IN THE LAMPARD INQUIRY

BEFORE BARONESS KATE LAMPARD CBE

WRITTEN OPENING STATEMENT
ON BEHALF OF INQUEST

A. Introduction

1. This Opening Statement is provided on behalf of the organisation INQUEST. INQUEST welcomes its designation as a Core Participant to this Inquiry. INQUEST is a charity and non-governmental organisation which provides expertise on state-related deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public, with a particular focus on deaths in custody and detention. As a result, INQUEST has extensive experience and understanding of the deaths of those detained under the Mental Health Act 1983 ("MHA") and in psychiatric inpatient settings. The charity works with bereaved families from the outset, supporting them through the investigation by the relevant NHS trust or private provider and then the inquest, and conducts significant policy and parliamentary work on issues arising.

2. INQUEST's specialist casework service has worked with and supported numerous bereaved people whose loved ones have died whilst under the care of mental health services, including in Essex and more widely in England and Wales. Currently, it is estimated that over a third of the organisation's casework focuses on such deaths.

3. INQUEST's casework and campaigning work alongside the bereaved gives the organisation a unique perspective on the delivery of mental health care and the systemic and policy issues arising from deaths, including within specific facilities and NHS trusts. This experience shows that mental health services are repeatedly failing those who experience mental ill health. Those repeated and systemic failures lead, on far too many occasions, to entirely preventable deaths.

B. INQUEST's Expertise and Experience

Supporting Bereaved Families in Essex

4. Since 2008, INQUEST has worked on over 49 cases involving deaths in mental health settings in Essex, as well as several further cases falling within the Inquiry's definition of "*inpatient death*" as set out in the Inquiry's explanatory note on scope.[1] Those deaths are marred by repeated failures that INQUEST have identified, including in relation to[2];

    a. poor information sharing and record keeping.

    b. inadequate risk assessments.

    c. poor practice in relation to the observation of patients and training of staff undertaking observations.

    d. wider inadequacies in staff training.

    e. dangerous ward environments.

    f. inappropriate use of restraint.

    g. a lack of understanding of the intersection between mental health and autism.

5. INQUEST has been extremely concerned that, despite countless investigations, inspection reports and inquests highlighting these failures, preventable deaths have continued.[3]

6. INQUEST has supported many of the bereaved families who have fought over many years for an adequate investigation into the deaths of loved ones under the care of mental health services in Essex.[4] Without the families' courage, persistence and determination, this Inquiry would not have come into existence.

7. Yet it should not fall to bereaved families alone to ensure that such serious and repeated state failings are properly investigated. One of INQUEST's core concerns is that state bodies, including NHS trusts and other healthcare providers, respond to deaths with defensiveness and denial, rather than candour, transparency, and a genuine commitment to

[1] Lampard Inquiry, "Explanatory note in relation to scope of the Lampard Inquiry" (2024)
[2] INQUEST, "Westminster Hall debate: "Deaths within mental health care" INQUEST briefing to MPs" (November 2020), p.1
[3] Parliamentary and Health Service Ombudsman, "Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust" (June 2019), p.10-12
[4] UK Parliament, "Petition: I request a full public inquiry into death of my son, Matthew Leahy. (20 yrs.)"

seeking improvement to policy and practice. This approach means that learning is not implemented, failures are repeated, and more preventable deaths occur.

8. This is particularly apparent in Essex, where INQUEST has seen a systemic failure of the trusts to tackle repeated and critical failings over an unacceptably prolonged period of time.[5]

Deaths In Custody

9. INQUEST has extensive experience and understanding of deaths in custody, including of patients detained under the MHA. This expertise is grounded in the day-to-day experience of working with bereaved people. Employing an integrated model, INQUEST brings together casework support, family participation, identification of thematic trends, statistics, and analysis that feeds into the organisation's work on campaigning, information sharing and policy and parliamentary work. This integrated approach is crucial not only to holding the state to account for individual deaths, but also in changing policy and practice to prevent future deaths.

10. This expertise is highly relevant to the Inquiry's scope of work and its findings and is vital to the Chair making effective recommendations at its conclusion. INQUEST has monitored and evaluated, over many years, the policy, legislative, investigatory and regulatory frameworks applicable to mental health deaths, and so is able to comment with considerable authority on the changes needed and the workability of proposed reforms.

11. Reports and publications produced by INQUEST with relevance to the Inquiry's Terms of Reference include:

    a. Deaths in mental health detention: an investigation framework fit for purpose? (February 2015);[6]

    b. Stolen Lives and Missed Opportunities The deaths of young adults and children in prison (March 2015);[7]

[5] See for example, Parliamentary and Health Service Ombudsman, "Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust", June 2019, p.8.
[6] INQUEST, "Deaths in mental health detention: an investigation framework fit for purpose?" (February 2015)
[7] INQUEST, "Stolen Lives and Missed Opportunities: The deaths of young adults and children in prison" (March 2015)

c. Submissions to the CQC review of investigations into deaths in NHS Trusts (October 2016);[8]

d. Report on the CQC Family Listening Day (October 2016);[9]

e. Briefing on the Mental Health (Use of Force) Bill, Independent investigations: the current system is not enough (June 2018);[10]

f. Briefing on Mental Health Act Reforms for Westminster Hall Debate on 25 July 2019;[11]

g. Briefing to MPs for Westminster Hall debate "Deaths within mental health care" on 30 November 2020;[12]

h. Family Consultation Day Report on deaths of people with mental ill health, a learning disability or autism (April 2023);[13]

i. Achieving Racial Justice at Inquests, a Practitioner's Guide (February 2024).[14]

12. INQUEST's considerable experience of deaths in custody also makes it particularly well-placed to assist with the Inquiry's investigation of the impact of racism, discrimination and inequality on care and treatment, and the role of these factors in deaths. As set out in our response to the List of Issues, it is plainly relevant to the Inquiry's Terms of Reference to consider whether patients' protected characteristics (as defined by section 4 Equality Act 2010) impacted on the standard of care provided. This issue is particularly important to the Inquiry's investigation of the treatment and care provided to those who died (Terms of Reference, §2(a)-(e)), as well as the overall management and monitoring of inpatient care and treatment, including leadership, culture and wider governance (§2(g)-(j)). This issue is discussed in further detail below (see Key Themes for the Inquiry, §14-47).

[8] INQUEST, "INQUEST's submission to the CQC review of investigations into deaths in NHS Trusts" (October 2016)
[9] INQUEST, "INQUEST's report on the CQC Family Listening Day" (October 2016)
[10] INQUEST, "Briefing on the Mental Health (Use of Force) Bill, Independent investigations: the current system is not enough" (June 2018)
[11] INQUEST, "INQUEST BRIEFING: Mental Health Act Reforms" (July 2019)
[12] INQUEST, "Westminster Hall debate "Deaths within mental health care"" (November 2020)
[13] INQUEST, "Family Consultation Day Report on deaths of people with mental ill health, a learning disability or autism" (April 2023)
[14] INQUEST, "Achieving Racial Justice at Inquests, a Practitioner's Guide" (February 2024)

National understanding of Issues

13. The Chair poses the question at the end of her Provisional List of Issues, "Is Essex an outlier?"[15] It is clear to INQUEST that sadly, it is not. INQUEST's national work with families and unique overview of the post-death investigation processes also gives it a national understanding of relevant themes arising in deaths in inpatient settings[16] (set out in more detail below, Key Themes for the Inquiry, §§14-47). INQUEST supports other groups of families nationally where concerns are raised in relation to suspected systemic failings in care and treatment by particular mental health trusts leading to preventable deaths. This includes families campaigning for a public inquiry into Tees, Esk and Wear Valleys NHS Foundation Trust ("TEWV")[17] and those who have lost loved ones due to poor care and treatment by Greater Manchester Mental Health NHS Foundation Trust.[18] INQUEST urges the Chair to look at issues that affect mental health inpatient care with a view to identifying themes on a national level in order to make recommendations with national impact.

C. Key Themes for the Inquiry

14. INQUEST welcomes the Chair's detailed expression of her Terms of Reference and her Provisional List of Key Issues. Given that the Inquiry is still in the early stages of gathering and hearing evidence, it is appreciated that these issues may evolve and grow. However, at this preliminary stage, we highlight some key themes that flow through the issues in the Chair's Inquiry and are worthy of early emphasis.

Structural Discrimination

15. Understanding the role of discrimination and structural racism is absolutely essential to any analysis of deaths in custody and has been a central theme in INQUEST's work. The INQUEST Practitioner's Guide, "*Achieving Racial Justice at Inquests",* explains that racial stereotyping is a prominent issue across custodial settings and can lead to an increase in

[15] Provisional List of Issues §106
[16] See, for example, INQUEST, "*Deaths in Mental Health Detention: An investigation framework fit for purpose?"* (February 2015)
[17] Aburzzese, P., "Bereaved North East families call on PM for health trust inquiry" (May 2024): INQUEST, "Tees, Esk & Wear Valleys: Critical governance report finds catastrophic leadership failure at NHS Trust" (March 2023). See also the family campaign "Rebuild Trust" at https://www.rebuildtrust.co.uk/about-us/. In TEWV between April 2017 and March 2020, the Trust recorded 357 deaths.
[18] INQUEST, *"Greater Manchester Mental Health: Review highlights significant learning in improving care"* (2024)

punitive treatment of detained people and bring about a "*culture of disbelief*" when detained individuals raise concerns around their treatment.[19] Black and racialised people with mental health issues are subject to additional stereotyping and *"double discrimination"* which can result in being met with discipline rather than care, and a refusal to accept symptoms of vulnerability or distress as genuine.[20]

16. The role of institutional racism in the mental health system first received state recognition following the death of David (Rocky) Bennett, a young Black Caribbean inpatient who died after ward staff applied excessive physical restraint against him.[21] The report of the inquiry into his death found that "*institutional racism has been present in the mental health services, both NHS and private, for many years*."[22]

17. In 2022, almost 20 years later, a rapid review by the NHS Race and Health Observatory, found persistent inequalities in healthcare in the UK, including mental health care, "*rooted in experiences of structural, institutional, and interpersonal racism*."[23] In particular, black and racialised people are disproportionately more likely to be subject to coercive mental health interventions and detentions, and, once in detention, evidence suggests that black and racialised people are also more likely to be subject to violence and mistreatment.[24] INQUEST worked with the family of Seni Lewis following his death in 2010, during which time the disproportionate restraint of black and racialised people came into sharp focus. The family's campaign led to the Mental Health Units (Use of Force) Act 2018, also known as 'Seni's Law'.

18. For these reasons, it is important to view individual inpatient deaths within a framework of institutional racism, rather than as either unrelated to race or as simply a result of individual bias or *"a few bad apples*".[25] The report of Dame Eilish Angiolini following her

[19] JUSTICE and INQUEST, "Achieving Racial Justice at Inquests, a Practitioner's Guide" (February 2024) p.19, available at: https://files.justice.org.uk/wp-content/uploads/2024/02/22174259/Feb-2024-Achieving-Racial-Justice-at-Inquests-1.pdf
[20] Ibid, p.20.
[21] Ibid, p.17, citing HM Chief Inspector of Prisons, "Thematic review: The experiences of adult black male prisoners and black prison" (2022) p. 65.
[22] The report of the inquiry into his death found that "*there was evidence of incidents of institutional racism from time to time through the lengthy period that David Bennett was suffering from mental health problems…They indicate that institutional racism has been present in the mental health services, both NHS and private, for many years.*" Blofeld, J., "Independent Inquiry into the death of David Bennett" (2003) p.25.
[23] JUSTICE and INQUEST, "Achieving Racial Justice at Inquests, a Practitioner's Guide" (February 2024) p.17, citing Kapadia, D., et al. "Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory" (2022) p.10.
[24] JUSTICE and INQUEST, "Achieving Racial Justice at Inquests, a Practitioner's Guide" (February 2024) p.18
[25] JUSTICE and INQUEST, "Achieving Racial Justice at Inquests, a Practitioner's Guide" (February 2024) p.13

"*Independent Review of Deaths and Serious Incidents in Police Custody*", to which Deborah Coles, Director of INQUEST, was appointed Expert Advisor,[26] found that:

> *"Racial stereotyping may or may not be a significant contributory factor in some deaths in custody. However, unless investigatory bodies operate transparently and are seen to give all due consideration to the possibility that stereotyping may have occurred or that discrimination took place in any given case, families and communities will continue to feel that the system is stacked against them."*[27]

19. Dame Angiolini recommended that the IPCC (now Independent Office of Police Conduct) should *"ensure that race and discrimination issues are considered as an integral part of its work"* and investigators should "*consider if discriminatory attitudes have played a part in restraint-related deaths in all cases where restraint, ethnicity and mental health play a part… A systematic approach should be adopted across the organisation*".[28] It is submitted that the Inquiry should adopt the same approach to the identification and consideration of structural racism in the deaths of all black and racialised patients identified in its investigations.

20. Another key consideration relates to the age of patients receiving care. The transition from Child and Adolescent Mental Health Services ("CAMHS") to Adult Mental Health Services is known to be a period of particular risk for patients. A 2018 Health Services Investigation Body report noted that although more than 25,000 young people transition from CAMHS each year, a "Transition from CAMHS to Adult Mental Health Services (TRACK)" study reported that only 4 per cent of young people received an 'ideal' transition.[29]

21. INQUEST has supported a number of families in cases raising issues regarding the transition from CAMHS to adult mental health services where there was a decrease in support following such transitions and where families were excluded from patients' care on the basis that the individual had now become an adult. Such cases have also raised concerns

[26] Dame Elish Angiolini DBE QC, "Report of the Independent Review of Deaths and Serious Incidents in Police Custody" (January 2017)
[27] Ibid, p.87, §5.17
[28] Ibid, p.93
[29] Health Services Safety Investigations Body, "Investigation report: Transition from child and adolescent mental health services to adult mental health services" (January 2018), available at: https://www.hssib.org.uk/patient-safety-investigations/transition-from-child-and-adolescent-mental-health-services-to-adult-mental-health-services/investigation-report/

regarding the communication and transfer of information between child and adult services as well as the suitability of ward environments for young people.

22. A further concern arising in relation to the deaths of children and young people is deficiencies in multi-agency working between health trusts and relevant agencies with safeguarding responsibilities, such as Essex County Council ("ECC").

23. These issues arose in the death of Molly Ann Sergeant, who was 17 years old when she died following discharge from the St Aubyn Centre, run by Essex Partnership University NHS Foundation Trust ("EPUT"). The Regulation 28 Report to Prevent Future Deaths issued by Area Coroner Sonia Hayes identified concerns including insufficient assessment for discharge planning purposes of the impact of Molly's recent diagnosis of autism by EPUT, a failure by ECC to act on referrals to social care, to conduct the required assessments of Molly during her detention and to appoint a social worker, as well as a lack of understanding of the impact of Molly's detention on her right to assessment as a child in need and their responsibilities under s117 MHA.[30]

24. INQUEST welcomes that the Explanatory Note in relation to the scope of the Inquiry confirms that the Chair will consider, as appropriate, the relevance of neurodiversity and learning disabilities to inpatient deaths.[31] It is submitted that this should be considered relevant to all aspects of the Inquiry's investigations. Further, we invite the Inquiry to specifically consider autism-related deaths.

25. INQUEST is aware of a number of individuals who died as inpatients under the care of the relevant trusts who were identified as (or likely to be) autistic and needed their needs as autistic people met. This is also an issue that has been repeatedly highlighted by coroners and is particularly acute for those with intersecting vulnerabilities, such as young people with autism. The Chair should specifically seek to identify whether where a patient was identified as autistic, care pathways and planning were sufficiently autism informed and autism focused, including adequate consideration of how environmental factors and staffing should be adjusted to meet the needs of autistic patients.

[30] Area Coroner of Essex, "Regulation 28 Report to Prevent Future Deaths" (February 2023)
[31] Explanatory note in relation to scope of the Lampard Inquiry, available at: https://lampardinquiry.org.uk/lampard-explanatory-note/

26. Further categories of people with protected characteristics requiring particular consideration include women and girls who have experienced sexual violence and abuse, and young transgender people.

27. In order to understand whether discriminatory treatment on account of one or more protected characteristic (and the intersection and interaction of these) took place, and further, where it was a relevant factor in mental health inpatient deaths, the Inquiry must investigate this issue from the outset. This should be considered relevant to all aspects of the Inquiry's investigations, including care and treatment, discharge and continuity of care, safety, data collection, staff training, governance and culture. The investigation will therefore need to obtain data, from patients' medical notes and other sources, in relation to the protected characteristics of mental health inpatients who died in the relevant period. This is an issue on which INQUEST has particular expertise across a range of custodial settings and so will gladly assist the Inquiry in this exercise where appropriate.

28. The Chair will note that in the Covid 19 Public Inquiry, Lady Hallett obtained expert evidence on the issue of structural discrimination to assist her in understanding decision making and policy formation, and it has formed part of the evidence in the first two Modules of her Inquiry to have completed oral evidence hearings. INQUEST urges the Chair to consider obtaining expert evidence to assist her in her Inquiry.

Patient Centred Care and a Trauma Informed Approach

29. The Chair has identified the need to consider the extent to which patients and families were involved in decisions made in relation to the patients care and we endorse this approach. INQUEST is aware from its case work, within Essex and nationally, of deaths where the patient's unique needs, identity, appearance or protected characteristic were not taken into proper consideration in care planning, resulting in inadequate care and risk assessments (as discussed above at §§15-29).

30. In analysing the degree to which patients' unique needs were assessed and understood within the inpatient setting, INQUEST urges the Chair to adopt a Trauma Informed Approach. In doing so, it will be important for the Chair to recognise that very few people present as in need of assessment for inpatient treatment under the MHA without having experienced some form of trauma, whether it be within a domestic, institutional or societal context.

31. For example, many patients are admitted during an acute crisis, a relationship breakdown, or have become vulnerably housed, been exploited or abused. Many have been separated from loved ones; partners, parents or children for the first time. Some have put themselves and/or others in danger whilst unwell. Some patients are brought to assessment under s.136 MHA by police officers or following arrest and detention. This intervention (even if necessary) can cause intense trauma for patients. All of these patients carry their trauma into the inpatient setting.

32. The Chair will therefore need to carefully analyse when exploring the evidence whether mental health clinicians were appropriately aware of and trained in methods of mental health assessment and treatment which understood and provided therapeutic support to patients' trauma. The Chair must also consider when examining clinical practices whether they were likely to expose patients to iatrogenic harm. For example, by the use of restraints, the delivery of depot injections without consent and the use of seclusion and isolation.[32] As part of her assessment of whether patients felt safe on mental health wards,[33] the Chair should also seek to understand the impact on patients of being in an acute setting and witnessing other patients self-harm or be subject to restraint.

33. A Trauma Informed Approach will be of particular relevance to the Chair's consideration of issues of Patient Safety and what steps were taken by providers to identify, assess, evaluate and mitigate safety risks,[34] and what crisis management systems were in place.[35]

Engagement of Family Members in Care and Investigations.

34. The involvement of family members in patient care cross-sects a number of the Chair's provisional list of issues touching on care planning, care management and safety. INQUEST have heard from many families through their casework in Essex over the years who have experienced being excluded from the care of their loved one once they have become an inpatient, a concern which is particularly acute in the care of young people.

35. The engagement of family members in raising concerns about their loved one's care is also a crucial issue in the Chair's understanding of both pre-death and post-death processes. The

[32] See the report of the Care Quality Commission, "Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition" (October 2020) on the importance of a trauma-informed approach (p.14, 16, 24, 48-49)
[33] Provisional List of Issues §45
[34] Provisional List of Issues §43
[35] Provisional List of Issues §44

Chair has properly recognised this within her Terms of Reference and in the Provisional List of Issues [§41 -42].

36. In 2022, INQUEST conducted a Family Consultation Day on deaths of people with mental ill health, a learning disability or autism.[36] This was a nationwide exercise. The process focused on thematic strands such as families' experiences of communicating with institutions prior to a death, their role in NHS trust investigations and the role of coroners.

37. Participants spoke about their anger and frustration at the inadequacy of systems and policies on information sharing prior to their relatives' death. Most commonly, families wanted to discuss with clinicians and nursing staff medical needs, changes in health and well-being or broader concerns around their relatives' treatment. Some participants expressed guilt and remorse, suggesting they could have done more, but in fact faced a system that was hostile to family input. Many tried to inform medical professionals about inappropriate treatment, deterioration in their relatives' mood and concerns about behaviour they knew to be indicative of unhappiness and isolation.

38. In many of these examples, mental ill health, learning disability and autism were seen by the health professionals as the cause of insularity, rather than a change in behaviour that required care and support. Families described how hospital staff didn't listen to those in their care.

39. There were also reported barriers to raising concerns regarding the quality of care, and many of the systems in place in mental health settings failed to either acknowledge or act after repeated warnings from parents and siblings. In some cases, families were met with indifference, in others, hostility.

40. In respect of post-death processes, which the Chair highlights in her provisional list of issues, Section L, families have reported to INQUEST a distinct failure to support families with information on what the processes following their family member's death would be, such as counselling and advice or offers/sources of bereavement support, what to expect of investigations and inquests, and the coroner's role.

41. Some felt information was hard to take in in the immediate aftermath of a bereavement and as such what is provided needs to be direct, simple and ideally supplied by one trusted

[36] INQUEST, "Family Consultation Day Report on deaths of people with mental ill health, a learning disability or autism" (April 2023)

source. For many of the families INQUEST spoke to, this role was filled by INQUEST, with families finding the organisation by word of mouth or online.

42. It is important for the Chair to recognise that a failure to provide information at an early stage has the potential to impact on the rest of the investigation process. Without prior knowledge of their rights, families are potentially denied insight into the cause of death of their loved one. INQUEST's listening day identified that ultimately, families are often faced with a completely alien system that can have inconsistent levels of information, empathy, openness and sensitivity.

43. Families have also shared common experiences with INQUEST regarding their roles in post-death investigations, such as resistance, apathy and the view that, unless families fought for a role, the investigation tended to be something that happened to them, rather than with them.

44. It became clear to INQUEST that families are rarely central to the process, and without grit, determination and perseverance, they can be excluded altogether. Whilst some had the means, time and skills to create engagement, it was pointed out that without those attributes, families will inevitably face investigations that were narrow in remit and could not possibly establish what happened and how future deaths could be avoided. In extreme cases, families were not made aware that an investigation was happening, and trusts failed to communicate what would happen following a death.

45. The families that INQUEST spoke to were broadly in agreement that the fundamental principles that should underpin the investigation process – namely, quality, independence and impartiality – were too often absent. As one person said about the trusts, "*they're marking their own homework*".[37] This leads to a lack of faith in how independent the system is and subsequently impacts on the families' trust in the credibility of subsequent findings.

46. Families report to INQUEST feeling let down by the apparent failure to investigate independently, which in some cases impacted very profoundly on the final report findings and much of this centred on the absence of critical information relating to medical care, missed observations, mistakes in administering medicines and incompetent staff.

[37] INQUEST, "Family Consultation Day Report on deaths of people with mental ill health, a learning disability or autism" (April 2023), p.16

D. Candour, accountability & systemic change

State Defensiveness and a Lack of Candour

47. INQUEST also remain concerned that the default position by trusts in response to deaths and evidence of failings tends to be one of institutional defensiveness and a lack of candour. This has been particularly acute around deaths in Essex and has been one of the reasons why this Inquiry was established.

48. INQUEST have supported a number of families through the difficult inquest process following the deaths of mental health inpatients in Essex. These processes are extremely important because it is often only when cases reach inquest that families can seek answers as to why their loved ones have died. The rigour and quality of the inquest will depend on the quality of the investigation undertaken, the approach taken by the coroner and if the family are legally represented. Yet, often, families and coroners are faced with defensiveness, a lack of candour and sometimes outright hostility when simply trying to get to the truth of what happened.

49. INQUEST wishes to highlight the significance of a lack of candour by trusts in coronial investigations as part of ensuring that lessons are learnt from the tragic and avoidable deaths of those within their care. Institutional defensiveness manifests itself in a number of ways including, lack of disclosure of relevant material to the coroner, refusing to acknowledge or accept failings at the outset of the coronial investigation and trust advocates at inquests adopting an adversarial approach and making submissions in order to dissuade coroners from making Prevention of Future Death Reports ("PFD" reports). All these factors have been the experience of bereaved families in Essex, and nationwide.

50. In a letter to the then Secretary of State for Health, Steve Barclay asking for his establishment of a statutory public Inquiry, INQUEST highlighted the inquest into the death of Chris Nota, which concluded in January 2023, which had to be abruptly adjourned by the Coroner when it was revealed that EPUT had failed to disclose thousands of pages of correspondence between staff about Chris and his care.[38] This is just one example of late disclosure and a failure of candour resulting in delay in a coroner's investigation identifying failings.

[38] INQUEST, "Chris Nota: Inquest finds multiple significant failures in care by EPUT contributed to death" (January 2023)

51. The difficulties faced by this Inquiry in its non-statutory form, the Essex Mental Health Independent Inquiry, evidenced an ongoing failure by those services to provide full and frank disclosure of the facts, and to cooperate openly and honestly with the investigatory process. Of course the Chair will recall that in January 2023, former Chair Dr Geraldine Strathdee wrote that, despite the considerable assistance that she had been given by the bereaved, the responses by current and former trust staff had been "*hugely disappointing*".[39] She noted that of over 14,000 staff written to, only 11 said that they would attend an evidence session.[40] INQUEST observes that neither the NHS Duty of Candour nor staff members' professional obligations were sufficient to compel their cooperation. Of further concern was that EPUT had originally informed the non-statutory inquiry of the deaths of 1,500 people under their care (and under the care of their predecessor trusts), but Dr Strathdee discovered in December 2022 that the true number was closer to 2,000.

52. These concerns in relation to candour and evidence ultimately led to conversion of the inquiry into this Chair's Inquiry under the 2005 Inquiries Act. The lack of cooperation by the trusts and their staff meant further delays to the investigatory process. As a result, it is now 2024 and the full scale of failings in Essex have yet to be fully uncovered. Without candour and openness, the public can have no confidence that there is learning from mistakes and the bereaved will be denied the truth of their loved ones' deaths. As the Parliamentary and Health Service Ombudsman ("PHSO") noted, it is important to understand why change has taken so long, "*despite the feedback from patients' grieving families and the numerous investigations and inspections highlighting that it was so clearly needed*."[41]

53. It is hoped that with the statutory powers that the Inquiry now has available to it, including the power to require the production of evidence through the issue of a section 21 notice if required,[42] this Inquiry will finally uncover the truth. INQUEST welcomes the expectation of "*complete candour*" as enshrined in the Terms of Reference.[43]

54. It is absolutely central to this Inquiry's investigations (in particular, §2(g) to (k) of the Terms of Reference), and to the recommendations made to improve the future provision of

[39] Lampard Inquiry, "Open Letter from Dr Geraldine Strathdee, Chair to the Essex Mental Health Independent Inquiry" (January 2023)
[40] Ibid
[41] Ibid.
[42] Sections 21 and 36 Inquiries Act 2005
[43] The Lampard Inquiry, "Terms of Reference", §7

mental health inpatient care (§4 of Terms of Reference), that it seeks to fully understand how a serious and enduring lack of candour prevailed in Essex for so long in the period under investigation. Were senior leaders at the trust aware of the "*significant and repeated failings*" identified by the PHSO? Did they purposefully hide evidence of failings from the public and from investigators? Was information provided misleading by omission? How did the trusts approach inquests; were coroners given the full picture? Were concerns raised by patients and the bereaved properly responded to, or were they dismissed and underplayed? What assurances were given to patients, the bereaved, the public and regulators in the relevant period? Were these assurances true? Where changes and improvements have been promised, did they materialise?

55. The Inquiry will no doubt obtain evidence relating to the response of public bodies at all levels to the failings in Essex in the relevant period, and the extent to which institutional defensiveness delayed or prevented learning from deaths. For example, when, in October 2019, the Parliamentary Under Secretary of State for Mental Health, Suicide Prevention and Patient Safety at the Department of Health and Social Care ("DHSC"), then Nadine Dorries MP, was asked by a House of Commons Select Committee whether the government would announce a public inquiry into failings by mental health services in Essex,[44] she said that she had been advised by the DHSC that:

> "*…public inquiries do not happen for individual cases; they tend to happen when there is a systemic problem or there are multiple cases. In this case, a public inquiry is not an appropriate response because we are talking about two cases*."[45]

56. By October 2019 it was patently clear that the problems in Essex were about more than two cases.[46] By this date, INQUEST had already worked with an estimated 17 families whose loved ones had died as inpatients under the care of Essex mental health trusts. Multiple cases had been publicly reported and there was ample evidence of "*systemic failings.*"[47] Yet the extent of the problem was still being downplayed, including at a national level. Was

[44] UK Parliament, "Oral evidence: PHSO Report: North Essex Partnership University NHS Foundation Trust, HC 31" (October 2019) p.30, Q55
[45] UK Parliament, "Oral evidence: PHSO Report: North Essex Partnership University NHS Foundation Trust, HC 31" (October 2019) p.30, Q55
[46] Parliamentary and Health Service Ombudsman, "Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust" (June 2019), p.10-12; Care Quality Commission, "Acute wards for adults of working age and psychiatric intensive care units" (January 2016)
[47] Parliamentary and Health Service Ombudsman, "Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust" (June 2019), p.8

the DHSC being, wrongly, advised that the problems in Essex only concerned a few isolated cases? Or was a collective effort being made to minimise the extent of reputational damage to the trusts and the government? Was this in keeping with the recommendations of previous investigations into health service failings, such as the Mid-Staffordshire Public Inquiry, that:

> "*The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible."*[48]

57. These issues must be considered against the background of other investigations which have identified a lack of candour and institutional defensiveness as a pervasive issue in investigations following deaths or serious harm.[49] For example, in her review of deaths and serious incidents in custody, Dame Elish Angiolini concluded: "*it is clear that the default position whenever there is a death or serious incident involving the police, tends to be one of defensiveness on the part of state bodies.*"[50] A wide-ranging report by JUSTICE into the response of the justice system to catastrophic events and systemic failures found that a *"lack of candour and institutional defensiveness on the part of State and corporate interested persons and core participants are invariably cited as a cause of further suffering and a barrier to accountability".*[51]

58. These issues have been repeatedly identified by investigations specifically into health service failings. For example, the Report of the Morecambe Bay maternity care investigation by Dr Bill Kirkup CBE concluded in 2015 that there had been "*inexcusable*" and "*repeated*" failures to "*examine adverse events properly, to be open and honest with those who suffered, and to learn so as to prevent recurrence."*[52]As a result, the very first recommendation of the Report was that:

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[48] The Mid-Staffordshire NHS Foundation Trust Public Inquiry, "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 3: Present and future" (February 2013), p.1705, Recommendation 290; Department for Health, "Hard Truths The Journey to Putting Patients First" (January 2014), p.243-244

[49] JUSTICE, "When Things Go Wrong The response of the justice system" (2020), p.66-67, §4.32-4.34; Dame Elish Angiolini DBE QC, "Report of the Independent Review of Deaths and Serious Incidents in Police Custody" (January 2017)

[50] Dame Elish Angiolini DBE QC, "Report of the Independent Review of Deaths and Serious Incidents in Police Custody" (January 2017), p.225, §17.2

[51] JUSTICE, "When Things Go Wrong The response of the justice system" (2020), p.56, §4.4

[52] Dr Bill Kirkup CBE, "The Report of the Morecambe Bay Investigation" (March 2015), p.183 §8.2

"The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report."[53]

59. In his foreword to the report of the Gosport Independent Panel which examined failings in the Gosport War Memorial Hospital, The Right Reverend James Jones KBE stated in 2018:

"*Over the many years during which the families have sought answers to their legitimate questions and concerns, they have been repeatedly frustrated by senior figures … The obfuscation by those in authority has often made the relatives of those who died angry and disillusioned … When relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions. These included the senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council and the Nursing and Midwifery Council. All failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved."*[54]

60. The Government response to the Gosport report described how:

"The culture at Gosport was defensive, hierarchical, and ignored the concerns of patients and families. The co-existence of closed cultures and poor and unsafe care is not a coincidence."[55]

61. The report of the Independent Investigation into Maternity and Neonatal Services in East Kent, by Dr Bill Kirkup, found:

"*Where things went wrong, clinical staff, managers and senior managers often failed to communicate openly with families about what had happened. Safety investigations were often conducted narrowly and defensively, if at all, and not in a way designed to achieve learning. The instinct was to minimise what had happened and to provide false*

[53] *Ibid,* p.185, Recommendation 1
[54] The Right Reverend James Jones KBE, "Foreword to the Panel Report of the Gosport Independent Panel" (June 2018)
[55] Department for Health and Social Care, "Learning from Gosport" (November 2018), p.8 §2.9

reassurance, rather than to acknowledge errors openly and to learn from them. Where the nature of the safety incident made this impossible, a junior obstetrician or midwife was often found who could be blamed."[56]

62. By minimising problems and attributing them to individual clinical error, usually on the part of more junior or locum staff, Dr Kirkup found that East Kent Hospitals University NHS Foundation Trust gave the appearance of "*covering up the scale and systematic nature of those problems*".[57] The task of regulators was made more difficult due to the extent to which problems were denied; "… *denial ran right through the Trust, from clinical staff to Trust Board level*".[58] The report also found that a "*pattern of false assurance and defensiveness… characterised much of the Trust's behaviour*".[59] This pattern recurred in many of the cases investigated by the Inquiry:

> *"It included denying that anything had gone amiss, minimising adverse features, finding reasons to treat deaths and other catastrophic outcomes as expected, and omitting key details in accounts given to families as well as to official bodies. Although we did not find evidence that there was a conscious conspiracy, the effect of these behaviours was to cover up the truth."*[60]

63. The report of the Infected Blood Inquiry, by Sir Brian Langstaff, identified that people had been failed, "*not once but repeatedly, by their doctors, by the bodies (NHS and other) responsible for the safety of their treatment, and by their governments*", and that a particular theme was "… *institutional defensiveness, from the NHS and in particular from government… and a lack of transparency and candour".*[61] These factors *"drove the response of government over the decades."*[62]

64. Sir Brian Langstaff found that such institutional defensiveness is not only damaging to the public interest, but also compounds the harm done to those affected by infected blood:

> *"… the sixth principal theme that emerges from this Report is the damage that was done by that defensiveness and the accompanying lack of transparency and candour to the*

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[56] Dr Bill Kirkup CBE, "Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation" (October 2022), p.6, §1.38
[57] *Ibid*, p.8, §1.40
[58] *Ibid*, p.10, §1.53
[59] *Ibid*, p.15, §1.95
[60] *Ibid*, p.17, §1.112
[61] Sir Brian Langstaff, "Infected Blood Inquiry The Report, Vol 1, Overview and Recommendations", p.14
[62] *Ibid*

very people whose lives had been destroyed by infection. The harms already done to them were compounded by the refusal to accept responsibility and offer accountability, the refusal to give the answers that people fervently sought, the refusal to provide compensation, leaving people struggling and in desperate circumstances, the thoughtless repetition of unjustified and misleading lines to take, and the lack of any real recognition and of any meaningful apology."[63]

65. INQUEST wishes to underline to the Chair that candour matters because it enables a full understanding and identification of issues at operational and systemic levels (and is therefore crucial to the state's discharge of its obligations under Article 2 ECHR), including the identification of deep seated, cultural issues in the provision of care and treatment.[64] As the DHSC intimated in its response to the Gosport Report,[65] a lack of candour goes hand in hand with poor and unsafe care. Closed and defensive cultures allow problems to go unaddressed, to take root and become systemic.[66] As Sir Brian Langstaff noted, candour is a matter *"of ensuring safety for the future."*[67]

66. The Inquiry must consider what changes are necessary to ensure that public bodies and private sector organisations proactively disclose the full extent of their knowledge surrounding fatal events. This includes proactive and truthful identification of problems and assisting investigations, inquests and inquiries of all official kinds, at the earliest possible point, including by the disclosure of all relevant documentation.

67. The Inquiry will also need to consider why the existing framework for post-death investigations and the statutory NHS Duty of Candour,[68] introduced following the Mid Staffordshire report,[69] have not succeeded in producing a culture of candour, accountability and learning following deaths.

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[63] *Ibid*
[64] Particularly relevant to §2(h) of the Inquiry Terms of Reference
[65] Department for Health and Social Care, "Learning from Gosport" (November 2018), p.8 §2.9
[66] See, for example, Dr Bill Kirkup CBE, "Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation" (October 2022), p.11-12, §1.70: *"It is likely that the sooner this was tackled, the more straightforward it would have been, before problematic attitudes and behaviour, and dysfunctional teamworking, became embedded. Yet each of these opportunities was missed in one way or another, and the consequences continued."*
[67] Sir Brian Langstaff, "Infected Blood Inquiry The Report, Vol 1, Overview and Recommendations", p.231
[68] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
[69] Robert Francis QC, "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 1: Analysis of evidence and lessons learned (Part 1)" (February 2013), p.246

68. INQUEST supports the introduction of a statutory duty of candour for all public bodies which is a key part of the Public Authority (Accountability) Bill which was introduced to Parliament in 2017 and welcomed the indication in the King's Speech that "Hillsborough Law" will be introduced.[70]

Action to Prevent Future Deaths

69. Candour is a necessary but not sufficient component of the response to deaths and other serious incidents which cause harm. Candour and openness must be paired with proper mechanisms for accountability, to ensure that actions are taken to prevent further harm.

70. Despite the many inquests which highlighted failings in Essex and the need for action to prevent future deaths, the same problems in care, treatment, and basic safety, recurred again and again. When the PHSO completed an investigation in 2019 into failings at the North Essex Partnership University NHS Foundation Trust ("NEP"), it found *"…wider systemic issues at the Trust, including a failure over many years to develop the learning culture necessary to prevent similar mistakes from being repeated."*[71] The PHSO described NEP's "*clear failure to learn from mistakes*" as "*inexcusable*".[72]

71. In 2016, INQUEST reported that between July 2013 and October 2016 there had been 71 PFD reports issued in England and Wales in cases where inpatients in mental health settings had died. 54 of these had died due to self-inflicted injuries and 17 related to an act or omission by the NHS which had caused a patient's death. In each of these cases, the coroner had concluded that action should be taken to prevent the occurrence to reduce the risk of death.[73] Recent figures show that nationally between 2013 and 2024, there have been a total of 501 PFDs issued in mental health related deaths.[74]

72. INQUEST has identified a range of common failures across the cases it has been involved in, and at various stages has undertaken analyses of themes and trends. Those failures include in relation to risk assessments and management, record keeping, observations, training, communication, the involvement of a patient's family, ligature points, use of

[70] INQUEST, King's Speech announcement will 'save lives', says Hillsborough Law Now campaign 17th July 2024
[71] Parliamentary and Health Service Ombudsman, "Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust" (June 2019), p.6
[72] Parliamentary and Health Service Ombudsman, "Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust" (June 2019), p.21
[73] INQUEST's "Submissions to the CQC review of investigations into deaths in NHS Trusts"
[74] Richards, GC, "The Preventable Deaths Tracker" (2024)

force, lack of local specialist units, staff shortages, management of leave and discharge processes, and oversight and management.

73. These repeated failures and inaction, despite the countless recommendations of coroners among others, underscores the specific and urgent concerns of the Essex families. Although coronial investigations can and do play a vital contribution to the prevention of future deaths and social harms, the current system for learning and implementing changes arising from inquests is not fit for purpose. There is no framework or coordinated response required from public bodies to ensure inquest outcomes feed into concrete implementation of learning and demonstrable action.

74. Similarly, for Public Inquiries, there remains no national mechanism to hold those subjected to recommendations accountable or to ensure meaningful steps are taken. As a result, many crucial recommendations are never actioned. A House of Lords Select Committee reported on a stark example of this failure in oversight when, in 2014, the Ministry of Justice were asked for copies of the lessons learned papers for inquiries that had taken place under the Inquiries Act 2005, they were "*astonished*" to be told that the Cabinet Office held only one, that of the Baha Mousa Inquiry.[75]

75. As The Institute for Government identified in 2017:

> "*The formal checks and procedures we have in place to ensure that public inquiries lead to change are inadequate. There is no routine procedure for holding the Government to account for promises made in the aftermath of inquiries, the implementation of recommendations is patchy, in some cases repeat incidents have occurred and there is no system for allowing inquiries to build on the learning of their predecessors.*"[76]

76. The National Audit Office highlighted in 2018 that government often failed to explain why it had chosen to accept or reject individual recommendations or set out its intended actions

[75] House of Lords, "Select Committee on the Inquiries Act 2005" (March 2014), p.52, para 162, as cited in JUSTICE, "When Things Go Wrong: The response of the justice system" (2020), p.14-15, §2.4
[76] Institute for Government, "How public inquiries can lead to change" (December 2017), p.3-4. As set out above (at §72-73), a similar pattern can be seen in the responses to concerns raised by Coroners which are not implemented, dashing the hopes of the bereaved that others will not have to endure the deaths of loved ones in similar circumstances; JUSTICE, "When Things Go Wrong: The response of the justice system" (2020), p.10, §1.17

in relation to a recommendation, and that there was variation in the extent to which departments were transparent about action taken in response to recommendations.[77]

77. This is an issue that has been raised by previous inquiries. In the Executive Summary of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry in 2013, Sir Robert Francis observed that:

> "*the experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent*".[78]

78. Almost a decade later, in the 2022 report of the Independent Investigation into Maternity and Neonatal Services in East Kent, Dr Bill Kirkup described exactly this pattern:

> *"This Investigation is simply the latest to focus on failings in an individual NHS trust. The list is now a long one, going back at least as far as the 1960s… The pattern is now sadly familiar: detailed investigation, lengthy reports, earnest and well-intentioned recommendations – all part of a collective conviction that this must be the last such moment of failure, with the lessons leading to improvement, not just locally but nationally. Experience shows that the aspirations are not matched by sustained improvement. Significant harm then follows, with almost always patients and families the first to raise the alarm."*[79]

79. The Thirlwall Inquiry, which examines events at the Countess of Chester Hospital following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby, recently completed a review of previous recommendations by inquiries relating to events which took place in hospitals and other healthcare settings.[80] The table which has been produced summarises recommendations from over thirty inquiries, and spans over 800 pages.[81] Recommendations were colour-coded to indicated whether there was evidence to suggest that they had been implemented. The number of recommendations for which there

[77] National Audit Office, "Investigation into government-funded inquiries" (May 2018) p.10, §§11-12, p.29-31, §§3.15-3.20
[78] Sir Robert Francis, "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary" (February 2013), p.18, §41
[79] Dr Bill Kirkup CBE, "Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation" (October 2022), p.19, §§1.124, 1.126
[80] Thirlwall Inquiry, "Review of previous recommendations published" (May 2024)
[81] Thirlwall Inquiry, "Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues prepared by the Thirlwall Inquiry Legal Team" (May 2024)

is no evidence of implementation, including from public inquiries which reported 30 years ago, is sadly striking, and powerfully illustrates the case for a National Oversight Mechanism (discussed below at §§97-105). Many of the recommendations featured relate to the issues of particular relevance to this Inquiry, including mental health services,[82] candour,[83] learning and scrutiny following deaths and serious incidents,[84] accountability (including oversight, regulation and enforcement);[85] engagement with patients, the public and families,[86] and responses to concerns and complaints.[87]

80. INQUEST invites the Inquiry to consider failings and systemic issues in accountability and oversight in Essex against the background of previous inquests and investigations, including failures to oversee or implement relevant recommendations made.

E. Recommendations

National Recommendations

81. The role of this Inquiry is not only to describe in the clearest possible terms what happened to patients in the care of Essex mental health trusts in the relevant period, but also to answer a fundamental question: how can we ensure that failings are properly recognised and acted upon in the future, at the earliest possible stage?

82. As described in the JUSTICE Report, "*When Things Go Wrong*", a "*key feature that distinguishes inquiries from other parts of the justice system is the expectation that recommendations will be made to prevent similar events from recurring."*[88] Similarly, the

[82] Thirlwall Inquiry, "Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues prepared by the Thirlwall Inquiry Legal Team" (May 2024) The Kerr/Haslam Inquiry, p.267-303, Ashworth Special Hospital Inquiry, p.12-13
[83] *Ibid* p.75, Bristol Royal Infirmary Inquiry, p.300 Thirlwall Inquiry, 376, 387, 467-472 Mid-Staffordshire Public Inquiry, p.589, 599-600 Morecambe Bay Investigation, p.841 Independent Investigation into Maternity and Neonatal Services in East Kent
[84] *Ibid,* p.100 Bristol Royal Infirmary Inquiry, p.402 Mid-Staffordshire Public Inquiry, p.525 Berwick Review, p.611-612 Morecambe Bay Investigation; p.638-641 Williams Review, p.683-685 Cwm Taf Inquiry: RCOG Review, p.785-788 Ockenden Independent Review of Maternity Services: Second Report
[85] Ibid, p. 368, 386-387, 390-410 Mid-Staffordshire Public Inquiry, p.535-540, 592 Berwick Review, p.655, 665-666 The Gosport Independent Panel, p.735-737 Paterson Inquiry
[86] Ibid, p.411, 413 Mid-Staffordshire Public Inquiry, p.597, 599 Morecambe Bay Investigation, p.652 The Gosport Independent Panel, p.694-697 Cwm Taf Inquiry, p.789 Ockenden Independent Review of Maternity Services: Second Report
[87] Ibid, p.346-347 Leeds Teaching Hospitals Inquiry, p.435-441 Mid-Staffordshire Public Inquiry, p.590, 597 Morecambe Bay Investigation, p.731 Paterson Inquiry, p.791 Ockenden Independent Review of Maternity Services: Second Report
[88] JUSTICE, "When Things Go Wrong The response of the justice system" (2020), p.86, §6.1

Institute for Government notes that one of the most important expectations of Public Inquiries is that:

> *"…inquiries should also aim to change the systems that gave rise to the tragedies in the first place and to prevent recurrence. This objective – to be forward-looking, to improve government and public services, and to prevent the same mistakes from being made again – is the most important contribution that an inquiry can make to the wider public interest. Government has itself argued that this is the key purpose of an inquiry."*[89]

83. Its Terms of Reference give this Inquiry a wide remit in the making of recommendations, including of national application.[90] INQUEST would encourage the Chair to make robust recommendations in order to effect systemic change at a national level wherever she sees fit. Although the nature of final proposals will of course be subject to the evidence heard, we highlight some key areas below in relation to which change is long overdue in order to improve the systems for preventing avoidable deaths.

84. The Inquiry is also urged to consider, from the outset any steps that can be taken to provide ongoing monitoring of recommendations made, in light of the current lack of any suitable structure to oversee implementation (the need for a National Oversight Mechanism for this purpose is outlined below at §§97-105).

85. In recognition of this challenge, previous Public Inquiry Chairs have taken what steps they can in order to provide some form of ongoing monitoring of important recommendations. For example:

    a. The recommendations of the Ladbroke Grove Rail Inquiry report by Lord Cullen PC were provided with time limits of between 6 months and 3 years paired with an institution responsible for implementation.[91]

    b. Sir Michael Bichard reconvened the Bichard Inquiry six months after it reported to establish progress on delivering the recommendations made in his original report and produced a further final report detailing his findings on progress made.[92]

[89] Institute for Government, "How public inquiries can lead to change" (December 2017), p.8
[90] Lampard Inquiry, "Terms of Reference", §§5-6
[91] Lord Cullen PC, "The Ladbroke Grove Rail Inquiry Part 2 Report" (2001), p.169-180
[92] Sir Michael Bichard, "The Bichard Inquiry Final Report" (March 2005)

c. Sir John Saunders, Chair of the Manchester Area Bombing Inquiry extended the duration of his Inquiry for over 12 months in order monitor recommendations and heard evidence on compliance. However, he noted that "*progress has been slow, or recommendations have been rejected*."[93]

d. The Module 1 Report of Baroness Hallet DBE, Chair of the UK Covid-19 Inquiry, sets timeframes for recommendations and indicates that the Inquiry will monitor implementation "*during its lifetime*".[94]

86. Sir John Saunders stated in an open letter to the media as his Inquiry came to an end, that there was an "*Ongoing problem*" of "*Making sure that recommendations from inquiries are implemented and not forgotten…What is missing is and needs to be thought about is public accountability…it is important for the public and, in this case particularly the bereaved families, that reports on progress are made in a public forum…whether that is to a select committee of Parliament as has been suggested, or in a report which is made public, there has to be public accountability*."[95]

87. When this Inquiry comes to make its own recommendations, INQUEST respectfully invites the Chair to set out specific, time-limited proposals, paired with clear institutional responsibility. In light of the critical nature of apparent failings in Essex, the urgent need for actions to be taken in order to prevent future deaths, and the history of institutional inability or unwillingness on the part of the relevant trusts to effect necessary changes, it is submitted that this Inquiry should reconvene after publication of any final report in order to monitor the implementation of its recommendations.

Independence and Transparency in Investigations

88. The Inquiry's ability to make recommendations of national application offers a critical opportunity to improve national investigatory processes following deaths or serious incidents in mental health inpatient services.

[93] BBC News, 4th July 2023, Manchester Arena bombing inquiry chairman raises progress concerns https://www.bbc.co.uk/news/uk-england-manchester-66098897
[94] Lady Hallett, "Module 1: The resilience and preparedness of the United Kingdom, Report and Recommendations In Brief" (July 2024), p.4; "Module 1: The resilience and preparedness of the United Kingdom A report by The Rt Hon the Lady Hallett DBE Chair of the UK Covid-19 Inquiry" (July 2024)
[95] BBC News, 4th July 2023, ibid.

89. Making recommendations which can change the systems that gave rise to the tragedies in Essex, and preventing recurrence will involve looking at why the existing framework for existing post-death investigations and the existing statutory NHS Duty of Candour were incapable of identifying problems in a timely fashion and securing an open culture of learning.

90. Central to creating a learning culture is having adequate processes to underpin the investigation of deaths and serious incidents. INQUEST have repeatedly raised concerns about the lack of a single independent investigating body for deaths of mental health inpatients. This contrasts with the investigation into deaths in prison, police or immigration detention where there is an automatic, external investigation by an independent national body. These bodies publish investigation reports, have oversight on all deaths and policy issues and share and publicise thematic reports. These independent mechanisms also increase the quality of data gathered in relation to those specific custodial settings through annual reports and learning bulletins.

91. INQUEST also ask the Chair to identify through her Inquiry how a lack of data has contributed to a lack of learning by these (and other) trusts and carefully consider how an independent body could properly collect and collate this data. This is a concern that has been raised for a number of years by INQUEST and others in relation to the poor quality of data available in respect of deaths of those detained under the MHA[96].

92. In the view of INQUEST, a crucial opportunity to strengthen the framework for investigations was missed in 2016 when the CQC reviewed the way that NHS trusts reviewed and investigated the deaths of patients in England but failed to acknowledge the need for independence in investigations.[97]

93. The current guidance for NHS trusts (and providers of NHS funded care) on the investigation of patient safety incidents is set out in the Patient Safety Incident Response Framework ("PSIRF").[98] This was introduced by NHS England in Spring 2022 to replace the previous framework for investigating serious incidents; the Serious Incident

[96] See for example Independent Advisory Panel on Deaths in Custody "Statistical analysis of recorded deaths in custody between 2017 and 2021" (April 2024)
[97] Care Quality Commission, "Learning, candour and accountability A review of the way NHS trusts review and investigate the deaths of patients in England" (December 2016)
[98] NHS England, "Patient Safety Incident Response Framework" (July 2024)

Framework.[99] It was expected that providers of NHS funded care would complete transition to the new framework and publish their patient safety incident response policies and plans by Autumn 2023. However, EPUT was one of the early adopters of the PSIRF and it is understood began using it from May 2021. The PSIRF confirms that the Root Cause Analysis approach to investigating incidents is no longer considered appropriate and instead implements a Systems Engineering Initiative for Patient Safety approach, which is a systems focused approach, rather than a contributory factors approach. The PSIRF is accompanied by supporting guidance called 'Engaging and involving patients, families and staff following a patient safety incident'.[100] This replaces the 'Being Open' guidance. According to NHS England, the guidance is specifically designed "to prevent compounded harm [to patients and families] during the investigation".

94. INQUEST has not seen any noticeable improvement in the investigation of patients' deaths following the introduction of the PSIRF and in fact has seen examples of worsening practice. There continue to be significant delays in deaths being investigated and lessons being learned. Importantly, they have not seen an improvement in the engagement of families. Families remain excluded from the process, and it is often only once they have obtained legal representation and request information that this is shared but even then, this does not necessarily lead to any meaningful engagement. In one Essex case in which INQUEST has supported the family, EUPT refused to share the names of the investigators with the family and provided no update between the family sharing a list of their questions and the provision of the draft report. The introduction of the process of sharing a draft report with families, as introduced by the PSIRF, does not appear to have made any material difference as generally, a final draft is shared by which time it is too late for the family to have any proper engagement or for further investigations to take place.

95. The PSIRF includes guidance that organisations "*should advise the coroner of the existence of any relevant documents they hold, even if these are not specifically requested*". INQUEST has not seen evidence that this is applied by EUPT in practice. They can provide the Inquiry with examples of inadequate and incomplete disclosure by EUPT in inquests which not only has caused further delay but has compounded the harm caused to families.

[99] NHS England, "Serious Incident Framework, Supporting learning to prevent recurrence" (2010, updated 2015)
[100] NHS England, "Engaging and involving patients, families and staff following a patient safety incident"

National Oversight Mechanism

96. As we set out above, hundreds of vital recommendations are made following inquests and inquiries. Yet there is no independent body analysing the implementation of these PFD reports or holding trusts accountable for failing to learn lessons and implement changes.

97. The result of this lacuna is that the life-saving recommendations of these processes are not implemented, and so the same failings take place again and again. This is a significant national failure of accountability.

98. INQUEST is determined to ensure that crucial learning and recommended changes which come from inquiries such as these are not lost, and are enacted in time to prevent further deaths. This lack of candour, accountability and learning cannot continue. It should not fall to the bereaved and organisations such as INQUEST to carry out a monitoring role and ensure that change is embedded. Therefore, in the making of national recommendations, we would invite the Inquiry to consider the specific issue of accountability and oversight, and the particular importance of ensuring that state institutions, including those providing mental health inpatient care, learn from post-death investigations and inquiries, and implement the changes necessary to save lives in the future beyond the lifetime of the Inquiry.

99. We submit that there is a pressing need for a new independent public body with singular responsibility for collating, analysing and following-up on recommendations arising from inquests, inquiries, official reviews and investigations into state-related deaths.[101] The need for an independent body or office to carry out such a function has been identified by INQUEST, JUSTICE,[102] the report of Dame Elish Angiolini,[103] and many other organisations who have endorsed INQUEST's calls for such a mechanism.[104]

100. The making of such a recommendation would update and consolidate proposals made in previous healthcare-related inquiries, many of which have identified a need for improved oversight following post-death investigations, and many of which were accepted by Government but not actioned. For example, the Shipman Inquiry recommended in 2003 that any "recommendation" by a coroner should be submitted to the Chief Coroner, who

[101] INQUEST, "No More Deaths Campaign" (2024)
[102] JUSTICE, "When Things Go Wrong: The response of the justice system" (2020), p.3. See also p.92-94
[103] Dame Elish Angiolini DBE QC, "Report of the Independent Review of Deaths and Serious Incidents in Police Custody" (January 2017), §17.22-36
[104] INQUEST, "No More Deaths Campaign" (2024)

would then hold responsibility at a high level for ensuring that a response is received and responded to, "*first by submitting it to the appropriate body and then by pursuing that body until a satisfactory response has been received and action taken*".[105] Whilst copies of PFD reports are published by the Chief Coroner, there is still no national state oversight or monitoring of coronial reports.[106]

101. Almost 20 years ago, the Kerr/Haslam report recommended that a committee should be appointed to oversee the recommendations of multiple inquiries relating to NHS handling of complaints and concerns and patient protection (the Shipman Report, the Neale Report, the Ayling Report and the Peter Green Report).[107] The Mid Cheshire Hospitals NHS Trust Inquiry recommended that the "*strategic health authority*" should have "*an effective means of testing the accuracy of reports from the trust on progress in clinical governance and the quality of care".* This should start with *"detailed, on-site scrutiny of the actions taken by the trust to implement the recommendations of this report*."[108]

102. Despite previous investigations identifying this issue over 20 years ago, it is clear that life-saving recommendations are too often forgotten, dismissed or simply not implemented, leading to yet more preventable deaths and harms.

103. A National Oversight Mechanism would play a crucial role in tackling this by collating proposals for change, analysing the responses of public bodies and following up on progress, escalating concerns and sharing thematic findings. This would help to ensure that life-saving recommendations can no longer be ignored and failings are properly recognised and acted upon in the future, at the earliest possible stage.

104. INQUEST would be pleased to provide further evidence in relation to the need for a National Oversight Mechanism as the Inquiry progresses its investigations.

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[105] Dame Janet Smith, "The Shipman Inquiry: Third Report" (July 2003), Chapter 19 Proposals for Change, p.28, recommendation 25

[106] The work of Dr. Georgia Richards in developing the Preventable Death Tracker, the first and only openly available database of Prevention of Future Death reports is conducted and maintained entirely by academic research and not by any Government agency. The database records all PFDs by Coronial jurisdiction and topic. It also tracks whether responses are received, and within the statutory time frame. Whilst INQUEST welcomes Dr. Richard's vital research, this work should have been instigated and funded from within government many years ago. Richards, GC, "The Preventable Deaths Tracker" (2024)

[107] Nigel Plemming QC, "The Kerr/Haslam Inquiry Volume 1 of 2" (July 2005), p.35

[108] Healthcare Commission, "Investigation into Mid Cheshire Hospitals NHS Trust" (January 2006), p.62

F. Conclusion

105. INQUEST is grateful to the Chair for designation as Core Participants to her Inquiry. INQUEST is committed to assisting the Chair and her Inquiry in order that its evidence, findings and recommendations are robust and capable of bringing about meaningful change for bereaved families, patients, and nationwide.

Anna Morris KC
Lily Lewis
Garden Court North Chambers

Charlotte Haworth Hird
Amy Ooi
Bhatt Murphy Solicitors

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