction orders.

But we will not hesitate to look for those who do not come forward. Chair, you have indicated that you are prepared to use your powers to compel evidence wherever necessary.

We recognise, however, that giving evidence at a hearing may be particularly difficult for the family and friends of those who have died, and for patients and former patients. The Inquiry's objective is to ensure that each witness is fully supported in a way that allows them to share their experiences to the best of their ability.

To achieve that objective and to encourage these witnesses to share their experiences with the Inquiry as safely as possible, Chair, you have confirmed that you will not exercise your powers under section 21 against the family and friends of those who have died, or against patients and former patients, unless in exceptional circumstances. This means that they will not, at any stage, be compelled to give evidence at any Inquiry hearing. They will be invited to do so on a voluntary basis. Further information about this is available in a Note that was published in July this year regarding section 21 of the Inquiries Act 2005.

This is an appropriate time to make clear that the Inquiry takes its safeguarding responsibilities very seriously. A Note about the approach the Inquiry will take in this regard is available on its website.

The Inquiry has produced various further notices. They provide additional information about the running of the Inquiry. It is important to mention one of those at this stage. The notice on the Prohibition on the destruction of documents refers to section 35. It makes clear that it is crucial that the Inquiry's investigation is not obstructed by the premature destruction of any material that may be relevant to the matters it is investigating, and that anyone holding such material should ensure that it is preserved. It spells out what is meant by "material" here, including all correspondence, emails, recordings, documentation, or data of different sorts. The Inquiry has also

contacted those it knows or believes to hold relevant documents in similar terms.

Inquiry Rules 2006

[Link to Rules]

Chair, you have decided that the Inquiry will also operate under the Inquiry Rules 2006. You were not required to do so, as the Inquiry started life as a non-statutory inquiry. But the Rules will provide a proper framework for participation by those who wish, or are asked, to engage with the Inquiry. This was explained in the April 2024 Statement of Approach you provided with the publication of the Inquiry's Terms of Reference.

The Rules cover matters such as the designation of core participants. I will talk about that in a moment. They also cover in rule 9 the process by which the Inquiry should seek evidence (initially by way of written request); and in rule 10 the framework for the questioning of witnesses who come to an Inquiry hearing to give evidence. The Rules cover a range of other matters, such as the award of legal and other costs and expenses, that I do not intend to go into now.

Protocols

The Inquiry has further spelt out the procedure it is to follow in a series of protocols. It is important that those engaging with the Inquiry and, where they are represented, their lawyers, have regard to these protocols. They cover the Inquiry's approach to a range of matters including (but not limited to):

- obtaining witness statements;

- the disclosure of documents to the Inquiry; and
- whistleblowing;

I will refer to some other protocols later. And further protocols will be added as appropriate as the Inquiry goes along.

Flexibility of approach

As we have seen, the Inquiry is not constrained by the strict rules of evidence in adversarial proceedings. Chair, given your commitment to ensuring that all those who engage with the Inquiry can be supported to do so as safely as possible, the Inquiry will carefully consider the processes it adopts and may be flexible about the types of evidence it is prepared to receive.

The Inquiry Team will continuously consider the most efficient way in which to address the issues being investigated, consistent with the requirements of thoroughness and fairness. We will also consider the views of core participants and others involved in the Inquiry's work about how to achieve this.

Core Participants

Becoming a core participant

I have already referred to core participants. I would like now to explain what a "core participant" is. It is a person or organisation afforded specific rights at the Inquiry. For example, they may have greater access to the Inquiry's evidence; they can make opening statements (as we will be seeing this week – and closing statements in due course); and they may suggest lines

of questioning for witnesses who come to give evidence at an Inquiry hearing.

The application process to become a core participant took place in April and May this year. It is still possible to apply, however, particularly for those who have only recently become involved in the work of the Inquiry.

Anyone interested in applying should look at the Protocol on Core Participants, which explains the relevant criteria and includes an application form. They should also look at the Chair's Statement of Approach on Determining Core Participant Applications of 15th July this year.

The inquiry core participants fall into the following broad categories:

- The Bereaved Family and Friends of those who died;
- living current and former Patients;
- Staff Members; and
- Health Bodies and other Organisations.

Families, Friends and Patients

The evidence of the Family, Friends and Patients will be key. At its heart, this Inquiry is about people, and most obviously those who died and those most closely affected by the issues under consideration.

The written Opening Statement provided on behalf of many of the Families, Friends and Patients expresses hope of building rapport and trust with the Inquiry. The Inquiry very much welcomes the opportunity to build those constructive relationships with the people most affected by the issues to be explored.

Health Bodies and other Organisations

There are various organisations with core participant status in this Inquiry, ranging from government departments and national health bodies through to local NHS Trusts and Integrated Care Boards. A number of these core participants have provided written opening statements which include relevant background. However, it will help if I provide a brief summary about each of them at this stage.

The Department of Health and Social Care (also known as the DHSC) is the government department which sets overall strategy for, funds and oversees the health and social care system in this country. This includes responsibility for overseeing services provided in clinical settings, such as hospitals and GP surgeries, and those provided in the community through nursing, social work and other professional services. The DHSC has a significant role to play in the development of policy in relation to mental health and patient safety. It works with a number of other public bodies, agencies, and authorities to provide health and social care. These include public bodies such as NHS England and the Care Quality Commission, who are also core participants in this Inquiry.

The DHSC is the government department sponsoring and funding this Inquiry. It is therefore important to state that the Inquiry requires, and will monitor, strict separation between the Department's sponsorship and core participant roles.

NHS England. The National Health Service is a series of interconnected organisations responsible for directing, planning, commissioning, organising and providing healthcare services. NHS England leads the National Health Service in England and has day to day responsibility for the

provision of health services in England. Its purpose is to deliver high-quality services for all users.

The Care Quality Commission (also known as the CQC), established in 2009, is the independent regulator of health and adult social care in England. The CQC regulates the organisations that provide health and social care (as distinct from the individuals within them). The CQC's role is to ensure that all health and social care services provided in this country are safe, effective and of high quality. Its remit is wide-ranging. The CQC regulates and scrutinises a variety of providers, from hospitals to care homes. It is an executive non-departmental public body sponsored by the DHSC. There is no question that work done by the CQC will be of interest and relevance to the work of this Inquiry; for example, the CQC undertook reviews of the Trusts with which we are concerned.

Three **Integrated Care Boards (also known as ICBs)** are core participants in this inquiry: Hertfordshire and West Essex; Suffolk and North East Essex; and Mid and South Essex. ICBs are statutory bodies responsible for planning and funding NHS services in their local area. ICBs allocate the NHS budget and commission services for the population, taking over the functions previously held by Clinical Commissioning Groups and some of the direct commissioning functions of NHS England. ICBs are directly accountable to NHS England; they are a key component of Integrated Care Systems. The three ICB core participants in this Inquiry are those responsible for planning and funding mental health services in Essex. They work with local providers to do so.

Essex Partnership University Trust (or "EPUT") is the main Trust providing mental health services in Essex which this Inquiry is investigating. EPUT was formed in April 2017 as a result of the merger of two predecessor trusts

operating in Essex: the North Essex Partnership University Trust and the South Essex Partnership University Trust. EPUT is commissioned to provide the majority of mental health services in Essex, but not community (outpatient) Child and Adolescent Mental Health Services. As the Inquiry's timeframe extends back to the start of 2000, the Inquiry will in addition consider the way in which predecessor Trusts operated.

North East London NHS Foundation Trust (also known as "NELFT") provides community Child and Adolescent Mental Health Services across the whole of Essex. NELFT also provided mental health services historically at Mascalls Park, a Mental Health inpatient unit in Essex, which closed in 2011. Furthermore, on occasions, patients from Essex were placed in NELFT units.

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists through their careers. Given its membership, the College works to promote the provision of high-quality mental health services and to secure the best outcomes for people with mental illness. the Inquiry expects to hear evidence from, and about, registered clinicians who work in this specialty.

The charity **INQUEST** is also a core participant in this Inquiry. INQUEST is independent from government. It provides advice and expertise on state-related deaths to bereaved people, lawyers and others. INQUEST has considerable experience of the deaths of those detained under the Mental Health Act and in psychiatric settings and has worked on a large number of cases involving deaths in mental health settings in Essex.

Staff Members

Staff member core participants and witnesses will fall into one of the following categories:

- doctors, ranging from trainees and specialist psychiatric trainees to consultant psychiatrists;
- those working in the psychological professions, such as clinical psychologists and CBT therapists;
- mental health nurses and nursing associates;
- occupational therapists;
- other therapists;
- paramedics;
- healthcare assistants; and
- managers.

The Inquiry is aware of highly concerning practices that must be brought to light. Staff members must come forward where they have relevant information. But, as has already been said, the Inquiry expects also to find examples of professionalism, dedication and good practice from which it wishes to learn.

We do not intend to provide a fuller list of Family, Friend and Patient core participants at the moment. This is for various reasons, including outstanding applications to protect the identities of certain individuals. A full list will be provided in due course, which may include cyphers in place of the names of those to whom the Inquiry has granted anonymity.

As far as is possible and appropriate, the Inquiry Team wishes to collaborate with core participants to advance the Inquiry's important work.

It is not necessary to be a core participant

Being a core participant does not mean that a person's evidence is any way more important or given any greater weight. Personal accounts and experiences shared by those who are witnesses but not core participants are of no less value in the eyes of the Inquiry, than those provided by persons who are. So, it is important to stress that it is not necessary to be a core participant to engage meaningfully with the Inquiry.

The Inquiry process is designed so that those engaging with it do not need to be legally represented. Each person or organisation, core participant or not, should decide for themselves whether they require legal representation. Funding is available for legal costs for individuals who meet the relevant criteria. Funding is also available for other expenses connected to assisting the Inquiry as a witness, whether legally represented or not. The Protocols on Legal Costs and on Witness Expenses explain more about this. Those can be found on the Inquiry's website, along with the other protocols.

Legal representation

Lawyers representing core participants are known as "recognised legal representatives", using the language of the Inquiry Rules. Our hope and expectation is that they will use that experience not only to provide a high level of representation to their clients but will also engage helpfully with the Inquiry Team. We look forward to working with them. The Inquiry Counsel Team will make itself available to speak with legal representatives and I encourage constructive dialogue during the course of this Inquiry.

We are pleased to see many of the core participants and their representatives here today. We are grateful for the written opening

statements that they have provided and look forward to the oral opening statements that will follow my own.

Scope

Moving now to consider the scope of this Inquiry.

Terms of Reference

The Terms of Reference are central to the Inquiry and delineate its scope. I would like to say a little bit more about them now.

"Terms of Reference" are defined in section 5 of the Inquiries Act to mean "*the matters to which the Inquiry relates*", as well as the matters as to which the Chair is to determine the facts, whether she is to make recommendations and any other matters that are specified relating to scope. The Inquiry has no power to consider matters outside its Terms of Reference.

The Lampard Inquiry Terms should be read along with the Explanatory Note in relation to Scope, which indicates how the Chair is minded to interpret them.

The Chair's Statement of Approach of 10th April this year was provided following the consultation on updated Terms of Reference to form the basis of the newly statutory Lampard Inquiry. It provides information about that consultation process and its outcome.

The Chair's further Statement of Approach of 15th July this year contains some further information about the Terms of Reference and how they are to be interpreted.

In addition, we now have produced a Provisional List of Issues. It is intended to spell out in further detail the issues under consideration and to help guide the Inquiry's investigative work. It is not intended to, nor would the Inquiry be permitted to, expand or capture issues outside the Terms of Reference.

The Inquiry recently invited written submissions about the Provisional List and we are grateful for the responses received. We are considering them and will provide a formal List of Issues following this hearing, to reflect the submissions as appropriate, along with any further matters that arise in the written and oral opening statements.

The Inquiry Team also continues to reflect upon these issues and is minded to add further matters to the List of Issues such as:

- the demographics of Essex and whether a person's background or ethnicity influenced the treatment they received;

- the risk of adverse therapeutic outcomes arising from coercive treatment aimed at promoting physical safety (such as confinement);

- how an appropriate balance was reached between medical and psychological treatment options; and the extent to which there was any practice or culture of over-medication;

- wider beliefs held by those working in psychiatric care, which may influence the care given, for example whether or not they consider suicide to be preventable; and

- the extent to which mental health has been prioritised by politicians and those in leadership positions in the major health bodies nationally and in Essex.

The List of Issues may further evolve as the Inquiry receives further evidence and undertakes its investigations, with issues being added, removed or amended, as appropriate.

Specific Terms of Reference

I would like now to turn to look at key points arising from the Terms of Reference themselves.

General

[Display page 1 of the Terms of Reference; top half]

The terms of reference as we can see start by encapsulating the Inquiry's task, namely:

> ***"To investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex … between 1 January 2000 and 31 December 2023."***

We can see that they then say:

"1. The Inquiry will investigate the circumstances surrounding the deaths of mental health inpatients within this timeframe.

2. To the extent necessary, to investigate the deaths and fulfil these Terms of Reference, the Inquiry will consider…"

we then see a series of specified issues.

So, we can see that from the start of the terms of reference that:

- The focus of the Inquiry is on the deaths of mental health inpatients under the care of Essex Trusts. This is not, therefore, an inquiry into community mental health, nor is it into mental health services outside Essex, with certain limited exceptions.

- The timeframe under consideration is approaching a quarter of a century: the 24 years from the start of 2000 to the end of 2023, during which there were significant changes, for example as to the applicable legislation and policy and as to the structure of the relevant health bodies, that the Inquiry will need to understand and take into account.

- The Inquiry will adopt a proportionate approach. It is required to investigate a series of issues but only to the extent necessary to fulfil the Terms of Reference. The Inquiry will be rigorous and thorough but it will also act with expedition to provide answers to the important issues raised within a reasonable period of time. It will be for the Chair to judge to what extent it will be necessary to investigate each of the matters that are then listed (from (a) to (k)

in the terms of reference), remembering that the Inquiry's focus is mental health inpatients' deaths.

Inpatient death

What constitutes an inpatient death is addressed in the Explanatory Note (and also in the July 2024 Statement of Approach). It includes, for example, not only those who died on relevant wards or units but also those who died in a range of other circumstances. They include (but are not limited to) deaths within three months of discharge or, at the other end of the spectrum, within three months of a mental health assessment provided by the Trusts where the decision was not to admit. In this way, certain deaths outside mental health inpatient units and in the community will be in scope; and we will greatly value evidence about them.

The Provisional List of Issues covers in greater detail important background issues such as the landscape to NHS funded mental health inpatient care in Essex; the care and treatment pathway of those who died; and discharge and continuity of care to those returning to the community (that is at sections A – C).

"Serious failings" and "serious harm short of death"

Specific issues for investigation include at 2(a): ***"serious failings related to the delivery of inpatient treatment and care"***. The draft Terms were extended to reflect responses received during the November consultation. This was to make clear that *"serious failings"* may include, as we can see, ***"consideration of circumstances where serious harm short of death***

occurred". It is recognised that such incidents may raise the same or similar issues as incidents that resulted in death.

Chair, as you said in your July Statement of Approach, you have defined *"serious harm short of death"* to apply to incidents and events that are serious in nature and which had a reasonable prospect of leading to death. They include, but are not limited to: attempted suicide, serious physical and/or sexual assault, and serious failure to look after patients' wellbeing.

Engagement, staff and physical and sexual safety

The Terms also address at 2(b) and (c) how the NHS engaged with patients and their families. The Inquiry knows that these are issues of grave concern to patients and families alike and they are further outlined in the Provisional List of Issues (at section D).

The Inquiry has received serious allegations about the way in which various Trusts and staff members have acted. Accordingly, the Terms expressly extend to matters relating to physical and sexual safety within the relevant units at 2(d) – and this is covered further within the Provisional List of Issues (at E).

[Display Terms of Reference page 1, bottom half]

Paragraphs 2(e) and (f) cover the actions of staff more generally as well as the Trusts' approach to staffing. This will be a major area of the Inquiry's investigations and the issues are further broken down in the Provisional List of Issues (at sections B, G, and elsewhere).

Leadership, culture and governance

The leadership, culture and wider governance within the Trusts is also a major area of investigation. It is covered in 2(g) and (h) and in the Provisional List of Issues (at sections H to J).

Investigations and response to concerns

The Inquiry will consider next at 2(i) and (j) the quality of the Trusts' investigations and, separately, how they responded to concerns and complaints that were raised with them. These issues are addressed in further detail in the Provisional List of Issues (at sections K and L).

Interaction between Trusts and other public bodies

[Display Terms of Reference page 2, top half]

Finally, as far as specific issues are concerned, the Inquiry will investigate how the Trusts interacted with other public bodies such as coroners and professional regulators.

This is at 2(k) and covered further in the Provisional List of Issues (at section M).

As the focus of this Inquiry is on the actions of the Trusts in the context of the treatment of mental health inpatients, we will not, other than in the way I have just described, be considering the operation of these other public bodies. This means that it is not the place of the Lampard Inquiry to consider

the workings and effectiveness of, for instance, the coronial or healthcare regulatory systems in their own right.

Recommendations

We can see at paragraph 4 that the Inquiry is indeed required to go on to ***"make recommendations to improve the provision of mental health inpatient care"***.

The Inquiry wishes to give a great deal of thought from an early stage about any recommendations it may make. The recommendations must be evidence-based, clearly expressed and, of course, implemented by the responsible bodies. The Inquiry will also carefully consider the ways in which the implementation of those recommendations could be monitored.

Explanatory Note

[Display Explanatory Note, page 1, top half]

This is the explanatory note in relation to scope to which I referred before.

As we can see at the top, it does not form part of the Terms of reference *"but indicates how the Chair is minded to interpret them"*.

[Display Explanatory Note, page 2, from "Further points to note"]

At this stage, I would like to draw attention to two paragraphs in the explanatory note.

Neurodivergence and other circumstances

The first is, the paragraph which starts “In undertaking her investigations”. This explains that the Chair will consider the particular circumstances relevant to those who have died. This may include a range of factors, such as

> ***“neurodiversity, learning disabilities, dementia, co-existing physical health issues, drug and alcohol addiction, and other social and economic factors”.***

Taking neurodiversity as an example, the issue of the adequacy of treatment of people who are neurodiverse, in the context of mental health inpatient care, emerged as a serious matter of concern in the responses to the Terms of Reference consultation. It is therefore important to reflect this within the work of the Inquiry and I know it is very important to a lot of people.

Sample

The second paragraph I want to look at comes next, it says:

> ***“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.”***

This approach will provide a sensible and proportionate way forward as it will unfortunately not be possible to investigate in depth each of the very many deaths that are potentially within scope. The Inquiry is acutely conscious of the fact that many of the issues it is investigating remain of ongoing concern, and that it must therefore work efficiently to identify those issues as a matter of urgent importance. The Inquiry is considering which cases should fall within the sample (and no doubt further cases will be added as we proceed and more information becomes available).

However, I can indicate now to all existing core participant families and friends, that we will be looking into the deaths of their relatives or friends and the issues and concerns arising, to the extent possible and appropriate.

[Stop displaying the Explanatory Note]

It is important to say that the Inquiry will consider the totality of the information and evidence it obtains and its focus will not be limited to individual cases.

Chair, the Terms of Reference provide the basis for a full investigation of the issues of major public concern giving rise to this Inquiry. They will allow the Inquiry to get to the heart of these issues, and to make findings about what actually happened. This will form the basis for significant recommendations to ensure, to the greatest extent possible, that they will not happen again. That is the mission of the Inquiry.

The starting point must be recognition of the rights and expectations of patients and their families in connection with care, treatment, dignity and respect. There must also be recognition of the tragedies experienced by so many, and agreement that lessons must now finally be learned and acted upon.

At this stage, I note the following from the written opening statements of the health bodies:

- **The Department of Health and Social Care** states that *"every patient deserves to be treated in an environment where they receive high quality care and are treated with dignity and respect"*; that it is

"determined to work with others to transform and improve mental health care"; and that it *"looks forward to assisting the Inquiry"* in this regard;

- **NHS England,** in their written opening, *"recognises the incredibly important role for this Inquiry in identifying lessons that can be learned from the events that led to these tragic deaths in order to improve NHS mental health services both in Essex and nationally"*; and that it is *"committed to assisting the Inquiry"*;

- the three **Integrated Care Boards** are *"committed to engaging with the Inquiry in full openness and transparency" and "highlight their willingness to reflect on key learning"*; and

- **EPUT** apologises to all those who have been failed by NHS mental health services in Essex and acknowledges that safe services were not always provided. It vows to learn and to implement change and states that it is committed to engage candidly with the Inquiry.

The Inquiry will hold these health bodies to their promises of engagement and assistance.

Geographical scope

It is important to say a little more about the geographical scope of the Inquiry. As the Terms of Reference make clear, the Inquiry is investigating the deaths of mental health inpatients *"under the care of NHS Trust(s) in Essex"*. The Explanatory Note says further that these include: *"EPUT…and…NELFT…and their predecessor organisations, where relevant"*.

Essex

The July Statement of Approach explains that "Essex" has been defined in accordance with Schedule 1 of the Lieutenancies Act 1997, as being comprised of the local government areas of Essex, Southend-on-Sea and Thurrock. This is the administrative county of Essex and does not include areas of Greater London.

However, the Inquiry will need to consider matters outside Essex in two ways.

Firstly, and as the July Statement of Approach explains, the Inquiry's definition of "inpatient" includes mental health inpatients who were under the care of NHS providers in Essex, but who were placed outside Essex. This was either because there was not enough bed space in Essex, or due to needing specialist services that were not at the relevant time available in Essex.

Secondly, the Terms of Reference state at paragraph 5 that, while the investigations will focus on the Essex Trusts:

> ***"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 inpatient health care in other areas or have evidence which may be relevant to the issues which the Inquiry is investigating."***

The evidence obtained in this way may provide useful comparators to the approach in Essex but it could also address, to a certain extent at least, whether the practices of concern revealed in Essex are specific to this County or whether they actually reflect the approach in other parts of the country.

Approach

The Inquiry's intention is to address the issues under investigation on a Trust-by-Trust basis.

We will start with a consideration of North Essex Partnership University Trust and the South Essex Partnership University Trust and will then move on to EPUT. We will also consider NELFT and the private providers to the extent that they are in scope.

As well as matters connected to the management of and leadership of the Trusts, we will consider events and issues as appropriate on a ward-by-ward basis within each Trust and broadly on a chronological basis within each ward.

We will of course be looking at other matters too, including other local and national bodies such as those that I have named, to the extent necessary.

Further information about the Inquiry's approach will be provided shortly.

Evidence and Disclosure

Categories

I move now to consider evidence and disclosure.

Important information was obtained during the non-statutory phase of this Inquiry, when it was the Essex Mental Health Independent Inquiry. This included, for instance, transcripts and recordings of evidence sessions with family members and others. That information is being reviewed and will be incorporated as appropriate into the Statutory Inquiry. So, in many cases, members of the Inquiry team are working with families who attended evidence sessions with the Non-Statutory Inquiry to use the transcripts of those sessions to form the basis of their witness statements to this Inquiry.

As a general principle, the Inquiry will only request, review and store material which is potentially relevant to the Terms of Reference.

The Inquiry will review the evidence it obtains prior to making disclosure of documents that it is relevant and necessary to provide to core participants and witnesses. Given the nature of this Inquiry, much of the evidence we receive will be highly sensitive. As I have said, the Inquiry will handle all the material it receives with extreme caution and will ensure that it is processed and stored in accordance with all relevant data protection laws.

Types of Evidence the Inquiry will obtain

In order to meet its Terms of Refence, the Inquiry will be looking to obtain and hear evidence from a wide variety of sources.

To begin with, the Inquiry is working very hard to obtain full information in relation to those who have died. We have asked the relevant healthcare

providers to provide us with the details of those who fall within the Inquiry's definition of inpatient deaths and who died whilst in their care.

Chair, as you have already said, this is proving to be a difficult exercise. This is in part because there are issues with the availability of data. We may never know the precise number of all those who died and come within the Inquiry's scope. But we will continue to work with, and require information from, the providers and intend to provide the best estimate possible. The further work done has already demonstrated that the figure previously given of 2,000 deaths will rise substantially. We will provide an update about this at the November hearing.

The evidence from the Families and Friends of those who have died, and from Patients with lived experience, will be at the heart of this Inquiry. We are very grateful to those who have engaged with the Inquiry already and we will do all that we can to support others who may wish to engage in due course. The Inquiry also understands however, that there may be some for whom such engagement is simply too difficult. We will continue to look for answers on their behalf.

As well as the powerful and moving commemorative evidence that we will hear over the next two weeks, the Inquiry will hear evidence from a number of patients about the impact on them of their experiences. We have already received courageous and compelling accounts from former patients.

The vital importance of that evidence is best illustrated by some excerpts from one of those accounts, which I would like to read at this stage. A former patient has told the Inquiry:

"I became ill when I was at university. I was a high achiever and like many young people I was overwhelmed with the pressures of university and this led to a real deterioration in my mental health and a number of suicide attempts that led to my eventual admission. What should have been a relatively straightforward encounter with services to develop mechanisms to cope with life, turned into a very traumatic experience and I am both physically and emotionally scarred from that experience. The point I would make is that I was just a relatively typical person who had a mental health crisis; something that could happen to anyone.

[When] I first heard about the possibility of an Inquiry into a number of deaths within... in patient settings... the aspect that affected me most was the sudden difficult realisation that a number of the things I had experienced whilst an inpatient were wrong. They had also happened to a lot of other people and the thing that probably upset me most was a realisation that I was not to blame for my presentation whilst unwell.

I feel terrible that so many people have lost loved ones and have experienced the same kinds of trauma that I did in a place where I should have been safe and supported to recover.

Whilst I have long since recovered from my mental illness, it was still very difficult to talk about what happened to me. However, I felt, and still feel, that I have a moral duty to speak up as there are so many people who cannot

Today I am well, but I am well despite my treatment from Essex Mental Health Services, not because of it. No one should have to say that they are a 'survivor' of a system that completely failed to keep them safe".

We are very grateful for that account.

From next year, the Inquiry will hear evidence from Families, Friends and Patients about the detail of the care and treatment that was, or was not, provided as part of inpatient mental health services in Essex.

The Inquiry will also seek evidence from those employed or engaged in the provision of this care. I have outlined the relevant categories of staff from whom we shall hear, from those on the frontline, through to clinical managers and those in executive roles at the relevant healthcare providers. The Inquiry has identified many such individuals and it is in the process of approaching them for assistance. The Inquiry is pleased to note EPUT's assurance that it is doing all it reasonably can to ensure that staff members engage fully with the Inquiry.

The Inquiry will examine all relevant information available to it (for example, Serious Incident Reviews; investigative work undertaken by regulators, the police and the Health and Safety Executive; and material from inquests) in order to understand the extent to which mental health services were being provided to an appropriate standard during the period with which we are concerned.

The Inquiry will rigorously scrutinise the management and governance of mental health services during the relevant period. It will look not only at the

way those services were being run, but also at how those in charge were learning lessons and implementing changes where necessary.

These are just examples of the investigative work the Inquiry intends to undertake. Put shortly, the Inquiry will be robust and unafraid in its pursuit of evidence to enable it to meet its Terms of Reference.

Data

The Inquiry recognises the importance of the data it will capture from the Trusts and others. Data has the potential to provide insight, to reveal trends and to expose further areas of concern. The Inquiry will instruct an expert statistician of appropriate standing and experience, as the chair said, to assist it with its work..

Issues of relevance to data collection are addressed in the Provisional List of Issues (at F). This identifies relevant lines of enquiry, including about the data that was captured during an inpatient's stay on a ward and how it was recorded and analysed at the time.

Issues concerning data adequacy, accuracy and availability have also been raised in core participants' responses to the Provisional List of Issues, as well as their written opening statements. We will consider what they have said with care.

Seminars

The Inquiry also intends to hold seminars this autumn and winter. They will provide an early and efficient way to provide uncontroversial but important background information. The intention is that they will provide necessary

context for the hearings that will take place next year, and will cover areas such as the structure and organisation of NHS mental health services on a national basis and in Essex over the period under consideration, as well as the relevant legal and policy background. We hope shortly to be able to give more information about the seminars we have planned.

Undertakings

I now turn to speak about two different types of undertakings.

Confidentiality Undertakings

First, confidentiality undertakings. The Inquiry will make disclosure of certain of the documents in advance of hearings to core participants and witnesses so that they can prepare and provide witness statements and other information, as necessary.

The documents may well contain sensitive information or otherwise be confidential. Those involved with the Inquiry are entitled to expect that the Inquiry itself and those to whom it provides disclosure will treat that disclosure responsibly and securely. That is why the Inquiry requires everyone to whom it provides documents to sign a confidentiality undertaking.

The undertaking requires that the documents that have been disclosed are kept secure and confidential, can only be used for the purposes of the Inquiry and directly related legal proceedings and can only be discussed with the Inquiry or others who have signed an undertaking.

The Inquiry takes the confidentiality of its material extremely seriously and there will be grave consequences for anyone breaching an undertaking.

Trust / Regulatory Undertakings

The second type of undertakings are those from Trusts and Regulators.

The Inquiry intends to use all means at its disposal to ensure that important evidence is heard. Where necessary, it will deploy its statutory powers to compel evidence. In addition, the Inquiry wishes to take all appropriate steps to encourage people to come forward with relevant evidence. It therefore considers it necessary to seek limited undertakings from the relevant healthcare providers and regulators that are designed to facilitate the flow of evidence to the Inquiry.

What this means is that the Inquiry is asking the healthcare providers and regulators to agree that they will not take action against individuals such as staff members in certain limited circumstances relating to their provision of information to the Inquiry, or their failure to have come forward to provide it in the past. Such undertakings would mean that a staff member does not need to worry about being held accountable for breaching confidences if they provide sensitive information to this Inquiry; or if they come forward now with information about an incident occurring some time ago and which they should have reported at the time.

The Inquiry has been in talks with the relevant healthcare providers and regulators on this issue. We reiterate that staff are encouraged to come forward to share their experiences and that they have the support of the Inquiry in doing so.

Hearings

Turning now to the Inquiry's hearings.

2024

September: opening statements and commemorative and impact sessions

I hope that those attending will now be aware of the Protocol and Code of Conduct for this September hearing. Both are on the website.

We will be hearing core participant opening statements this week, followed by two weeks of commemorative and impact evidence. There will be no hearing tomorrow afternoon. This short pause has proved necessary in order to enable legal representatives of core participants to be present and fully engage in the opening statements section of the hearing. Opening statements will conclude on Wednesday morning.

I would like to say something now about the commemorative and impact evidence commencing on Monday, 16th September. I have had the great privilege of reading the statements that have been provided and viewing the videos and photographs too.

On behalf of the Inquiry Team, I would like to stress three particularly important points.

First, next week, when we start to hear this evidence, will mark the most important stage in the Inquiry so far. It is when we will hear about the lives of those who have died from their families and friends.

Second, we will be hearing about people who were deeply loved, from people giving evidence with dignity and pride.

And third, those coming forward are doing so with immense courage. We do not underestimate the difficulty of doing this and I want them to know that we thank them and will support them.

25 November to 5 December

A further, virtual hearing is planned from 25th November to 5th December this year. The Inquiry recognises that not everyone who might wish to would be ready to give commemorative and impact evidence at this September hearing. The November hearing provides another important opportunity for the Inquiry to hear from them. We will provide details about the November hearings shortly.

2025-2026

We then move onto 2025 and 2026. This is the stage when the Inquiry will hear further evidence from the families and friends of those who have died; from patients and former patients; from those who work in mental health settings; and from a range of other witnesses who can help us understand what has been happening in inpatient mental health services in Essex, and how things need to change. These future hearings will be evidential hearings, to address the issues raised in the Terms of Reference.

There will be hearings throughout 2025 and into 2026, as follows:

In 2025:

From April 28th to May 15th

July 7th to 24th

October 6th to 23rd

In 2026:

From February 2nd to 19th

April 20th to May 7th

July 6th to 23rd

The Inquiry will provide details of what each hearing will cover well in advance. We intend to fix the schedule of witnesses as far in advance of each hearing as possible. Our current intention is also to circulate an electronic bundle of evidence of relevance to each specific hearing to core participants.

We wish to provide as much certainty as possible about the Inquiry's hearings and arrangements. In this way we hope to assist those involved with their own planning. These dates are therefore fixed, barring unforeseen circumstances.

Venue

The Inquiry considered that an inquiry which has an Essex focus should hold its opening hearing in Essex. However, we are aware of the real sensitivities concerning a number of locations in this County. In short, they include locations where individuals took their own lives or which have connections to government, health or other bodies that may be involved in the matters that may be investigated by the Inquiry.

In securing a venue for the hearings in 2025 and 2026, we have borne this in mind. In addition, we have been determined to find a hearing centre that is

suitable for holding an investigation into matters of such sensitivity, which will as far as possible be conducive to receiving the best evidence from a full range of witnesses. It needs to be neutral with sufficient and appropriate space. This must include trauma-informed space; in other words, a venue allowing access to emotional support and that is considerate of those who have experienced or continue to experience trauma, avoiding links that may be triggering for witnesses and attendees.

The Inquiry has therefore decided on a venue in London with good transport links to Essex, with the set up and facilities that are required to ensure that this Inquiry supports those engaging with it and runs efficiently. It is a neutral venue with ample space, good facilities, and natural light. It is **Arundel House**, near Temple Underground Station, and we will provide further information about it, and indeed about the hearings, in due course.

It will not be necessary to attend hearings to view what is taking place. Hearings will be filmed and a live feed will be available for those wishing to follow proceedings in that way. A secure link will be made available to core participants and their legal representatives, should they wish to access the hearings in that way.

Finally on the question of venues, I would like to say that that the Inquiry may hold a further hearing or hearings in Essex. We will liaise closely with core participants and others about this.

Creating the right environment

We intend to ensure that we create the right environment for this Inquiry.

We place the wellbeing of those involved in the Inquiry's work at the centre of the evidence gathering process and acknowledge that the giving of evidence may be challenging. Our aim is that that the Inquiry and its hearing spaces are safe spaces.

Every person engaging with the Inquiry should be able to share their experiences to the best of their ability. We will wish to engage with core participants and their legal representatives about the best way to achieve this.

The Inquiry will put in place "special measures" and support to ensure that those who are vulnerable are looked after properly. "Special measures" are adjustments at hearings which may be made for witnesses to ensure they are able to provide their best evidence. Further information about this can be found in the Inquiry's Vulnerable Witness and Restriction Orders Protocols.

The Terms of Reference require (at paragraph 9) that:

> ***"Those engaging with the Inquiry are to be treated by all parties with courtesy".***

We ask that Inquiry participants respect the right of all witnesses to be heard. We understand how difficult it may be to hear some of the evidence, and the anger and the distress to which it might give rise, particularly in the hearings from next year. But all witnesses must be heard and treated with courtesy, no matter what subjects they are addressing, if the Inquiry is to be able properly to fulfil its role.

Terminology

Chair, you have referred already to the terminology the Inquiry Team plans to use in connection with the deaths and other matters you are considering. The Lampard Inquiry document on Terminology and Abbreviations is available on the website. It will be reviewed and expanded after this hearing. Although the language set out in the document is not mandatory, as witnesses are free to express themselves as they choose, it is helpful to have a reference document explaining the terms the inquiry will be adopting. We will keep this document under review and would be happy to engage with core participants and others who have suggestions for its development.

Conclusion

Chair, a written version of this Opening Statement, my opening statement, will go onto the website, with hyperlinks to most of the documents to which I have referred.

I conclude by saying that the Inquiry's Legal Team recognises the urgency and importance of the task upon which we are embarking. We will be dedicated, determined and thorough in our pursuit of the truth. We look forward to working with core participants and others to advance the work of the Inquiry. We look forward to assisting you throughout so that you are able to meet your Terms of Reference and to deliver a strong report with robust recommendations.

NICHOLAS GRIFFIN KC
Counsel to the Inquiry