Tuesday, 10 September 2024

(10.00 am)

(Proceedings delayed)

(11.00 am)

THE CHAIR: Thank you.

MR GRIFFIN: Good morning, Chair. Chair, today is World Suicide Prevention Day. This was established by the International Association for Suicide Prevention in conjunction with the World Health Organization. 10 September each year aims to focus attention on the issue, reduce stigma and raise awareness.

Chair, we are starting a little later this morning than planned because of difficulties on the trains. We're grateful to Ms Islam who will be speaking a little out of turn and we'll come to her just in one moment. What we plan to do is to hear from Ms Islam, even though she may be a little brief, we will break at that stage and come back for the second opening statement after that. So with that, on behalf the three Integrated Care Boards, I would introduce Zeenat Islam.

THE CHAIR: Thank you very much. Thank you for saying you will go now. That is helpful.

Opening statement by MS ISLAM

MS ISLAM: Thank you very much.

Good morning, Chair. As has been indicated, I appear on behalf of the Mid and South Essex,

Hertfordshire and West Essex and Suffolk and North East Essex Integrated Care Boards, which I'll refer to as the ICBs. The ICBs would like to, at the outset of this opening statement, express their deepest sympathy to all of those who have lost loved ones and who have been and remain affected by the matters that this Inquiry is examining.

It is hoped that the Inquiry's robust investigation will provide the answers that many have been waiting for for a long time. The ICBs would like to recognise the courage of those engaging with this process, despite their loss and suffering.

The ICBs are committed to engaging with the Inquiry in full openness and transparency to assist it in discharging its Terms of Reference. The ICBs recognise the considerable work being done by the Inquiry team and are keen to establish an ongoing dialogue to ensure that the ICBs can be as helpful as possible.

To date, the ICBs have provided a draft Rule 9 statement, with accompanying documents, and stand ready to respond to further requests for evidence. The ICBs have been proactive in beginning a scoping exercise of potentially relevant material and by putting in place structures to ensure they can engage with and respond to the Inquiry as effectively and efficiently as possible.

The ICBs are grateful for the opportunity to participate, to listen to those impacted and to learn the necessary lessons for the future. The ICBs are committed to better understanding and responding to the needs of people accessing mental health services in their areas of responsibility.

Throughout the remainder of this statement, I will provide a brief overview of the role and functions of ICBs and some background to the changing landscape that led to their establishment, which I hope will assist the Inquiry and those listening to better understand where the ICBs fit within the context of the Inquiry's areas of consideration.

The ICBs were established in July 2022 as part of wide-ranging reforms introduced by the Health and Care Act 2022. The Act legally established integrated care systems comprising of ICBs and integrated care partnerships. The 2022 Act abolished clinical commissioning groups, known as CCGs, and consequently ICBs took on commissioning functions of CCGs as well as some of NHS England's commissioning functions, which was formerly known as the NHS Commissioning Board.

The 2022 Act outlines the various general duties of ICBs, which include improvement in quality of services, reducing inequalities, promoting the involvement of

patients and carers, enabling patient choice and promoting the integration of health services.

A core function of ICBs is commissioning. Their statutory duty is to arrange for the provision of health services to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility. NHS England defines commissioning as follows:

"Commissioning is the continual process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment."

In summary, commissioning involves a range of activities including assessing needs, planning services, procuring services and quality assessment.

There is an important distinction between the provision of health services and their commissioning. Whilst the particular statutory duties have changed over the years, the duty has been of one of arrangement rather than direct involvement in patient care, which is delivered by care providers such as an NHS trust.

The commissioning arrangements are designed to

enable the efficient provision of services under existing contracting arrangements to best meet the needs of the population. The arrangements recognise that expertise in care, treatment and clinical decision-making in individual cases is at the provider level rather than the commissioning level. In cases where individuals have complex needs and require bespoke commissioned care, systems exist enabling commissioners to work collaboratively with providers to deliver this.

As the Inquiry is undoubtedly aware, significant reforms have taken place throughout the time period under examination. At the beginning of the year 2000, NHS providers were funded by health authorities and GP fund holders. Primary care trusts, known as PCTs, began to be established throughout 2000 and 2001, reflecting a desire to shift the balance of influence of services towards local communities. PCTs became the lead NHS organisation in assessing needs, planning and securing all health services and improving health.

Strategic health authorities were established to replace health authorities and to lead the strategic development of the local health service and performance-manage PCTs and NHS trusts.

In 2010, there was a shift to changing the role of the Department of Health to become more strategic while

empowering clinicians to have a greater say in commissioning as part of a move towards becoming more outcomes-focused and responsibility for public health moving to local authorities. PCTs were formally disestablished and replaced by clinical commissioning groups, as I've already said, following the Health and Social Care Act 2012. CCGs were responsible for commissioning most NHS services supported by and accountable to the NHS Commissioning Board.

Responsibility for some specialist services transferred from PCTs to the NHS Commissioning Board. As I have outlined, as a result of those 2022 reforms, CCGs were disbanded and ICBs, together with NHS England, formerly known as the NHS Commissioning Board, became responsible for commissioning NHS services.

The various legislative and policy changes that have led to several structural changes over many years presents a complex picture. It is hoped that this brief overview provides a useful introduction in understanding the changing landscape and the current picture in respect of ICBs. The ICBs look forward to providing further explanation and evidence as the Inquiry progresses.

To conclude, the ICBs would like to reiterate their firm commitment to supporting the Inquiry in its

investigation. In particular, the ICBs would like to highlight their willingness to reflect on key learning that emerges from the Inquiry to enable them to ensure that the people they are responsible for can safely and confidently access mental health services in future. As such, the ICBs will listen carefully to the evidence and contributions from other core participants and look forward to the Inquiry's reports and recommendations in due course.

THE CHAIR: Ms Islam, thank you very much.

MS ISLAM: Thank you very much.

MR GRIFFIN: Thank you. Chair, we are still waiting for some people to arrive. They have been interrupted by problems with the trains, so may I invite you to rise and we'll reconvene at 11.30.

(11.10 am)

(A short break)

(11.32 am)

MR GRIFFIN: The second opening statement this morning is on behalf of INQUEST and will be given by Lily Lewis.

Opening statement by MS LEWIS

MS LEWIS: Thank you. Chair, I along with Ms Morris King's Counsel, Ms Haworth Hird and Ms Ooi of Bhatt Murphy Solicitors represent the organisation INQUEST, and I make this opening statement to you on their behalf.

INQUEST is a charity and a non-governmental organisation which provides expertise on state-related deaths and their investigation to bereaved people, lawyers, 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 and in psychiatric inpatient settings.

INQUEST specialist case work service has worked with numerous bereaved people whose loved ones have died whilst under the care of mental health services, providing support from the outset through the investigation by the relevant NHS trust or private provider and then the inquest.

Since 2008, the charity has worked on over 49 cases involving the deaths of those in the care of Essex mental health services, as well as several further cases falling within the Inquiry's definition of an inpatient death, as set out in the Note on Scope. Those deaths are marred by repeated failures that INQUEST have identified through case work with families. We heard details yesterday of just some of the appalling failures and abuses from Mr Snowden King's Counsel who spoke on behalf of a number of bereaved families and patients.

INQUEST shares their horror and concern at the fact that, despite countless investigations, inspection reports and inquests highlighting these failures, preventable deaths have continued.

INQUEST has supported many of the bereaved families and friends who have fought over many years for an adequate investigation into these deaths and, Chair, as has already been rightly acknowledged, without their courage, persistence and determination, this Inquiry would not have come into existence.

We do not underestimate how difficult it is for many of those affected to be here today, either in person or remotely, and to participate in this intensely difficult process. We commend their courage and perseverance, although it should not have been necessary.

Chair, it should not fall to bereaved families, friends, patients and former patients to ensure that such serious and repeated state failings are properly investigated. Yet, instead of openness and honesty in response to deaths and serious incidents, the default position of the relevant Trusts appears to be defensiveness, denial and delay.

INQUEST has seen first-hand the way in which bereaved families have been disbelieved, patronised and lied to when attempting to draw attention to the ways in which

the care and treatment of their loved ones has fallen below expected standards.

Chair, we therefore invite this Inquiry not only to describe in the clearest possible terms what has been happening 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? Chair, put another way, what work must be done so that we see no more preventable deaths?

INQUEST hopes to bring its considerable experience and expertise to assist the Inquiry in its investigations and to answer this critical question.

Chair, against this background, I will use the time I have this morning to address you on the following topics.

First, Chair, I'll draw your attention to the key themes that we say should run through your Inquiry and all of its investigations, evidence and findings.

Second, I'll focus on the critical topic of candour, identifying the central role that a lack of candour and institutional defensiveness has played in allowing failings to go unchallenged.

My third and final topic is possibly the most

important. It goes to the heart of how this Inquiry and future inquiries can bring about the change that is needed. It is the pressing need for a national oversight mechanism to ensure that the recommendations identified by critical investigations into deaths such as this one are acted upon.

Turning then to themes. Chair, you and your team have very helpfully provided core participants with a detailed provisional list of issues. In line with that list and with the Inquiry's Terms of Reference, we highlight a number of common failures in care and treatment at paragraph 4 of our written opening statement which have repeatedly arisen in INQUEST's work with affected families.

Mr Snowden KC also powerfully drew your attention yesterday in his opening statement to a number of issues identified by families and patients. We do not seek to repeat those lists and entirely understand that the Inquiry is still in the early stages of gathering and hearing evidence. However, we do wish to highlight some key themes that relate to a number of issues under consideration by this Inquiry and of which INQUEST has significant experience through its case work with families.

In highlighting these themes, we do not seek to

suggest they're more important than other issues that have been identified but rather to draw attention to them now because, in our submission, it is important that the Inquiry considers their relevance from a very early stage in its investigations.

The first of those themes is the engagement of family members in patient care and in investigations. Chair, the involvement of family members in patient care cross-sects a number of issues, as identified in your provisional list, and touches on care planning, care management and basic patient safety. INQUEST have heard from many families through their case work in Essex over the years who have experienced being excluded from the care of their loved one once they've become an inpatient, a concern which is particularly acute in the care of young people. Indeed, INQUEST's national research and consultation with families shows that this is a pervasive issue in the deaths of individuals experiencing mental ill health and is often both symptomatic and causative of a range of other failings in care and treatment, as we expect to see on the evidence in this Inquiry.

Families have shared their anger and frustration at inadequate systems and policies on information-sharing prior to their relative's death, difficulties in

discussing medical needs with clinicians and nursing staff and broader concerns around relatives' treatment. Many tried to inform medical professionals about inappropriate treatment, deterioration in their relative's mood and concerns about behaviour that they knew to be indicative of unhappiness and isolation. In some cases family were met with indifference, in others hostility. This approach continued in many cases following patients' deaths.

The families that INQUEST has spoken to, Chair, are broadly in agreement that the fundamental principles that should underpin the investigation process - namely quality, independence and impartiality - are too often absent. As one person has said about trusts, they're marking their own homework. They report a distinct failure to support families with information on what the processes following their family member's death would be and what to expect of investigations and inquests.

Chair, we submit that it is important for your Inquiry to recognise that a failure to provide information at an early stage has the potential to impact on the rest of the post-death investigation. Without prior knowledge of their rights, families are potentially denied insight into the cause of death of their loved one. It is clear to INQUEST that families

are rarely central to the process and without grit, determination and perseverance, they can be excluded all together.

A further important theme, in my submission, is structural discrimination. We submit that 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, as we set out in some detail in our opening statement in writing. This was also an issue to which we drew your attention, Chair, in our response to the provisional list of issues, and we welcome the announcement by Counsel to the Inquiry, Mr Griffin King's Counsel, yesterday that the Inquiry team is minded to add to the list of issues and to include demographics, patient backgrounds and ethnicity and whether this influenced the treatment received by patients. Chair, we take this to mean that the Inquiry will consider and record patients' protected characteristics in order to understand whether they impacted on the standard of care and treatment provided and whether this was a relevant factor in inpatient deaths.

We would wish to highlight today that groups that require particular consideration, including the role played by structural discrimination, include young

people, especially those transitioning from CAMHS to adult care, women and girls who have experienced sexual violence and abuse, young transgender people, black and racialised people, and the experience of neurodiverse and learning disabled patients.

Within this particular theme, 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 yet did not have 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.

We invite you, Chair, and your legal team to specifically seek to identify whether -- where a patient was identified as autistic, whether 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.

Chair, with that in mind, we urge the Inquiry to seek to obtain data from patients' medical notes and other sources on protected characteristics in order to understand whether discriminatory treatment on account of one or more characteristic, and the intersection and

interaction of these, took place and whether it was a relevant factor in mental health inpatient deaths.

We would also ask you, Chair, to consider obtaining expert evidence on this crucial issue as, for example, Lady Hallett has done in modules 1 and 2 of the Covid-19 Inquiry on the particular issue of structural discrimination. This is also an issue on which INQUEST has particular expertise across a range of custodial settings, and so we'll gladly assist the Inquiry in this exercise where appropriate.

Turning then to a third theme, and that is patient-centred care and a trauma-informed 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, treatment and risk assessments.

In analysing the degree to which patients' unique needs were assessed and understood within the inpatient setting, we urge you, Chair, to adopt a trauma-informed approach. By this we mean that it will be important for the Inquiry to recognise that very few people present as in need of assessment for inpatient treatment under the Mental Health Act without having experienced some form

of trauma, whether it be within a domestic, institutional or societal context. 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 section 136 of the Mental Health Act by police officers or following arrest and detention. This intervention can cause intense trauma for patients. All patients carry their trauma into the inpatient setting.

Chair, you will 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. We say, Chair, that you must also consider, when examining clinical practices, whether they were likely to expose patients to further trauma in themselves, for example by the use of restraints, the delivery of medication without consent and the use of seclusion and isolation. On that point, we welcome the proposed addition to the Inquiry's list of issues on the risk of

adverse therapeutic outcomes arising from coercive treatment such as confinement.

As part of your assessment, Chair, on whether patients felt safe on mental health wards, we urge you to understand the impact on patients of being in an acute setting and suffering abuse, being subject to restraint or witnessing the abuse or self-harm of others.

I turn then to the important topic of candour. This was a topic that we heard emphasised by Mr Snowden KC on behalf of families and patients yesterday and, in my submission, is central to the Inquiry's work. INQUEST 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.

We note and welcome the observations of Essex Partnership University NHS Foundation Trust at paragraph 55 of their written submissions that they see this Inquiry as a space for openness and transparency and that they're willing to be accountable and to take action that exceeds the reputations of cultures or individual organisations. This is the right approach if

implemented in practice, not least in an inquiry whose beginnings have been marred by failures in candour.

Even now, Chair, it is staggering that the public bodies providing mental health services in Essex have not yet been able to provide the Inquiry with a full and accurate figure for the total number of deaths in the relevant period.

Chair, we note your indication yesterday that the figure is likely to be far in excess of 2,000. The fact that it has taken a statutory inquiry to even begin to uncover the true extent of deaths points, in my submission, to an abject failure in candour, data collection and governance on the part of the relevant Trusts. And, whilst admissions are welcome, we wish to emphasise that the failures in candour and resistance to accountability go far beyond the Trusts' participation in this Inquiry and its predecessor, and without full recognition of this fact there can be little hope of rehabilitation.

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 failings, and the bereaved will be denied the truth of their loved ones' deaths. We welcome, Chair, your assurance yesterday that you will

not hesitate to use your statutory powers where necessary, and your expectation is enshrined in the Terms of Reference of complete candour in this Inquiry. It is hoped that with the powers that it now has available to it that this Inquiry will finally uncover the truth.

Chair, it is absolutely central to your investigations and to the recommendations that you will make that you seek to understand how a serious and enduring lack of candour prevailed in Essex for so many years. There are significant questions for state core participants to answer. Were senior leaders in the Trust aware of the significant and repeated failings since identified by the Parliamentary Health Service Ombudsman and others?

Did they purposefully hide evidence of failings from the public and from investigators?

Was the information that was provided misleading by omission?

How did 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?

It seems clear now that defensiveness flowed from the very top. For example, when, in October 2019, then Parliamentary Under-Secretary of State for Mental Health, Suicide Prevention and Public Safety, Nadine Dorries MP, was asked whether the Government would announce a public inquiry into failings in mental health services in Essex, she said that she'd been advised by the Department for Health and Social Care that, and I quote:

"... Public inquiries do not happen for individual cases. They tend to happen where there is a systemic problem or there are multiple cases. In this case a public inquiry is not an appropriate response because we're talking about two cases."

By October 2019 it was patently clear that the problems in Essex were about more than two cases. By this date, INQUEST had already worked with at least 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 at that stage. Yet the extent of the problem was not only being downplayed by those within the heart of Government, but it appears that the calls for a public inquiry were being actively resisted by those at the top of the Department for Health and Social Care.

As we heard from Mr Snowden KC on behalf of families and patients yesterday, we now know that in 2020 Ms Dorries sent appalling messages to then Health Secretary Matt Hancock, informing him of her plans to isolate Melanie Leahy and undermine her calls for a public inquiry. Sadly, these revelations are the latest in a pattern of defence and denial which has characterised the response of Government to state-related deaths.

Sir Brian Langstaff, in his report into the Infected Blood Inquiry this year, identified that a particular theme apparent in the multiple failings that he uncovered was institutional defensiveness from the NHS and in particular from Government and a lack of transparency and candour. He found that these factors drove the response of Government over the decades.

The WhatsApp exchange between Ms Dorries and Mr Hancock was seven years after the report of Sir Robert Francis' Inquiry into the failings in

Mid Staffordshire NHS Foundation Trust which set out in 2013, and I quote:

"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."

Whether the actions of the Government in response to deaths in Essex lived up to this expectation will be a matter for this Inquiry to consider.

Chair, 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 of the European Convention on Human Rights, including the identification of deep-seated cultural issues in the provision of care and treatment.

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. To this end, INQUEST, together with the Essex, Grenfell, Hillsborough and countless other bereaved family groups, have been at the forefront of the campaign for a statutory duty of candour and have

high expectations that the work of this Inquiry and of Government could finally lead to the codification and embedding of candour across public institutions.

I turn then to my fourth and final topic, and that is the national oversight mechanism. Chair, INQUEST would invite the Inquiry to consider the case for a national oversight mechanism, a new independent body with singular responsibility for collating, analysing and following up on recommendations arising from investigations into state-related deaths. 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.

The lack of candour, accountability and meaningful change cannot continue. It should not fall to the bereaved and to organisations such as INQUEST to carry out a monitoring role and seek to ensure that change is embedded.

As we have heard, despite the many inquests which highlighted failings in Essex and the need for urgent action to prevent future deaths, the same problems in care, treatment and basic safety recurred again and again. Although coronial investigations can and do make 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 co-ordinated response required from public bodies to ensure that inquest outcomes lead to concrete action. Similarly, for public inquiries, there remains no national mechanism to hold those subjected to recommendations accountable or to ensure that meaningful steps are taken. As a result, many crucial recommendations are simply forgotten or dismissed.

In the 2022 report of the independent investigation into maternity and neonatal services in East Kent, Dr Bill Kirkup characterised the issues as follows, and I quote from his report:

"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."

Chair, a national oversight mechanism 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. It is a crucial next step in ensuring that there are no more preventable deaths.

Finally then, before closing, we wish to raise a number of discrete issues arising on matters raised yesterday.

Firstly, on private providers. We note that the Inquiry will consider the actions of private providers to the extent that they're in scope. Chair, we would invite you to ensure that care and treatment provided to Essex patients by those providers is considered even where placements are not funded by Essex Trusts, so, for example, where placements, either in Essex or out of area, are funded by national bodies, such as NHS England, but are relevant to the care provided to patients whose cases meet the criteria for investigation under your Terms of Reference, Chair.

Then on regulators. We wish to note that bodies with responsibility for commissioning, oversight and

regulation cannot be left out of the picture of the Inquiry's investigations, and their role in protecting patients and addressing failures in Essex over such a long period of time must be investigated. This includes the role of bodies such as the CQC and the adequacy of its response to evidence that patients were at risk in the relevant period.

Then on recommendations. Chair, as you are well aware, one of the most important expectations of this Inquiry is that it should aim to change the systems that gave rise to the tragedies in the first place and to prevent recurrence. For that reason, Chair, INQUEST welcome your commitment to the making of robust recommendations in order to effect systemic change at a national level wherever you see fit. INQUEST are clear that this should not take away from the particular failings as seen in Essex and the evident toxicity of the culture there.

Although the nature of final proposals will of course be subject to the evidence heard, we highlight in our written opening statement some key areas in relation to which change is long overdue in order to improve the systems for preventing avoidable deaths.

One such area relates to difficulties faced by this Inquiry and its predecessor in collating data on numbers

of deaths of those detained under the Mental Health Act. INQUEST ask you to identify, through your Inquiry, how a lack of data has contributed to a lack of learning by these and other Trusts, and to carefully consider how an independent body could properly collect and collate this important data. We anticipate, Chair, that the case for change will be strengthened by the important work of the expert statistician which the Inquiry intends to instruct.

Then on urgent statements. Chair, as you have yourself made clear, the work now needed is careful work but it is also urgent. Since the first iteration of this Inquiry was announced in January 2021, at least 19 people under the care of mental health Trusts in Essex have died. We therefore welcome your commitment to issue an urgent statement where the Inquiry identifies systemic matters that require urgent attention. In light of the history of institutional inability or unwillingness on the part of the relevant Trusts in Essex to effect necessary changes, we would invite you to closely monitor the implementation of any of those changes recommended or specified in your urgent notices through the lifetime of this Inquiry in order to provide ongoing monitoring.

Chair, in closing, INQUEST commits its expertise and

experience to assist you and your team with this Inquiry. Our ask of the Inquiry is that it adopts an open and collaborative approach with core participants and, in particular, is led by the experiences of the bereaved as well as those of current and former patients. Chair, INQUEST's work with the bereaved over decades shows that, unfortunately, their interactions with investigatory processes are often characterised by a sense of exclusion. In order to ensure that that does not happen in this case, we ask that the Inquiry undertakes advance engagement and collaboration with those who are involved in its processes on important topics such as disclosure, experts and timetabling. Without that, there is a risk that trust is lost.

Finally, we reaffirm our commitment to the bereaved who have walked this long journey to discover the truth about what happened to their loved ones in the hope, Chair, that you can provide them with the answers that they deserve as well as the change that they and all patients so badly need.

THE CHAIR: Ms Lewis, thank you very much indeed. Thank you.

MR GRIFFIN: Thank you.

Chair, that is it for today, for reasons that I explained yesterday. We are back here tomorrow morning at 10.00 for the final morning of opening

statements.

(12.03 pm)

(The hearing adjourned until

Wednesday, 11 September 2024 at 10.00 am)

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