**IN THE INQUIRY INTO MENTAL HEALTH TREATMENT IN ESSEX**
**('THE LAMPARD INQUIRY')**

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**OPENING STATEMENT SUBMITTED ON BEHALF OF THE PATIENTS AND FAMILIES REPRESENTED BY HODGE JONES & ALLEN SOLICITORS**

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## Section A. Introduction

1. An Inquiry is an extremely serious matter. A Statutory Inquiry is granted only if it appears to the Minister that: (a) particular events have occurred that have caused, or are capable of causing, public concern, or (b) there is public concern that particular events have occurred. There is therefore a high bar.

2. But in the case of this Inquiry, that high bar has easily been passed. The various NHS Trusts which have been responsible for mental health provision in Essex over the last few decades (referred to hereafter in this note simply as "the Essex Trusts") have – we suggest – fallen appreciably below acceptable standards and have (despite repeated expressions of concern from, amongst others, Coroners, the CQC, the Health Ombudsman and other bodies) failed to learn lessons from the deaths of psychiatric patients in their care, with the result that men, women and children have unnecessarily and preventably lost their lives or come to harm. And, worse, that situation persists.

3. The very fact of there being a Statutory Inquiry is recognition that there is something of public concern in Essex mental health care. That's what our clients have said for years: poor care, poor treatment decisions, statistically high levels of suicide, preventable deaths, lack of continuity between inpatient and outpatient care, abuse and maltreatment.

4. It seems extraordinary in the 21st Century that an NHS Trust should have been *prosecuted* in a Criminal Court for failing sufficiently to manage the environmental risks within its mental health wards with the result that 11 patients died by using ligature points. Yet that is precisely what happened – the Trust was prosecuted by the HSE, it pleaded guilty and was sentenced in June 2021.

5. Avoidable death by use of ligature points is – we say – only one aspect of the many shortcomings of the Essex Trusts. A number of others were graphically illustrated by the Channel 4 Dispatches documentary *"Hospital Undercover Are They Safe"* which aired in October 2022.

6. It seems extraordinary in the NHS in the 21st Century that when a non-statutory Inquiry into the shortcomings of the Essex Trusts began in 2021, rather than there being full co-operation to allow a swift and successful investigation and for things to be put right, it was thwarted by lack of co-operation and engagement.
   (i) On the issue of engagement, for example, the Trust did email c.8,150 current employees. Surprisingly, however, with c.6,500 former employees for whom it did not have a current email address, the Trust did not send any letters by post.
   (ii) Of the many thousands of current and former employees contacted, it is understood that only 11 had agreed to give evidence.[1]
   (iii) Dr Strathdee, Chair of the non-statutory Inquiry, considered that a Statutory Inquiry was necessary due to lack of engagement and her lack of powers of compulsion. Fewer than 30% of what Dr Strathdee considered to be essential witnesses had agreed to attend evidence sessions.[2]

7. In September 2023, the BBC reported that that Essex County Council were hiring a public mental health suicide officer as suicide rates in Essex are higher than national average. The average for England 2019-21 was said to be 10.6 per 100,000 whereas in Colchester it was 15 per 100,000 – almost 50% higher than the national average.

8. The group of families and patients represented by HJA include fifty-two (52) Core Participants. A number of them have campaigned for many years about the shortcoming of the Essex Trusts and have, to date, got nowhere despite inquests, regulatory proceedings, complaints to ombudsmen, speaking to journalists, campaigning, debates in Parliament, the independent inquiry that made no progress, marches, umpteen different chief executives and mergers of Trusts, etc. They continue to suffer because

[1] Vicky Ford MP – Westminster Hall debate in January 2023.

[2] Letter of early 2023 from Dr Strathdee to the then-Secretary of State for Health.

of past failings. Ongoing failings will affect the lives of patients today, tomorrow and hereafter until they are remedied.

9. Our clients now place their hope of a proper, thorough investigation and their hope for implementation of change in this Statutory Inquiry and its Chair, Baroness Lampard and her team.

10. This written opening statement is, necessarily, incomplete. Initially, each of the families and patients affected by these shortcomings believed that they were alone in having received such poor care. Then as public concern grew and campaign groups coalesced, there was a growing awareness that failings were being repeated and that individual cases were not one-offs. But we and our clients do not have the full picture. We are only at the outset of this Inquiry. Each individual knows about the loss they have suffered (though, even then, Coroners' Inquests have in many cases been provided with only limited information) but it will be for the Inquiry as it proceeds to see the full picture and join the dots.

11. Only as the Inquiry fulfils its remit will our clients gain a clear overview of the systemic and repeated failures which they believe have occurred. The time for detailed submissions about those will be at the conclusion of all the evidence.

12. In the meantime, we offer in this Opening Statement three things:

    (i) An outline of what our clients expected, and were entitled to expect from the Essex Trusts.
    (ii) An outline of what they in fact got, what actually happened contrary to expectations.
    (iii) An indication of what they hope for from this Inquiry.

**Section B. What we expected**

13. When we entrust our own health, or the health of loved one, into the care of an NHS hospital, we are expecting to be taken care of, and to recover. We expect to recover because mental illness is not a terminal diagnosis – even if it may carry risks to life

and/or have lifelong impact, including the need to manage the challenges of living with neurodiversity.

14. Fundamentally, we do not expect our loved ones to die whilst undergoing treatment for psychiatric illness.

15. Instead, we expect their symptoms to get better and, ideally, to resolve entirely. We do not expect them to be traumatised, or re-traumatised, by ill-treatment and abuse that they suffer or that they witness while under NHS care. We do not expect their physical health to be poorly treated, or for them to suffer avoidable injury, whilst on an NHS ward – whether it be a psychiatric ward or otherwise.

16. Yet all this happened to patients in the care of the Essex Trusts. What is more, it happened time and again. Every time it happened, there was an opportunity to prevent further death and ill-treatment. But lessons were not learned, practices did not change, poor decisions were repeated, the tragedies continued, and continue to this day.

17. Our clients were entitled to expect better than this under the law of England & Wales. Whilst the function of a public inquiry is not to find civil or criminal fault, it is important to understand at the outset that our clients' expectations had a basis in law. They were entitled to expect good care; it was their due.

18. The first expectation that is worth highlighting is the entitlement to be treated competently and with dignity. The law entitles us to be provided with medical treatment of the standard that a reasonably competent medical professional would provide.[3] This is sometimes called a "duty of care", a phrase that is widely used because it is so resonant of what patients hope for. It is both a moral duty and a legal duty deriving from the law of negligence and trespass to the person.

19. The above duty clearly applies to – and should be discharged by – individual healthcare workers and NHS Trusts. However, there is also a wider duty upon the state to provide for the health of the population. The European Court of Human Rights has explicitly

[3] See *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582 and subsequent case-law.

connected healthcare with the duty of Member States to look after the safety of their populations[4]. Article 1 of the European Convention on Human Rights provides that Member States must secure the rights and freedoms enshrined in the Convention to everyone within their jurisdiction.

20. The specific rights and freedoms extended to those in the jurisdiction are several. Most pertinent to this context, they include the rights and freedoms protected by Articles 2, 3, 5 and 8 ECHR.[5] They are moral and legal duties. Among these are:

    (i) **The right to life**. This is protected by Article 2 ECHR. In a precedent established against the South Essex Partnership (as was), the House of Lords (as was) confirmed the following points. They are summarised in paragraphs 68-72 of *Savage v South Essex Partnership NHS Foundation Trust* (2009).[6]

        i. First, "*a state is under an obligation to adopt appropriate (general) measures for protecting the lives of patients in hospitals. This will involve, for example, ensuring that competent staff are recruited, that high professional standards are maintained and that suitable systems of working are put in place*." [45]

        ii. We anticipate that this Inquiry will find that many relevant systems of working simply were not properly implemented – from accessing relevant patient data, communications within the Trust as well as between the Trust and other agencies, to staff being asleep while on duty. The Inquiry may well find that some of these systems of work were not suitable to begin with.

        iii. The House of Lords was cognisant of the risks that befell patients of the Essex Trusts. "*Plainly, patients, who have been detained because their*

[4] *Pretty v United Kingdom* (2346/02), (2002) 35 E.H.R.R. 1, [51].

[5] Article 14 (non-discrimination) may also be relevant.

[6] *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 A.C. 681, [68]-[72] per Lord Rodger of Earlsferry.

*health or safety demands that they should receive treatment in the hospital, are vulnerable. They are vulnerable not only by reason of their illness which may affect their ability to look after themselves, but also because they are under the control of the hospital authorities. Like anyone else in detention, they are vulnerable to exploitation, abuse, bullying and all the other potential dangers of a closed institution*." [49]

iv. Patients and their families were entitled to expect under the general Article 2 obligation that Trusts would proactively monitor and remove risks to patients' lives, such as sharps and ligature points. The Trusts were criticised contemporaneously by Monitor, the Care Quality Commission, and in the sentencing remarks following a HSE prosecution, for failures in this regard.

v. Of particular note, the House of Lords confirmed in *Savage* that '*Article 2 imposes a further "operational" obligation on health authorities and their hospital staff. This obligation is distinct from, and additional to, the authorities' more general obligations. The operational obligation arises only if members of staff know or ought to know that a particular patient presents a "real and immediate" risk of suicide. In these circumstances article 2 requires them to do all that can reasonably be expected to prevent the patient from committing suicide*.' [72]

vi. This operational duty is not confined to detained patients. A later Supreme Court case against a different Trust clarified this beyond doubt.[7]

(ii) **The right to freedom from inhuman and degrading treatment and suffering**. Article 3 ECHR. The suffering which flows from illness may be covered by Article 3, when it is, or risks being, exacerbated by treatment for which the authorities can be held responsible. The type of treatment for which

[7] *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, [2012] 2 A.C. 72.

authorities can be held responsible includes situations where the authority inflicted ill-treatment on the patient and/or where the patient receives inadequate care from state medical authorities.[8] Cruel and inhuman treatment of inpatients can be seen in the Channel 4 Dispatches documentary.[9] We anticipate that the Inquiry will find instances of degrading treatment and suffering being imposed upon patients who were vulnerable for all the reasons identified by the House of Lords in *Savage*. This ought to have led to the authorities treating these patients with more sensitivity, rather than less.

(iii) **The right to liberty and security of person**. This is encapsulated in Article 5 ECHR. This right cannot be infringed (e.g. by use of force, restraint or involuntary treatment) without strict conditions being duly observed.[10] The detained person also has a right to challenge their detention under Article 5(4) ECHR.

(iv) **The right to respect for personal and family life, to privacy, to respect for autonomy, and to dignity**. Once again, we anticipate that the Inquiry will find that there was insensitive treatment of patients generally and specifically, including inappropriate and unnecessary use of force and restraint. In terms of the specifics, there was a lack of sensitivity to trauma history, and a lack of dignity and/or privacy around important human bodily functions, such as menstruation and appropriate toilet facilities.

21. As *Maintaining Momentum*, the report of the Parliamentary Health Service Ombudsman into mental health provision, records: the NHS Constitution states that patients "*have the right to be treated with dignity and respect in accordance with [their]*

[8] *Pretty v United Kingdom* (2346/02), (2002) 35 E.H.R.R. 1, [53]; *Keenan v UK* (2001) 33 EHRR 38.

[9] 'Hospital Undercover Are They Safe?'. https://www.channel4.com/programmes/hospital-undercover-are-they-safe-dispatches/on-demand/72849-001 Three of our clients speak on this documentary. In addition, the broadcaster commissioned a retired police officer to train as a ward assistant and to film scenes within some of the psychiatric units run by EPUT.

[10] Article 5(1)(e), and see e.g. *Winterwerp v The Netherlands* (6301/73), (1979) 2 EHRR 387. See also the Liberty Protection Safeguards in domestic law.

*human rights*."[11] The report goes on to observe: "*Our casework shows that an individual's human rights can be infringed as a matter of poor care*."

22. Further, the Ombudsman reiterates: "*Patients who use mental health services should be treated with dignity at all times, particularly so in times of crisis, when an individual's illness may compromise their ability to understand their own actions. It is vital to the trust we place in mental health services that they protect and respect our human rights when we cannot do so ourselves. […].*"[12] The report was written following the Five Year Forward View for Mental Health published in 2016. This Forward View policy, and the Ombudsman's report, is one of a myriad of policies and reports that were published during the period identified in the Inquiry's Terms of Reference.

23. The Ombudsman's reference to the NHS Constitution is apt. The *NHS Constitution for England* begins as follows:

> The NHS belongs to the people.
>
> *It is there to improve our health and wellbeing,* ***supporting us to keep mentally and physically well, to get better when we are ill*** *and, when we cannot fully recover, to stay as well as we can to the end of our lives*. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most. […]
>
> It is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. ***The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights***. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. […]

[11] Rob Behrens OBE, PHSO, available at https://www.ombudsman.org.uk/node/1242 (page 19)

[12] ibid.

> Everyone who uses the NHS should understand what legal rights they have. For this reason, important legal rights are summarised in this Constitution […] *The Constitution also contains pledges that the NHS is committed to achieve. Pledges go above and beyond legal rights. This means that pledges are not legally binding but represent a commitment by the NHS to provide comprehensive high-quality services.* [13] (emphasis added)

The NHS Constitution goes on to set out, and elaborate on, various rights and pledges.

24. As further evidence of the legitimacy of our clients' expectations, consider the Rapid Review commissioned by the government of the day from Dr Geraldine Strathdee. Its Ministerial Foreword states: '*Every patient deserves to be treated in an environment where they receive high quality care and are treated with dignity and respect, and their families and carers deserve to be reassured that their loved ones are safe.*'[14]

25. None of this would have needed to be articulated explicitly had things not gone so wrong.

26. Our clients' expectations were legitimate expectations, reflected in reports and healthcare policies of the time. Yet, despite various iterations of national and local policy and numerous reports, things did not get noticeably better during the period under review. There was rhetoric without reality.

27. As NHS patients, we do not expect to be denied treatment when it is warranted, or for agreed treatment or emergency treatment to be impossible to access in practice – whatever the reason for this may be. We do not expect ourselves or our families to be at risk from our own loved ones simply because patients are not being given proper treatment. Equally, we do not expect to receive accusations that we pose a risk to our loved ones, who are patients, when those accusations are false.

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[13] *The NHS Constitution for England* (Department of Health and Social Care, 2021). First published 2012.

[14] Ministerial Forward by Maria Caulfield, Parliamentary Under Secretary of State for Mental Health, available at https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations

28. Generally, patients and their families expected their own interactions with the treating staff to be cordial, welcoming and professional. They expected their concerned enquires for a loved one's welfare or whereabouts to be promptly, fully and courteously answered. They expected staff to be candid and forthcoming with them about anything untoward, and to involve them in important decisions relating to their care or that of their loved one. Family members were an invaluable source of wisdom about their loved one, especially at times when the patient themselves lacked capacity, but this wisdom went unheeded.

29. These expectations were reasonable, and firmly rooted in both ethics and law. All healthcare professionals have a **duty of candour**, which is set out in a joint statement dated October 2014 from eight regulators of healthcare professionals in the UK, including the General Medical Council and Nursing & Midwifery Council.[15] There are two components to this professional duty of candour. Firstly, there is a duty to be open and honest with patients, or those close to them, if something goes wrong. Professional guidance from the regulators includes advice on apologising. The second component is a duty to be open and honest with the organisation, and to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses (paragraphs 22–33).

30. Given this, our clients were entitled to expect their complaints and concerns they raised to be listened to, and promptly addressed. Unfortunately, we anticipate that this Inquiry will find that the duty of candour was not adhered to.

31. We also submit that a **learning culture** was not established, even after a report by the Parliamentary and Health Service Ombudsman into the deaths of Matthew Leahy and another patient in 2019, or after numerous internal investigations (e.g. audits, Serious Incident Reports), Monitor/CQC reports, and Prevention of Future Death reports issued by coroners. Wherever there is a Trust response to a Coroner's report publicly available, the following words invariably appear. '*I would like to begin by extending my deepest condolences to* [the patient]*'s family. This has been an extremely difficult time for them*

[15] The NMC's guidance on the professional duty of candour can be found online.

*and I hope that my response provides* [the patient]*'s family, and you* [the Coroner], *with assurance that the Trust takes their loss seriously and has taken action to address the issue of concern raised in your report.'* By dint of their repetition, coupled with the lack of meaningful action, and the frequent redaction of the writer's name, these words ring hollow.

32. The fact that all this happened betrayed the trust placed in the Essex Trusts by patients and their families. Often, these families had been caring for their relatives for some time. They were exhausted and upset from the experience, but they expected at a minimum that healthcare practitioners would treat their relatives with the same compassion, decency and tenderness as they would themselves. They did not expect loved ones to be belittled, ignored, or abused – physically, sexually or psychologically. If these things did happen, the least they expected was transparency about the incidents and to be informed compassionately. They did not expect to be themselves dismissed when they sought accountability for these things.

33. Rather, they expected appropriate support for the toll that such horrifying incidents took on them as a family. The suicide of a family member can itself have detrimental, and sometimes fatal, effects on the health of those around them. These effects too often went unaddressed.

34. Subsequently, our clients have come to expect little that is good and much that is bad due to what they experienced and what their families experienced at the hands of these Trusts. Sadly, many of our clients (and other patients) have no option but to continue to be under the care of these same Trusts despite the breakdown of the proper physician-patient relationship. Most disturbingly, many of the same healthcare professionals continue work in the NHS or in related fields, remaining in the area and/or on the relevant healthcare professions register (including after disciplinary action or Fitness to Practice proceedings). Our clients' distrust thus extends to all the people and bodies who let them down: everyone from commissioners of healthcare services to the Department of Health and Social Care. Their distrust also extends, in some cases, to investigatory bodies (internal and external, such as the police) when these bodies failed to hold the Trusts to account.

35. This Inquiry has to demonstrate its trustworthiness, and capability for meaningful change, to our clients. We expect no less.

**Section C. What actually happened**

36. Instead of seeing their loved ones getting better, as they had hoped and expected, family members had to watch helplessly as their loved ones got worse. Their own efforts to intervene were rebuffed by the Trust(s).

37. It is devastating to lose a child, parent, sibling, spouse, partner, friend or any family member to mental illness. It is unimaginably devastating when this did not have to happen and should not have happened.

38. Worse still to lose more than one family member to suicide, or to heartbreak following the suicide of a loved one. As one Core Participant says, "*Suicide can have such far reaching consequences. I have now lost two brothers as a result of a failed system – one to suicide, and the other to an early heart attack after his brother's death. This has impacted our whole family. So many lives affected. Losses that were preventable*."

39. For current and/or former patients – or their families – it is unimaginably dispiriting to see the same treatment happening to others which they have complained about and investigative reports have been written about. It is rubbing salt into a wound.

40. However, it is also thanks to them that this Inquiry has been convened. Were it not for the tireless energy of those who campaigned during times of unimaginable loss, with little help from government and with deliberate lack of cooperation from those who should have been accountable, this Inquiry would not be taking place.

41. We do not set out here the myriad individual failings that our clients have faced. This is not to minimise the importance of each of them, which is immense, but only to express our hope that the Inquiry will investigate them thoroughly and fairly. Our clients will give evidence in due course about what has happened to them, and on matters within their knowledge relevant to the List of Issues (as updated from time to time).

42. Some of what has befallen our clients is due to a lack of care, neglect, systemic failings of organisation and governance, and medical malpractice. This Inquiry, doubtless assisted by experts where appropriate, will be able to recognise themes that emerge. We anticipate the following themes emerging:

    (i) Poor engagement with patients and families, dismissive language, lack of compassion (including after incidents of fatal and/or serious harm to patients),
    (ii) Failure to involve patients and families in decisions relating to their care or the care of their loved one;
    (iii) Poor inter-agency collaboration, including between departments of the same Trust, and/or between inpatient and community teams, and/or with other agencies;
    (iv) Discharge of patients at inappropriate times;
    (v) Conversely, failure to admit patients in desperate need;
    (vi) Inaccessible emergency/out-of-hours services;
    (vii) Lack of understanding of neurodiversity;
    (viii) Lack of understanding of addiction;
    (ix) Inappropriate medication;
    (x) Misdiagnosis/failure to update diagnoses;
    (xi) Mismanagement of comorbidities and physical ailments and/or injuries sustained during inpatient treatment;
    (xii) Inappropriate restraint/use of force;
    (xiii) Treatment of patients which undermined their dignity/human rights, was insensitive, and/or inappropriate given their trauma history;
    (xiv) Rapid turnover of staff, unavailability/inaccessibility of a named contact;
    (xv) Incompetent staff, including staff who were sleeping or looking at their phone screens while on duty;
    (xvi) Failure to manage risks which patients posed to themselves or others;
    (xvii) Baseless accusations toward families that they posed a risk to patients;
    (xviii) Failure to manage absconsion or non-return of patients;
    (xix) Inadequate premises, plant and/or equipment;
    (xx) Poor record-keeping, clerical errors, inaccessible patient records;

(xxi) Failures to follow own internal and/or external procedures and protocols, or to meet own internal and/or external deadlines.

43. Other aspects of what our clients experienced stem from a lack of humanity, empathy and ethics. Whilst there is an overlap in this regard with the problems identified in the paragraph immediately above, the below incidents cannot merely be explained away as due to negligence or inadvertence. The below are clear examples of malpractice, misfeasance and wrongdoing. To take four examples:

(i) The Conduct and Competence Committee of the Nursing & Midwifery Council found that a nurse employed by the Essex Trusts had said about a patient words to the effect of "*he was just a drunk anyway*" in the context his death. Further, she had previously said words to the effect of "*if I ever get like that* [patient], *I want to go to Switzerland*."

(ii) This nurse's conduct came under investigation after it was found that she and two others had attempted a 'cover up' by manufacturing a backdated care plan for a patient after his death;

(iii) Separately, an inquest jury found that two groups of staff claimed to have unlocked a door behind which another patient was dying. They concluded that both groups were correct; the horrifying implication being that the first group had simply closed and locked the door after they found the patient dying.

(iv) Still further, sexual abuse was perpetrated on an inpatient and/or complaints about sexual abuse were not appropriately followed up (failures of safeguarding).

44. More generally, there are further sinister aspects to what our clients have experienced that indicate a toxic culture which avoids accountability. We append a chronology of deaths and investigations into those deaths. Whilst it is not by any means complete or comprehensive, it speaks for itself. It shows that there was a failure to establish a **learning culture** after critical incidents.

45. Whilst the current state of evidence and disclosure does not allow us to say much about organisation and governance, we hope the Inquiry will investigate those parts of its List of Issues so as to give a better overall picture. Our clients' experience to date shows that there are serious concerns in relation to a learning culture. Not only was there cover-up (as adverted to immediately above), several of our clients were not informed of incidents of serious harm to their loved ones.

46. Where information did come to light or concerning events were witnessed first-hand, our clients' complaints went unheeded, or were followed by exonerating reports (e.g. Serious Incident Reports or Patient Safety Investigations). Frequently, patients and families were not informed about, or involved in, any actions or investigations at all.

47. Further evidence of a lack of learning culture is seen in the Trusts' inadequate preparation for inquests and lack of response or change as a result of Prevention of Future Death reports, inadequate responses (including deliberate lack of cooperation) with other quasi-judicial investigations such as Dr Strathdee's independent inquiry, and a general failure to hold themselves to account through internal audits, After Action Reviews, etc. Our clients report a palpable culture of blaming others, including (for minor infractions) blaming other clerical staff within the same team.

48. Furthermore, the Trusts have not understood the distress that this itself causes families and patients.

49. Finally, the government must also take its share of responsibility. It was not until our clients gained the requisite number of signatures in e-petitions, marched on London, and demanded an inquiry that they were given the requisite attention. Even at that stage, and despite their demand for a statutory inquiry, the government insisted on calling an independent inquiry. Several years more delay and frustration was the result.

**Section D. What we want**

50. First, our clients want the **truth**. Our clients will assist the Inquiry with their own evidence. Yet there remain significant issues touching on their own care, or their loved ones' care, life or death, which trouble our clients. Our clients have learned some horrendous truths touching on these matters, but there remain silences, omissions, gaps,

and unanswered questions. For answers, we look to this Inquiry and ask the Chair to use the full breadth of her statutory powers to compel evidence and air it in public.

51. In due course, we hope the Chair will report on what has happened. However, this Inquiry will not have served its function, in the view of our clients, if it merely reports. Reports have already been written, many of them, including by Dr Strathdee, the Parliamentary and Health Service Ombudsman, as well as by journalists. There have been judicial and quasi-judicial processes in the form of inquests and a criminal prosecution. There has been regulatory enforcement from Monitor/CQC, the HSE, and professional healthcare Fitness to Practice proceedings. There have been police investigations that did not proceed to prosecution.

52. What our clients want, most of all, is **meaningful change**.

53. In order to achieve meaningful change, this Inquiry will have to succeed where many others have failed. This, in our submission, is its primary moral obligation. It is a tall order, but no less will suffice to discharge the duty which the state owes our clients because of all that they have gone through.

54. This Inquiry must make recommendations that will put the Trusts, and any other relevant entities, in a position to meet our clients' expectations as set out in Section B above. In particular, this will mean that there should be no more preventable deaths, and an end to substandard and abusive practices relating to patients.

55. Again, however, it will not suffice merely to make written recommendations. This Inquiry must be prepared to act creatively within the full scope of its formal powers and its informal influence to ensure that change happens.

56. This, and no less, will bring comfort to those who have lost family members.

57. We have no doubt that the Chair is well aware of the practical obstacles that stand in the way of meaningful change. Inquiry Chairpersons and the PHSO have noted as much. For example, the recent report of the Infected Blood Inquiry noted. "*It is a sad fact that very few inquiries into aspects of the health service or parts of it have ended without recognition that the culture needed to change. Over the past 50 to 60 years*

*there have been several inquiries, of different types – but nearly all have had some such recommendation* […]"[16]

58. Sir Brian Langstaff goes on: "*[T]he retiring Parliamentary and Health Service Ombudsman, Rob Behrens, was reported as recently as 17 March 2024 as describing part of his experience over the last seven years as "having to confront a cover-up culture [within the NHS], including the altering of care plans and the disappearance of crucial documents after patients have died and robust denial in the face of documentary evidence*".[17]

59. We raise the question of the Inquiry's efficacy now, at the very beginning, because we say that this consideration must affect all the work the Inquiry does going forward. In that regard, we make the following proposals:

    (i) First, this Inquiry and the Chair must keep an open mind, must not fetter their discretion unnecessarily, and must be prepared to respond to changing circumstances. For example, the 'About Inquiries' section of the website for the 'Lampard Inquiry' states, "*Baroness Lampard remains committed to publishing her final report as soon as possible, while ensuring thorough investigations. She is not currently minded to publish interim reports*."[18] In our submission, Baroness Lampard should keep an entirely open mind on the question of interim reports, as with other matters.

    (ii) Second, the Inquiry should be prepared to use the full extent of its formal powers and influence. It should not feel restricted or hampered by what is commonplace for Inquiries to do, or by what other Inquiries have done. However, in our submission, it should emulate best practice from other Inquiries. As to what constitutes best practice, the Inquiry should seek the views of Core Participants and involve them throughout.

[16] Report of the Infected Blood Inquiry, volume 1, page 231.

[17] Report of the Infected Blood Inquiry, volume 6, page 309.

[18] https://lampardinquiry.org.uk/about-inquiries/ dated April 2024, accessed 29 August 2024.

(iii) Third, as an experienced Chair, Baroness Lampard should be mindful of lessons learned from conducting previous inquiries – both her own experience and the findings of others. For example, in a comprehensive review of previous recommendations concerning the NHS carried out by the Thirlwall Inquiry, it is noted that the government accepted in principle thirteen out of fourteen recommendations from the Independent Inquiry into Investigations at NHS Trusts concerning Jimmy Savile (the latter conducted by Baroness Lampard).[19] Yet, implementation of these recommendations had been patchy at the time the last available data was collected in 2015. There was little up-to-date data, at least until prompted by the Thirlwall Inquiry. Further, we anticipate that some of the same failures will emerge in this Inquiry as from the Savile reports. For example, The Leeds Teaching Hospital NHS Trust, in its review into the abuses perpetrated by Jimmy Savile for over 45 years, considered the role that compassion should play in the care of vulnerable individuals: *"Acting with compassion requires a shared commitment to protect and safeguard the most vulnerable, to take responsibility to raise concerns, and to expect and demand action by those in authority."*[20] When organisations fail to be receptive to complaints, the institutional legacy of this culture can endure. At the same time, this Inquiry is not simply re-treading old ground; sub-paragraph (i) above (as to keeping an open mind) is repeated.

(iv) Our fourth submission is that the Inquiry should turn its mind at the very outset, and from hereon in (as the Thirlwall Inquiry has done), to the question of ensuring the efficacy of recommendations. To this end, again, the Inquiry should seek the views of Core Participants and involve them throughout.

(v) Fifth, the Inquiry should foster an environment of collaboration with, and among, Core Participants as well as the wider institutions that support the Inquiry (such as government departments and the Civil Service). Only through cooperative endeavour, and a common aim of getting to the truth and

[19] The Thirlwall Inquiry Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues prepared by the Thirlwall Inquiry Legal Team (15 May 2024), 543.

[20] The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust (2014), 215.

overcoming the obstacles to meaningful change, can anything productive be done. This is not in any way to suggest that the Inquiry should compromise its independence or do anything other than act fearlessly and fairly. It is only to say that turning rhetoric into reality, succeeding whether others have failed, means leveraging every available source of good ideas and influence toward that objective.

60. It might be thought that it is easier to be effective in the context of this Inquiry by comparison with a national issue. However, complacency would be unwarranted. Changing the culture in a small number of Essex Trusts, from such toxic beginnings, is not easy. Furthermore, the problems themselves are both large and small – they are both in the details of individual cases and at a systemic level. The crucial point, though, is that **change is *possible* with the right approach and resources**.

61. We hope that this inquiry will be more successful than its predecessor, and previous interventions in both its investigations (including engagement with those investigations) and in getting its recommendations implemented.

62. Further, given their experience of being fobbed off when calling for a statutory inquiry, our clients ask that government takes them seriously. We call on the present government and this Inquiry to deliver on the hopes of our clients. As to the government, the King's Speech of 17 July 2024 mentioned mental health, and a 'Hillsborough law'. It was said: "*My Government will improve the National Health Service as a service for all, providing care on the basis of need regardless of the ability to pay. It will seek to reduce the waiting times, focus on prevention and improve mental health provision for young people. It will ensure mental health is given the same attention and focus as physical health. My ministers will legislate to modernise the Mental Health Act so it is fit for the twenty first century [Mental Health Bill]*. […] *My Government will take steps to help rebuild trust and foster respect. Legislation will be brought forward to introduce a duty of candour for public servants [Hillsborough Law]*."[21]

63. We have been given a new opportunity: a new government following the general election, and the convening of a statutory inquiry with full powers. Our clients put their

[21] https://www.gov.uk/government/speeches/the-kings-speech-2024

faith in both, and hope their faith will be rewarded. We understand that what we ask for will be difficult to deliver, but lives depend on it.

64. As we have said, our clients put their faith in both the government and this Inquiry. Faith can be blind, but trust has to be earned. The final request from our clients is for the Inquiry and the government to demonstrate their trustworthiness during the conduct of this Inquiry and in the implementation of recommendations.

**Conclusion**

65. Re-phrasing paragraph 1 above, *this* Statutory Inquiry is an extremely serious matter. Our clients hope that it will be thorough and complete, they look forward to building rapport with it and trust in it, and they want it to ascertain the truth and effect meaningful change.

66. We look forward to working with the Inquiry on their behalf.

**Steven Snowden KC**
**Achas Burin**
**Rebecca Henshaw-Keene**
**Jake Loomes**

29th August 2024

12 King's Bench Walk
Temple
London EC4Y 7EL

**IN THE INQUIRY INTO MENTAL HEALTH TREATMENT IN ESSEX ('THE LAMPARD INQUIRY')**

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**APPENDIX 1:**

**AMENDED CHRONOLOGY OF DEATHS AND INVESTIGATIONS INTO THOSE DEATHS**

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*This amended chronology adopts the precaution of not naming an individual where either that individual or their family is not represented by Hodge Jones & Allen Solicitors and/or their preferences on privacy are unknown.*

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| 5 July 2004 | Carol Savage killed herself after absconding from the Runwell Hospital, where she was detained under section 3 of the Mental Health Act 1983.<br><br>A claim was brought by her daughter against the Trust under the Human Rights Act 1998, and eventually went to the House of Lords on appeal. |
| 25 October 2004 | Denise Gregory died. The circumstances of her death are described in the sentencing remarks following the HSE prosecution (para 42).<br><br>Outcome of subsequent inquest reported in media in 2006. |
| 4 December 2004 | Death of a patient known as 'FP' on Gosfield Ward, The Lakes.<br><br>The circumstances of death and related failings are described in the sentencing remarks following the HSE prosecution (para 43). |
| 21 December 2006 | High Court judgment handed down in *Savage v South Essex Partnership NHS Foundation Trust* [2006] EWHC 3562 (QB); appealed eventually to the House of Lords. |
| 20 December 2007 | Judgment handed down by Court of Appeal in *Savage v South Essex Partnership NHS Foundation Trust* [2007] EWCA Civ 1375. |
| 31 December 2007 | Death of a patient known as 'EJ' on Maple Ward, Willow House.<br><br>The circumstances of death and related failings are described in the sentencing remarks following the HSE prosecution (para 44). |
| A date in 2008 | Death of 'R', a patient whose care was criticised by the Parliamentary Health Service Ombudsman (PHSO) in its report of June 2019 (see below). |
| 10 December 2008 | Judgment of House of Lords in *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74 extending the approach in |

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| | *Osman v United Kingdom* (23452/94) to patients detained under the Mental Health Act 1983. |
| 28 December 2008 | Ben Morris died in the Linden Centre.<br><br>His mother provided a Victim Impact Statement for the HSE prosecution in 2020, summarised at paras 45-46 of the sentencing remarks. |
| 20 December 2009 | A patient died on Peter Bruff Ward.<br><br>His family provided a Victim Impact Statement for the HSE prosecution in 2020, summarised at paras 47-49 of the sentencing remarks. |
| 10 December 2009 | Sacha Marsh died. |
| A date in 2012 | A patient died, who is noted in the sentencing remarks of the HSE prosecution in 2020. |
| 7 July 2012 | Glenn Holmes died.<br><br>The following acknowledgement is recorded in the press reporting dated 26 September 2020:<br><br>*'In a letter sent to [the family] from the Trust in February 2016, following the PHSO's investigation, they acknowledged the failings and recommendations set out in the [PHSO] report.*<br><br>*These included the fact that there was "no evidence" of a detailed risk assessment being carried out when Glenn was discharged from the Lakes, and the omission of "impulsivity" from the CHRT team's final risk documentation.*<br><br>*An Essex Partnership University NHS Foundation Trust spokesperson said: "We extend our deepest sympathies to Glenn's loved ones.*<br><br>*"Since EPUT was established in 2017 our top priority has been to continuously improve patient safety, and we work with every patient to create a personalised care plan when they are admitted which includes planning and support for when they leave hospital.*<br><br>*"We continue to cooperate fully with ongoing investigations into the care of patients under the former North Essex Partnership University NHS Foundation Trust."'*<br><br>An account from campaigners is provided here. |
| 3 September 2012 | Recorded date of death of Mark Tyler. |

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| | It is believed he killed his mother Maureen Tyler on 27 August 2012.<br><br>A Domestic Homicide Review conducted by Basildon Community Safety Partnership noted that he had asked for help in respect of his deteriorating mental health on 28 recorded occasions over the course of two years prior to his death. It noted a number of other concerns relating to his care. |
| 15 November 2012 | Matthew Leahy died in the Galleywood Ward at the Linden Centre.<br><br>An inquest jury determined that there were a series of multiple failings and missed opportunities over a prolonged period of time and that "*relevant policies and procedures were not adhered to*".<br><br>It also came to light during the inquest that three nurses at NEP – a senior manager, a staff nurse and a charge nurse – falsified a care plan after he died (below). One of these employees was dismissed for gross misconduct. Two others faced fitness to practice proceedings before the NMC.<br><br>Matthew's care was criticised by the Parliamentary Health Service Ombudsman (PHSO) in its report of June 2019 (see below).<br><br>His mother provided a Victim Impact Statement for the HSE prosecution in 2020, summarised at paras 53-54 of the sentencing remarks. |
| From 2013 | A series of CQC inspections commence which comment on problems with ligature management (noted in sentencing remarks following HSE prosecution, para 38). |
| 18 January 2013 | Marion Joanne Turner died under the care of the community mental health team.<br><br>A Prevention of Future Deaths Report was issued dated 25 June 2014. It stated that her solicitor had telephoned the Trust the day before her death. He left a message for her CPN which was unread until sometime the next day, when it was too late.<br><br>The report can be found on the judiciary.uk site. No response from the Trust is available there. |
| February 2013 | A patient died after not being admitted into inpatient care.<br><br>In press reporting of the inquest, it was said that: "*The North Essex NHS Partnership Trust admitted they had made errors in the lead up to her death after her inquest concluded that one of 24 beds was free at the Linden Centre's Galleywood ward, but was marked "in* |

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| | *use" in case a previous patient returned when [this patient] sought help two days prior to*" her death. |
| 18 April 2013 | A 'near miss' incident occurred, identified in the sentencing remarks following HSE prosecution, para 55. |
| 1 March 2014 | Iris Scott died.<br><br>The circumstances of her death are set out in the sentencing remarks following HSE prosecution, para 56. |
| May 2014 | Deaths of a married couple.<br><br>An inquest concluded on 17 March 2015 that the husband had killed himself after unlawfully killing his wife with a shotgun. He was receiving input from NEP for dementia and had made them aware he had a shotgun. Essex Police were not informed of his firearms licence. On the day of his death, he telephoned Essex Police and told them that he had killed his wife and would shoot himself in the near future. When police attended, both had died.<br><br>A Prevention of Future Deaths Report was issued dated 25 March 2015, and sent (*inter alia*) to Teresa May MP, Home Office. |
| 4 August 2014 | A young person died on a day visit whilst an inpatient at the St Aubyn Centre, Colchester.<br><br>In a press report dated 2 July 2015, '*A North Essex Partnership NHS Trust (NEP) spokesman expressed sorrow over the death of a "promising young woman". "We have already implemented the recommendations," he said*.' |
| 26-30 January 2015 | Fitness to practise proceedings against a registered nurse by the Conduct and Competence Committee of the NMC.<br><br>The registered nurse was employed at the Linden Centre as a Registered Mental Health Nurse. They were referred to the NMC by their employer (NEP) on 23 August 2013 due to their actions on 15 November 2012, the date on which Matthew Leahy died.<br><br>Following an enquiry conducted by an external investigator and a disciplinary hearing, they were given a 12-month written warning.<br><br>Further charges in relation to their conduct toward other patients were before the panel, some of which were found proven.<br><br>A third charge was proven in relation to 22 January 2014.<br><br>The sanction was a caution order of 12 months. |

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| | As at 9 August 2024, the NMC registered shows they are a registered mental health nurse with no restrictions on practice. |
| Early in 2015 | A patient died, as reported in the *Guardian*. |
| February 2015 | NMC fitness to practise proceedings against another registered nurse after referral from their employer due to falsification of records following the death of Matthew Leahy.<br><br>The panel stated: "*You must have known that it was wrong to tamper with a record, particularly one that was going to come under scrutiny in an internal serious incident investigation*" and would be seen by the patient's family.<br><br>The panel suspended them from practise for three months. They were also subject to internal disciplinary proceedings.<br><br>As at 9 August 2024, the NMC register shows they are a registered mental health nurse with no restrictions on practice. |
| 12 February 2015 | An anonymous patient died.<br><br>The circumstances of their death are set out in the sentencing remarks following HSE prosecution, para 57. |
| March 2015 | A patient died.<br><br>An inquest concluded on 17 March 2016 that she killed herself at the Lakes Mental Health Unit, Colchester. "*Based on the evidence provided, the jury have concluded there was a failure to provide a safe environment at the unit and this, in conjunction with ineffective communication, more than minimally contributed to her death*."<br><br>A Prevention of Future Deaths Report was issued on 29 March 2016. It stated: "*The outcome of the review meeting was not signed off in writing by those in attendance (consultant psychiatrist, middle grade doctor, review nurse) and clearly communicated to [the patient]… Such important decisions must be agreed by all present and signed off in writing so that there is no confusion as to the outcome of the review.*"<br><br>The report can be found on judiciary.uk. No response from the Trust is available there.<br><br>The circumstances of her death are described in the sentencing remarks following HSE prosecution, para 58, and additional failures to those found by the inquest are identified. |
| 20 May 2015 | A patient died at Basildon Hospital. |

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| | On 30 October 2015, the inquest concluded: "*[The patient] killed himself whilst suffering from depression. [His] risk of self harm/suicide was not properly and adequately assessed and reviewed*."<br><br>A Prevention of Future Deaths Report was issued on 3 November 2015. It stated: "*Contrary to the trust's policy, there was no named nurse allocated until the day before [the patient's] death. The role of the named nurse had not therefore been carried out – this entails the devising of a risk assessment, care plans, one to ones, contact with the patient's family etc. […] The appropriate assessments and reviews were therefore not carried out*."<br><br>The Report can be found on judiciary.uk. No response from the South Essex Mental Health Partnership Trust is available on that page. |
| 20 May 2015 | Report published following inspection on 20 February 2015 at NEP.<br><br>CQC found that following a serious incident in 2012, an action point to review the door hinges at one centre had yet to be fully addressed by the Trust. Care plans lacked sufficient detail.<br><br>Trust governance was found to be robust. |
| 21 May 2015 | Richard Wade died in the Linden Centre.<br><br>An inquest jury, sitting at Chelmsford coroner's court, determined: "*Richard's risk of suicide was not properly and adequately assessed and reviewed. Adequate and appropriate precautions were not taken to manage Richard's risk of suicide*." They stated further: "*current policies at the time and previous recommendations on risk and environmental factors were not implemented adequately*".<br><br>His family provided a Victim Impact Statement for the HSE prosecution in 2020, which was considered as part of the sentencing remarks (para 59) although the HSE investigation had concluded prior to his death. |
| 3 July 2015 | Margaret Annequin died. |
| 6 August 2015 | Report published following an inspection of NEP in April 2015.<br><br>Significant steps had been taken to address environmental risks on the ward. Ligature points were found which had not been addressed in the Trust's risk assessment.<br><br>The seclusion room on one ward did not meet the standards required by the Mental Health Act code of practice (April 2015). |

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| 9 October 2015 | A patient died.<br><br>In a statement given to the press in 2020, the Trust said: "*We extend our deepest sympathies to [the patient]'s loved ones. Since EPUT was established in 2017 our top priority has been to continuously improve patient safety. We now work alongside all our patients to create them a personalised care plan when they are admitted, which includes planning for the support they may need when they leave our care, and linking with partner agencies for those patients who may need a longer-term placement. We continue to cooperate fully with ongoing investigations into the care of patients under the former North Essex Partnership University NHS Foundation Trust.*" |
| 19 November 2015 | SEP CQC report published following inspection on 29 June – 3 July 2015.<br><br>The safety of services required improvement. Concerns were raised with seclusion and segregation practice across the Trust. CQC found ligature points that had not been noted in the forensic service.<br><br>Acute wards for adults of working age and psychiatric intensive care units were rated "good" overall. The safety in forensic services required improvement. |
| January 2016 | A patient died.<br><br>On 17 August 2016, an inquest jury returned a narrative verdict that indicated the deceased had suffered a number of falls, the last of which (at least) contributed to her death. The jury stated: "*There were failings in the implementation of the North Essex Mental Health Partnership Trusts' Prevention and Management of Falls Policy…*"<br><br>A Prevention of Future Deaths Report was issued on 19 August 2018. It stated that a "*robust Action Plan with timescales needs to be put in place following the findings of the Serious Incident Investigation and the evidence heard during the inquest.*"<br><br>The Report is available on the judiciary.uk site. No response from the Trust is available on that page. |
| 26 January 2016 | NEP CQC report published following inspection on 24 – 28 August 2015.<br><br>One patient attempted to asphyxiate themselves during the CQC inspection.<br><br>Some care records and risk assessments did not contain enough detail. Ligature-free doors had not been installed or even |

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| | commissioned despite these having been agreed some time ago. The Trust's leadership style did not "*promote sufficient grip or pace to bring about changes*".<br><br>Most damningly: "*The Care Quality Commission and Mental Health Act reviewers have inspected the trust several times over the last five years. Each time they identified areas where the trust must act. For example, around safety on both the Linden centre and the Lakes locations. Each time the trust made assurances that they would make changes. Senior managers and board directors* ***could not explain why the trust had not addressed the problems."***<br><br>Enforcement action was carried out and the Trust had to ensure compliance by 30 November 2015 (outcome is not clear from this report).<br><br>The in-depth report for acute wards/PICUs found seclusion rooms on two wards to be unfit for purpose and that there were a number of blind spots in the corridors of 3 wards. On 2 wards, staff were not immediately aware of where the ligature cutters were located.<br><br>4 services were rated good, 3 required improvement, and the acute wards/PICUs were rated inadequate. |
| March 2016 | A patient died.<br><br>The jury added a narrative conclusion that the patient's risk of harm/suicide was not adequately assessed or reviewed, and that appropriate precautions were not taken in respect of the risk.<br><br>A Prevention of Future Deaths Report was issued on 11 November 2016. The Coroner stated: "*The trust's action plan is very basic, lacking specific detail. Some elements are blank and there is an absence of supporting evidence. A far more rigorous action plan is required in an effort to prevent future deaths such as [this patient's]*."<br><br>On 5 July 2017, the Trust responded to say that it had updated the plan and that it would carry out an audit to identify that the actions had been embedded into practice. The CEO, Sally Morris, added: "*I would like to offer my condolences to the family of Melanie and I hope this response provides them, and you, with assurance that the Trust regarded this situation very seriously and has taken action to address the issues raised*."<br><br>The report, together with the Trust's response, is available on the judiciary.uk site. |
| 22 March 2016 | North Essex Partnership University NHS Foundation Trust provides enforcement undertakings to Monitor. Governance |

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| | breaches are identified, specifically a failure to establish and effectively implement effective board and committee structures (para 2.3). Undertakings are given to improve governance as well as to improve quality of care findings following a CQC report dated 26 January 2016 and S29A Warning Notices dated 21 September 2015.<br><br>The undertakings can be found on a campaign page. |
| March 2016 | A patient died.<br><br>An inquest concluded on 31 January 2017 that her death was possibly contributed to by the failure of NEP to provide any psychiatric treatment and care after 16 February 2016 despite an urgent need for the same, and to put in any plan for management of the risk of suicide.<br><br>A Prevention of Future Deaths Report was issued, and reissued on 20 April 2017. It identified five areas of concern. No response is available from the Trust. |
| 5 December 2016 | CQC publish a full report on NEP following inspections in September 2016.<br><br>CQC say this was done following their 2015 Section 29A warning notice, and where subsequent monitoring highlighted a number of concerns and warranted a focused inspection.<br><br>CQC were concerned about the safety of some of the wards, many issues having been raised on previous inspections. The Trust did not monitor that actions from the last inspection had been completed effectively. CQC issued a further section 29A warning notice for regulation 17 (good governance) pursuant to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014<br><br>Staff did not always assess risks on wards or manage risk from ligature points well. One unit's seclusion room did not meet the standards outlined in the Mental Health Act Code of Practice. The safety investigation outlines numerous issues with sight lines.<br><br>Staff did not share learning and the Trust's incident reporting was not in line with national guidance. Wards were not fully staffed. 15% of patients' records did not include detailed information which included risks. |
| 1 April 2017 | North Essex Partnership University NHS Foundation Trust (NEP) merged with South Essex Partnership University NHS Foundation Trust (SEP) to become the Essex Partnership University NHS Foundation Trust (EPUT). |

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| May 2017 | Kent and Essex serious crime directorate commence investigation into deaths at the Linden Centre, based at Broomfield Acute General Hospital in Chelmsford.<br><br>No prosecution followed as there was insufficient evidence to convict for corporate manslaughter, as reported in *The Independent* on 14 November 2018, although police uncovered "*clear and basic failings*" in care.<br><br>"*Areas of concern identified by the police include policies on searching to uncover items that could pose a risk to patients, care plans, communication with families and the appointment of appropriate staff.*<br><br>*There was also issues with the numbers of "ligature points" where patients experiencing suicidal thoughts might try to hang themselves.*<br><br>*This is the focus of a separate investigation by the Health and Safety Executive which is due to report in the next six months and which Essex Police said it was assisting with.*"<br><br>The Trust entered a guilty plea to the HSE prosecution in 2020 (see below). |
| 26 September 2017 | CQC report following an inspection of Byron Court (EPUT) on 27 July 2017.<br><br>The report identified ineffective systems for identifying and responding to environmental risks. The ward contained fixtures that patients might have used as ligature anchor points. Audit systems failed to identify some ligature points and *"were not fully effective"*. Staff used a room to seclude patients that did not meet the Mental Health Act Code of Practice standards. Patients did not have identified positive behavioural support plans (identified by DoH policy to assist staff to manage patients with complex behaviours). The use of physical restrain to control patients had *"increased substantially"* in 2016/17. |
| 11 October 2017 | CQC report following inspections of Ardleigh Ward, Gosfield Ward, and Peter Bruff Ward (EPUT) on 22 and 23 August 2017.<br><br>A blind spot was found on a seclusion room in one ward which had not been resolved despite being reported to senior managers four months prior. 14 of 21 care records reviewed showed that information highlighted on initial risk assessments did not always feature on follow up assessments, despite risks still being present. Staff did not record patient nursing observations on the enhanced observation charts. Issues identified with medication on Peter Bruff ward with prescription charts being unclear, medication prescribed |

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| | and administered without a certificate of second opinion, medication prescribed to a patient that had not been included on the certificate of consent to treatment. |
| 26 January 2018 | Six CQC reports following inspection of 30 EPUT wards in November 2017.<br><br>The reports showed widespread blind spots across wards hindered patient monitoring and safety. Heavy reliance on agency staff led to frequent staffing shortages, activity cancellations, and restricted patient freedoms. Seclusion facilities and paperwork were inadequate, compromising patient dignity and safety. Ligature points were poorly managed, with unclear guidance and missing visual aids for staff. Medicine management issues included unlabelled drugs and errors in drug charts. Insufficient bathrooms and mixed-sex dormitories failed care standards. Governance failures post-merger, with persistent issues from previous inspections unaddressed. Environmental hazards, outdated policies, and inadequate training were common across multiple wards. Frequent use of restraint with poor incident follow-up and inconsistent care planning. |
| 16 April 2018 | Terrence Dicks died. |
| 25 July 2018 | An anonymous patient died. |
| 26 July 2018 | CQC report following inspections between 30 April 2018 and 23 May 2018 of all mental health and community health core services (EPUT). This was described as the "*first comprehensive inspection of the trust since its creation, following the merger of two trusts on 1 April 2017"*.<br><br>The overall trust quality rating was marked as good. “Are services safe?” was assessed as “requires improvement”.<br><br>8 of 12 ratings for mental health services safety were marked as “requires improvement”. Wards for older people with mental health issues, learning disabilities or autism, and some community-based mental health services were ranked as “good”. There remained inconsistencies in the assessment of environmental risks at some locations. This included the identification and mitigation of ligatures and the use of appropriate furniture. However, it was evident that the trust had taken significant steps to address this issue. This included the removal of ligature anchor points and the introduction of ligature heat maps. Handover at both Linden and the Lakes was undocumented, risking communication lapses. Crisis plans lacked detail, there were gaps in records at the Linden team and records at the Lakes were not properly scanned into the system. |
| 16 January 2019 | A patient died on Thorpe Ward at Basildon Mental Health Unit. |

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| | An inquest in March 2022 concluded that her death was contributed to by neglect due to a plethora of failings by EPUT. |
| 14 April 2019 | Terry White died.<br><br>A Root Cause Analysis Investigation was completed in May 2019. |
| 20 May 2019 | Local media, *Essex Live*, reports that whistleblowers from within different mental health units around Essex (under the operation of EPUT) have released photographs showing ward staff sleeping on duty. The photographs were sent to a Core Participant.<br><br>The response from the Trust is recorded as follows: "*We are grateful that the photos allegedly showing our staff sleeping have been shared with us so we can take prompt action. A full investigation has been opened in line with relevant Trust policies and procedures*." |
| 12 June 2019 | Parliamentary and Health Service Ombudsman report on NEP, following two individual complaints regarding the deaths of 'Mr R' and Matthew Leahy.<br><br>The Ombudsman upheld the complaints in both individual cases, which indicated significant failings on the part of the Trust.<br><br>The Ombudsman commented further: "*The timeline in the next chapter highlights a range of additional evidence that should have acted as a warning signal to the Trust's leadership that there were serious failings that needed to be addressed. These are not issues that we have looked at through our own investigations, which are limited by the scope of the individual complaints we receive. However, we believe that in an organisation committed to learning and improvement, the evidence from these cases should have prompted immediate action led from the very top of the Trust with senior accountability for delivering and evidencing improvement. Instead, it appears there was a systemic failure to tackle repeated and critical failings over an unacceptable period of time*." (page 8)<br><br>Further, "*In this case, the broader evidence we have seen indicates that there were serious deficiencies in the culture of learning and improvement across NEP. In addition, although recent evidence suggests the situation has improved since the creation of EPUT, according to the CQC's most recent inspection report there remains work to do.*<br><br>*We believe there could be valuable learning taken from a more fundamental review of the approach to leadership, learning and* |

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| | *improvement at NEP and why the pace of change only seemed to improve following the merger to create EPUT. It is important that the opportunity to do this is not lost*." (page 9)<br><br>This recommendation is revisited with a suggestion that NHS Improvement should review what went wrong at NEP and consider whether the broader evidence it sees suggests that a public inquiry is necessary. (page 14)<br><br>The Ombudsman noted that the HSE investigation was ongoing and that the local Clinical Commissioning Group (North East Essex) was planning to undertake a Commissioner-led review into these cases. (page 14)<br><br>Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust (ombudsman.org.uk) |
| 18 June 2019 | Sir Norman Lamb, MP for North Norfolk, writes to the Secretary of State in support of families' call for a public inquiry. His letter states: "*The PHSO has passed the buck by calling on NHS Improvement to conduct another review. This is very disappointing. It is clear that the only way justice can be done is for the Government to launch a public inquiry*."<br><br>Sir Norman Lamb backs mother's call for a Public Inquiry. |
| 26 June 2019 | CQC report following inspection of Basildon Mental Health Unit (MHU, Broomfield Hospital Mental Health Wards, and Chelmer and Stort Mental Health Wards on 3 April 2019 and 11 April 2019.<br><br>It concluded that staff failed to apply lessons from a serious incident, leading to a repeat incident at Basildon Mental Health Unit. There was inconsistent staff knowledge of risks on Thorpe Ward, including ignorance of past incidents with ceiling tiles. There was persistent understaffing on all wards; 98 nursing and 110 healthcare worker shifts unfilled in three months. Two different databases across localities caused patient information sharing issues. Ligature risk assessments were incomplete, with unmitigated anchor points on the Grangewater and Thorpe wards, and staff were unaware of some environmental risks. |
| 27 June 2019 | 'Ela', Malgorzata Elzbieta Breczko-Nowak, died. |
| 21 July 2019 | Zak Farmer died.<br><br>An Inquest concluded on 15 September 2020 with a narrative conclusion and a Prevention of Future Death Report was issued on 24 September 2020. |

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| | The Report stated: '*There appeared to be a lack of clarity over the meaning of the word "urgent" when a referral is made to the Access and Assessment Team and what steps will be taken if a patient cannot be contacted. 2. The trust document Clinical Guidelines for Community Mental Health Service Users disengaging or non concordant with current prescribed treatment plans was found lacking and requires perfecting*.'<br><br>The Response from EPUT dated 26 November 2020 stated: '*I can confirm that the Access and Assessment Service respond to all referrals in line with nationally accepted guidelines and standards. A crisis response is responded to within 4 hours, an urgent response within 24 hours and a routine response within 28 days. All referrals are triaged by the team to establish the response required and risk 'red flags' are used to inform this decision.* [A list of red flags follows] *Since April 2020 the Trust has established a separate Crisis Response Service and all crisis referrals are now actioned by this team. In response to the matter of concern regarding the EPUT Clinical Guidelines for Community Mental Health Service Users disengaging or non-concordant with current prescribed treatment plan, I can confirm that this document is currently under review and we will ensure that it is comprehensive and provides clear guidance for staff.*'<br><br>The name of the Trust CE is redacted, but the letter further states: '*I would like to begin by extending my deepest condolences to the family of Mr Farmer. This has been an extremely difficult time for them and I hope that my response provides the family, and you, with assurance that the Trust takes their loss seriously and has taken action to address the issues of concern raised in your report.*'<br><br>There is a further response to the Report from the Castle Rock Group in respect of Mr Farmer's time at the medium secure unit at Brockfield House.<br><br>The above documents are available at the judiciary.uk website. |
| 27 August 2019 | Lee Spencer died.<br><br>An Inquest took place in January 2020 and the Coroner made a Prevention of Future Deaths Report. |
| 2 September 2019 | Ellise Sambora died.<br><br>A Root Cause Analysis Investigation Report was prepared by NELFT in and/or around 10 June 2020.<br><br>An Inquest concluded in July 2020. |

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| 9 October 2019 | CQC report following a routine inspection of 5 areas of EPUT mental health services between 29 July to 22 August 2019.<br><br>The overall trust quality rating was marked as good. “Are services safe?” was again assessed as “requires improvement”. "Are services caring?" was ranked as "outstanding".<br><br>9 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were recorded. 5 requirement notices were issued to EPUT requiring them report to CQC the actions it would take to meet the requirements.<br><br>Key criticisms included: That the trust failed to ensure lessons from incidents were learned, leading to recurring issues in communication, record keeping, and emergency treatment.<br>There was persistent use of prone restraint despite policy changes; 183 incidents recorded, 85% for administering medication.<br>There was a lack of a system to monitor and address blanket restrictions across the organisation. Data quality issues impacted record keeping, training, and performance reports, with senior leaders acknowledging inaccuracies. The engagement with equality and diversity networks was insufficient, with missed opportunities and a narrow focus on race. |
| 8 December 2019 | Michelle Amanda Morton died. |
| 21 February 2020 | James ‘Jim’ Hulton died. |
| 8 March 2020 | Tillie-Anne King died. |
| 8 July 2020 | Christopher Nota died.<br><br>An inquest into his death opened on 12 September 2022 and concluded on 6 January 2023. |
| 15 September 2020 | Darren Porter died. |
| 14 October 2020 | Doris Joyce Smith died.<br><br>A Serious Incident Report was completed, and an Article 2 Inquest took place. The Inquest concluded on 27 January 2023 with a narrative conclusion.<br><br>The conclusion stated, inter alia, “*Doris Joyce Smith died as a direct result of the fall on Ruby Ward on the 9th October 2020. Had Mrs Smith been observed and monitored as she should have been, the fall on 9th October 2020 would either have been avoided or there would have been a staff member present to break her fall. Had the fall been broken, it is likely that Mrs Smith would have avoided injury, or her injuries would have been less severe. The fall* |

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| | *suffered by Mrs Smith on 9 th October 2020 caused her to suffer a traumatic subarachnoid haemorrhage, which led to her death on 14th October 2020. In addition, the falls risk assessment and the level of observations were inadequate. There is no evidence of effective communication between the different professionals as to the correct care Doris Smith should be receiving. As well as the lack of implementation of correct and accurate record keeping. Evidence heard as to inconsistencies between staff on Ruby Ward as to which were the correct levels of observations, especially following the falls on the 1st, 8th and 9th October 2020. All of these factors led to the incorrect observation of Doris Smith which contributed to the circumstances leading to her death*."<br><br>A Prevention of Future Deaths Report was issued dated 27 February 2023. It recorded the following concerns:<br><br>"*(1) Essex Partnership NHS Foundation Trust staff:*<br>*a. delayed the completion of a falls risk assessment*<br>*b. completed the falls risk assessment with inaccurate information to assess Doris Smith's risk and updates were also inaccurate*<br>*c. did not follow the advice of the physiotherapist that would have required Doris Smith to mobilise only with assistance of staff and whether her level of observations should have been changed.*<br><br>*(2) Neurological observations following a sustained head injury were not completed as required*<br><br>*(3) Doris Smith had falls on the ward and her level of observations was not reconsidered in light of advice from the physiotherapist after each fall.*<br><br>*(4) The Trust Observation Policy is used in different therapeutic settings and is confusing as to the Levels of Observation required and the focus is on risk for mental health rather then physical healthcare issues that may arise.*<br><br>*Quality of record keeping:*<br>*a. The Trust medical records recording system is electronic and evidence was heard that the window on the screen used for staff to type their records is very small and difficult to use.*<br>*b. There were significant examples of cut and paste including out-of- date information recorded in the medical records.*<br><br>*(6) Lack of effective communication as to the care and treatment required for Doris Smith between Trust staff and the levels of observations required to keep her safe on the ward*."<br><br>A response from the Trust dated 26 April 2023 responds to these six concerns. Whilst the name of the Chief Executive is redacted, it |

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| | states: "*I would like to begin by extending my deepest condolences to Doris's family. This has been an extremely difficult time for them and I hope that my response provides Doris's family, and you, with assurance that the Trust takes their loss seriously and has taken action to address the issue of concern raised in your report.*"<br><br>For brevity, the full response to all six concerns is not set out here but can be found on the judiciary.uk website. |
| 23 October 2020 | Jayden Booroff took his own life.<br><br>An Inquest concluded on 25 November 2022 with a narrative conclusion, inter alia: '*The layout of The Linden Centre in particular the areas around the main doors was not appropriate for ensuring the safety of its more vulnerable patients. Procedures around the use and allocation of Pinpoint alarms was inadequate. The Policy recording and reporting absconsions from The Linden Centre was not clear enough and led to a lack of awareness and a delay in addressing the flaws in the system. Responsibility for Jayden was not in line with policy and this contributed to a reduction in observation levels and inconsistencies in prescribed medications. Communication between all healthcare professionals involved in Jayden's treatment was unsatisfactory, with mistakes being made in updating key documents. Risk assessments were not updated accurately enough or in good time, and failed to capture important information, including historical and emerging information.*'<br><br>A Prevention of Future Deaths Report was issued dated 27 January 2023. This identified four concerns:<br><br>"(*1) Essex Partnership NHS Foundation Trust risk assessments missed key risk information that led to a reduction in observations levels on the ward.*<br><br>*(2) There is a lack of understanding at Essex Partnership NHS Foundation Trust level about the difference between:*<br>*a. a patient who has been granted section 17 leave under the Mental Health Act who does not return from a period of authorised leave, and*<br>*b. a patient who being subject to detention under the Mental Health Act, who has escaped from the confines of the ward and who has not been granted section 17 leave by the Responsible Clinician and therefore, there is a concern as to how this information is then communicated to emergency services searching for the patient of the risks of self-harm.*<br><br>*(3) Miscommunication between:*<br>*a. Essex Partnership NHS Foundation Trust to emergency services* |

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| | *b. Essex Police to Essex Partnership NHS Foundation Trust*<br>*c. Essex Police to other emergency services*<br><br>*In seeking further information, how a risk managed within the confines of a secure mental health ward may change for an escaped patient and whether there is real and immediate risk of serious or fatal harm to self or others, rather than assumptions that language is being used in the same way by different services.*<br><br>*(4) Lack of an Essex Partnership NHS Foundation Trust senior single point of contact for communications with emergency services who would provide any further information or receive updates and how this could be managed across change of shifts*."<br><br>An undated response from EPUT, and a response from the Chief Constable of Essex Police, are available at the judiciary.uk website. They are not set out here for brevity. However, the Trust states:<br><br>"*I would like to begin by extending my deepest condolences to the family of Jayden. This has been an extremely difficult time for them and I hope that my response provides Jayden's family, and you, with assurance that the Trust takes their loss seriously and has taken action to address the issue of concern raised in your report*."<br><br>The name of the letter-writer is redacted. |
| 20 November 2020 | Guilty plea in the case of *R v EPUT* to an offence contrary to s.3(1) and section 33(1)(a) of the Health and Safety at Work etc. Act 1974. The prosecution was brought by the Health and Safety Executive.<br><br>EPUT statement on HSE prosecution \| Essex Partnership University NHS Trust |
| 30 November 2020 | Debate in Westminster Hall following families' campaign petition (e-petition 255823) receiving more than 105,000 signatures online, triggering the debate. (Hansard, vol 685, col 1WH)<br><br>Nadine Dorries MP, Minister for Patient Safety, Mental Health and Suicide Prevention, announced an intention to convene an independent inquiry.<br><br>Barbara Keeley MP, Member for Worsley South and Eccles, said: "*I think it would be easier if the Minister just let me ask the question. It was clear … that Melanie Leahy* [a Core Participant] *is not necessarily happy with an independent inquiry. We should be clear about that. There is the question of compelling witnesses to attend*."<br><br>It was noted that the families' campaign had been underway for eight years. |

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| | Ms Dorries stated that she wished to get the inquiry underway before Christmas and expressed her hope for an interim report. (col 22WH)<br><br>*The Independent* reported the families' disappointment that a full statutory inquiry was not called. |
| 27 December 2020 | Darian Bankwala died.<br><br>An inquest into his death opened on 23 March 2022 and concluded on 12 April 2022. |
| 14 January 2021 | CQC report following a focused inspection on 29 October 2020 and 6 November 2020 of Finchingfield Ward. The reason for the inspection was that the CQC had received "concerning information and incidents relating to patient safety".<br><br>A requirement notice for three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was issued requiring EPUT to send CQC a report setting out the actions it would take to meet requirements.<br><br>Key criticisms included: That staff failed to follow patient care plans and Trust policy, neglecting required observations in the garden, leading to patient absconsion. Staff made clinical decisions beyond their role and responsibilities. There was poor record-keeping: inaccurate, untimely entries, including failures to document patients' Mental Health Act status. Managers did not check the quality and accuracy of patient records, including observation times. There was a failure to ensure experienced staff were available on all shifts to meet patients' needs. |
| 21 January 2021 | Announcement in Parliament of the independent inquiry.<br><br>Mental Health In-patient Deaths in Essex: Independent - Hansard - UK Parliament<br><br>Families continued to campaign for a statutory inquiry.<br><br>NHS mental health deaths: dozens of families join forces in call for statutory public inquiry (inews.co.uk) |
| 21 February 2021 | Roy Breaker-Rolfe died. |
| 16 March 2021 | Dorothy Reditt died.<br><br>A Root Cause Analysis Investigation Report dated 28 July 2021 made three recommendations. |
| 20 March 2021 | Andrew Kynaston died. |

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| April 2021 | Commencement of the work of Essex Mental Health Independent Inquiry under Dr Geraldine Strathdee MBE. |
| 19 April 2021 | Elise Sebastian died. |
| 16 June 2021 | Sentencing remarks of Mr Justice Cavanagh in the case of *R v EPUT* at Chelmsford Crown Court. The defendant was fined £1,500,000 to be paid in instalments due to its financial position.<br><br>The Sentencing Remarks note that between 1 October 2004 and 31 March 2015, "*11 inpatients hanged themselves using ligature points, and at least one other, and probably more, tried unsuccessfully to do so*." (para 1)<br><br>It was held that "*the defendant 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*" (para 1) and that EPUT was legally liable for the acts and omissions of its predecessor Trusts (para 3).<br><br>Cavanagh J stated: "*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 (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, such as, for example, door hinges or wardrobe handles, were not identified and dealt with*." (para 6)<br><br>These failures were particularised in the sentencing remarks that followed. However, there was no full trial of the issues due to the guilty plea.<br><br>On behalf of the Trust, "*a profound apology and expressions of remorse and sympathy for the failings which had taken place*" were put forward. (paras 12-13)<br><br>At paragraphs 62-65, the judge sets out the current governance position and recent CQC findings and rating. At para 65, he states: "*There is now a new Chief Executive in place, and patient safety is being given the highest priority. I am satisfied that matters have* |

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| | *improved since 2019, and that things are moving in the right direction.*" |
| 24 August 2021 | Terms of Reference in independent inquiry published.<br><br>Essex Mental Health Independent Inquiry: Terms of Reference - Hansard - UK Parliament |
| 7 September 2021 | Colin Flatt died.<br><br>Mr Flatt was the partner of Melanie Leahy, a Core Participant, who is also the mother of Matthew Leahy. |
| 15 September 2021 | CQC report following unannounced focused inspections in May and June 2021 of Larkwood Ward, Longview Ward and the Poplar unit.<br><br>The cause of the inspections was the notification of a serious incident and information of concern about the safety and quality of the services. CQC gave an overall rating for the services as "inadequate".<br><br>As a result of the serious concerns from the inspection, urgent enforcement action was taken by CQC using powers under section 31 of the Health and Social Care Act 2008. This included a condition to restrict the provider from admitting any new patients without the prior written agreement of the Care Quality Commission and a condition to staff all three wards with the required numbers of suitably skilled staff to meet the patient's needs and to undertake patient observations as prescribed. Requirement notices were issued for 5 breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>Key criticisms included: The service did not have enough nursing and support staff to keep patients safe. Managers failed to accurately determine staff numbers and qualifications, leading to unsafe shifts lacking enough staff for physical interventions and patient observations. High reliance on agency staff, with concerns about their skills and impact on patient care. Staff unfamiliar with patients' needs, missing opportunities to prevent harm and not following enhanced support policies. Inadequate tear-proof clothing on wards, with poor incident reporting and ineffective sharing of lessons learned. Leadership lacked necessary skills and governance processes were ineffective, with risks poorly managed and reactive responses. |
| 6 January 2022 | Paula Parretti died. |
| 11 January 2022 | Daniel Lee Marcovitch died. |

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| | An ‘After Action Review’ was carried out on 15 July 2022. |
| 12 February 2022 | Amanda ‘Mandy’ Susan Hitch died.<br><br>The Coroner issued a Prevention of Future Deaths Report, dated 19 December 2023, following an inquest in December 2023. This was addressed to EPUT as well as to the British Transport Police. Relevant concerns as they related to EPUT included, inter alia:<br><br>‘*During the inquest, it became clear that one significant entry in the clinical notes made by someone in a separate service commissioned by the Essex Partnership University Trust, and which expressed a very specific and imminent intention from the deceased to end her life, was not seen by others in the clinical team. This was almost certainly because the clinical record does not present on computer screens as a continuous chronological running record, but is instead viewed thematically. That means that readers are likely to look at entries made within their particular clinical team, rather than see what others have recorded more recently. There is an obvious risk that critical and important information garnered by others and put into the medical records will not be seen, and that those making clinical decisions on risk management will thus be unaware of potentially very significant information.*<br><br>*The evidence was such that neither the care co-ordinator nor the consultant psychiatrist as the medical lead of the service specifically considered the structured risk management tools that the Trust operates, preferring to rely on clinical experience and judgment alone. There may be a risk that not using such risk management tools in combination with clinical experience and judgment, particularly if this is being done by one clinician at an appointment rather than multidisciplinary discussion of changes in presentation, may lead to information being missed*.’<br><br>The Report is available on the judiciary.uk site. No response from the Trust is available on that page. |
| 16 February 2022 | Abbigail Louise Smith died.<br><br>A Patient Safety Investigation Report was prepared, dated 27 March 2023. |
| 4 March 2022 | Marion Michel died. |
| 10 July 2022 | Michael Nolan died. |
| July 2022 | A patient died after being found unresponsive on 6 July 2022 on Chelmer Ward at the Derwent Centre. |

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| | An inquest found that neglect contributed to her death. |
| 29 July 2022 | CQC report following unannounced focused inspections in March and April 2022 of Larkwood Ward, Longview Ward and the Poplar unit.<br><br>CQC concluded improvements have been made. The overall rating was changed from "inadequate" to "requires improvement". The previously imposed Section 31 conditions were removed.<br><br>Of nine children and young people spoken to, two told the inspectors that there was a lot of restraint on the wards. One young person told them that they felt non-regular staff panicked and didn't de-escalate incidents as often as they should. One young person told them they felt they were restrained more than they should have been. |
| August 2022 | A patient died at Willow Ward, Rochford Hospital, Essex. |
| October 2022 | Channel 4 Dispatches documentary airs, entitled: 'Hospital Undercover Are They Safe?'<br><br>It interviews three Core Participants and also indicates that the CQC carried out unannounced visits on 5 and 6 October 2022 and that the Trust had commissioned a review (further details of this are not known).<br><br>The media response to the documentary can be seen in, for example, the local media and the Daily Mail: Shocking scenes uncovered inside Britain's mental health service crisis \| Daily Mail Online<br><br>and in *The Guardian*'s commentary, tellingly entitled "England's mental health care lacks money, yes – but it also lacks compassion". The author, a clinical psychologist, states:<br><br>"*The same themes occur again and again. The overuse of restraint, which can spill over into the violence of being dragged down corridors; arbitrary and, at times, punitive boundaries being set; a lack of understanding of autism, eating disorders and self-injury; suicidal patients left at high risk; a lack of compassion.*<br><br>*It is easy to blame "bad apples" to protect our collective fantasy of angelic NHS staff. But life is more complicated than this, as are the dynamics in health systems. Teams can and do become toxic, caught up in coercive and cruel practices into which new members become socialised. We are all vulnerable to these processes, though it scares us to think so, and never more so than in a brutally underfunded, over-pressurised system.* |

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| | *England has fewer psychiatric beds than ever before, with numbers having fallen by a quarter since 2010, from 23,447 to 17,610. Such a drop would always be catastrophic, let alone at a time of increasing demand and with community services drastically underfunded.*"<br><br>On 29 October 2022, families of those who had died in mental health and other custody settings processed to Downing Street to present new Prime Minister Rishi Sunak and others with a request for a meeting.<br><br>Bereaved families march to Downing Street to demand justice for deaths in custody \| Inquest |
| 5 to 6 October 2022 | CQC inspected two wards identified in the Channel 4 documentary.<br><br>CQC sent a 'Letter of Intent' to EPUT stating that it considered using potential urgent enforcement action. |
| 31 October 2022 | CQC issued a 'Warning Notice' to EPUT under section 29 of the Health and Social Care Act, asking the Trust to make significant improvements by 18 November 2022 regarding:<br><br>• Patient observations<br>• Sufficient numbers of regular staff<br>• Patient consent<br>• Blanket restrictions<br>• Incident reporting<br>• Ligature cutters |
| 15 December 2022 | Written question tabled in the House of Commons by Dame Priti Patel, Member for Witham, to ask the Secretary of State for Health and Social Care whether the independent inquiry could be placed on a statutory footing.<br><br>The answer, on 23 December 2022, was that the progress of the inquiry would be monitored and its status considered. |
| 18 January 2023 | Letter from CEO of EPUT to Dr Geraldine Strathdee:<br><br>Regarding staff engagement: "*A request to issue the letter to all historic staff was made by the Inquiry. EPUT sent circa 8150 letters via email. Circa 6500 former staff did not have an email address registered with the Trust and the Inquiry took the decision not issue* [sic] *letters by post to these remaining staff.*"<br><br>https://eput.nhs.uk/media/qnrpk4pd/eput-foi-23-2817-letter.pdf |

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| 31 January 2023 | Debate in Westminster Hall on the progress of the independent inquiry tabled by Vicky Ford MP, Member for Chelmsford. (Hansard, vol 727, col 46WH)<br><br>Vicky Ford MP commented: *"It is incredibly disappointing that, of the 14,000 members of EPUT staff whom the inquiry had written to, only 11 had agreed to give evidence."*<br><br>The Parliamentary Under-Secretary for Health and Social Care, Neil O'Brien, commented:<br><br>"*Dr Strathdee has raised two particular concerns. The first is about the participation of current and former staff, and the second is about the availability of documents for the inquiry. As a result of Dr Strathdee's concerns, the Secretary of State met Paul Scott, the chief executive of Essex Partnership University NHS Foundation Trust, showing location of to better understand how the trust will support the inquiry. The Secretary of State sought assurance on two key issues. The first is what actions the trust will take to encourage more staff engagement with the inquiry, and the second is assurance that the trust will provide all the evidence and information requested by the inquiry, to enable it to fulfil its terms of reference. I know that Mr Scott has also written to local MPs setting out the steps that he thinks necessary to improve engagement, and he feels confident that progress can be made.*<br><br>*On staff participation, I remind the House that it is incumbent on all holders of public office and all health professionals to demonstrate their fitness for office by voluntarily co-operating with independent inquiries. In their guidance on the duty of candour, professional regulators advise that health and care professionals must be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. Similarly, they must support and encourage each other to be open and honest. I therefore hope that anybody who is asked to contribute evidence will co-operate fully with the inquiry in the public interest and in fulfilment of their professional obligations. The Department is also working closely with the inquiry and NHS England to look at what more can be done.*<br><br>*Dr Strathdee has expressed her concern that an additional 600 cases were recently sent to the inquiry. The trust has advised that they were identified during a validation process. I appreciate that this is not ideal, but I understand that the trust has allocated appropriate staffing and resource to ensure the thoroughness of the searches requested by the inquiry*."<br><br>He added, "*We have recently announced a rapid review into patient safety in mental health settings across England. The review will* |

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| | *focus on what data and evidence is available to healthcare services. I am pleased that Dr Strathdee will be leading the rapid review*." |
| 14 March 2023 | Phephisa Mabuza died.<br><br>A Root Cause Analysis Investigation Report was prepared.<br>An inquest has recently concluded. |
| April 2023 | Dr Geraldine Strathdee writes to then- Health Secretary, Steve Barclay, and asks that he grant a statutory inquiry.<br><br>The letter said staff evidence is "vital" to the inquiry and not enough frontline workers had come forward, despite efforts to engage staff.<br><br>https://www.independent.co.uk/news/health/mental-health-deaths-inquiry-b2339114.html |
| 3 April 2023 | CQC report following unannounced focused inspections in on 5 and 6 October 2022 of Galleywood Ward and Willow Ward. These were the two wards identified in the Channel 4 documentary.<br><br>CQC suspended EPUT's rating for Acute wards for adults of working age and psychiatric intensive care units as a result of concerns about the service.<br><br>Key criticisms included: Staff frequently failed to follow Trust policies on patient observations, incident reporting, and general procedures. High levels of staff vacancies and sickness led to reliance on temporary staff unfamiliar with patients, impacting care quality. Excessive use of bank and agency staff, despite Trust systems for recording patient needs and risks. Persistent blind spots in patient observation areas remained unaddressed.<br>Care and treatment were not consistently provided with proper consent. Restrictive practices limited patient access to essential areas. Ligature cutters were not consistently accessible to staff.<br><br>Of nine patients interviewed, three stated they had seen staff sleeping on duty. This was corroborated in part by CCTV footage showing a member of staff sleeping and body worn camera footage recording a patient disclosing that they had seen a staff member sleeping. |
| 11 April 2023 | Clive Harwood died.<br><br>A Learning Response report was prepared dated 28 November 2023, and an inquest was subsequently held. |
| 1 March 2023 | Dame Priti Patel raises in the House of Commons the question of the statutory footing of the inquiry. (vol 728) |

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| 5 June 2023 | Jack Peatling died. |
| A date in mid-2023 | A person died who will be the subject of a restriction order, with a cipher to be determined. |
| 28 June 2023 | Report of Dr Strathdee's rapid review published: 'Rapid review into data on mental health inpatient settings: final report and recommendations'. |
| 12 July 2023 | CQC report following an unannounced comprehensive inspection of 6 core services. Four out of five key criteria were graded as "requires improvement". The Trust was graded overall as "requires improvement".<br><br>Acute wards for adults of working age and psychiatric intensive care units were selected to see how many improvements had been made following CQC's inspection in October 2022 where EPUT safety ranking was graded "inadequate" and a warning notice had been issued. These wards were again graded as "inadequate". Specific criticism of these wards included that "[l]eaders had shown little evidence of learning from previous inspections or taken sufficient action to improve safety", "[s]taff did not manage patient safety incidents well; recognise incidents and reported them appropriately", and "Staff were still falling asleep while carrying out therapeutic observations".<br><br>Key general criticisms included: Governance, assurance, and performance management systems were ineffective, with new strategies still in early stages and lacking impact. Persistent regulatory breaches since 2019; the pace of change remained a concern. Staffing challenges: high vacancy rates (21%), high use of bank/agency staff, and issues with staff observation and patient interaction. Data quality issues hindered performance monitoring and risk management. Medicines management and pharmacy services were compromised by a 45% vacancy rate. Inconsistent staff support, supervision, and engagement, with significant concerns about staff expressing concerns. Long-standing complaints were unresolved, with delays in addressing them. |
| 21 November 2023 | Carol Ann Taylor died. |
| 1 February 2024 | Patient 11, a new podcast investigation by Sky News and The Independent, uncovers nearly 20,000 complaints of sexual assault, abuse and harassment across mental health trusts in England since 2019.<br><br>A related article on Sky News features an interview with Stephanie Tutty regarding her complaint of sexual assault by an abuser at EPUT and subsequent failure to proceed to a prosecution. |

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| 10 April 2024 | Department of Health and Social Care publishes terms of reference for statutory inquiry. |