1 Monday, 9 September 2024
2 (11.00 am)
3 Opening statement by THE CHAIR
4 THE CHAIR: Well, good morning everybody. I'm
5 Baroness Lampard and, with this statement, I'm opening
6 the hearings of the Independent Statutory Inquiry into
7 the deaths of mental health inpatients in Essex. I want
8 to welcome everyone here today at the Civic Centre and
9 those watching over the live feed.
10 The purpose of this Inquiry is, according to my
11 terms of reference, to "investigate the circumstances
12 surrounding the deaths of mental health inpatients under
13 the care of NHS Trusts in Essex" over the 24-year period
14 between the start of 2000 and the end of 2023.
15 This is the first Public Inquiry set up in the UK to
16 investigate mental healthcare. We'll be investigating
17 matters of the gravest public concern and significance.
18 The Inquiry is not considering one single event, one set
19 of circumstances or one individual. Instead, we're
20 investigating alleged failings in mental healthcare on a
21 scale that is deeply shocking.
22 As you may be aware, during the Inquiry's
23 non-statutory phase, when it was called "The Essex
24 Mental Health Independent Inquiry", the Inquiry was
25 informed of approximately 2,000 deaths being in scope.

1 This information was provided to the Inquiry by relevant
2 mental healthcare providers.
3 Following publication of the Terms of Reference for
4 the Lampard Inquiry, I requested that Essex Partnership
5 University Trust, known as "EPUT", as well as other
6 relevant providers, submit updated figures of the number
7 of deaths in scope in line with the Inquiry's definition
8 of "inpatient death".
9 Data quality and retention issues over the 24-year
10 period, as well as varying interpretations of the terms
11 of reference, have meant that this process has taken
12 longer than anticipated. The Inquiry is working with
13 all providers to obtain figures which are as accurate as
14 possible. I have and will continue to reject
15 information and data from providers which I do not
16 consider to be an appropriate or reliable standard.
17 It's worth noting that the Lampard Inquiry's Terms
18 of Reference, including our definition of "inpatient
19 death", are broader than those of the non-statutory
20 Inquiry, with the timeframe having been extended by
21 a further three years. In addition, the Lampard Terms
22 of Reference include, for example, private sector
23 providers of NHS care and those who were assessed but
24 not admitted to inpatient care. The Essex Mental Health
25 Independent Inquiry did not include such deaths in

1 scope.
2 I do not at this stage have a number of deaths in
3 scope to share with you. The tragedy is that we may
4 never have a definitive number of deaths that fall
5 within the Inquiry's remit. The Inquiry is committed to
6 publishing a figure of the number of deaths as soon as
7 we have finished analysing and interrogating the
8 information provided to us. I will release the figure
9 when I feel confident that it is the most accurate
10 representation of the number of deaths in scope that can
11 be achieved.
12 This number is likely only ever to be approximate
13 and I find it shocking that we may never be able to say
14 for sure how many people died within the remit of this
15 Inquiry. What I can tell you now is that the number of
16 deaths in scope will be significantly in excess of the
17 2,000 that were being considered by the Inquiry during
18 its non-statutory phase.
19 I wish to express my deepest sympathy for the loss
20 and heartbreak experienced by families and friends of
21 those who have died while an inpatient in a mental
22 health facility in Essex and also to current and former
23 patients who have experienced harm or unnecessary
24 suffering when in inpatient facilities in Essex.
25 I invite us to pause for one minute of silence in

1 respect of those who died.
2 (One minute of silence observed)
3 The purpose of these initial hearings is to hear
4 opening statements from the core participants involved
5 in the Inquiry. I will listen with interest to what
6 they have to say and their suggestions for working with
7 the Inquiry to achieve its objectives. I've read with
8 care the statements they have already provided.
9 Significantly, the purpose is also to hear about
10 those who have died. Each death represents a tragedy.
11 I am profoundly grateful to have the opportunity to
12 learn more about these individuals from their families
13 and friends and to commemorate them. I will also be
14 hearing deeply personal and difficult accounts of the
15 impact of the events which are the focus of this Inquiry
16 on families and friends.
17 I want to thank all those who have contributed
18 written accounts, photographs, videos and other forms of
19 commemoration as well as those who are coming to speak
20 at the hearing. It will be crucial to my understanding
21 and the understanding of all of us involved in the
22 Inquiry of the true impact of the deaths and harms which
23 have occurred.
24 There will be a further opportunity for families,
25 friends and former patients to provide commemorative and

1 impact evidence in the hearings conducted remotely
2 in November and I urge anyone who thinks they might want
3 to do that to get in touch with the Inquiry team.
4 The Essex Mental Health Independent Inquiry was
5 launched in 2021 with Dr Geraldine Strathdee as its
6 chair. I am grateful for the important work that she
7 undertook in that role. In June 2023 the former
8 Secretary of State for Health and Social Care,
9 Steve Barclay, announced that the Inquiry would be
10 converted to statutory status under the
11 2005 Inquiries Act, with new powers to compel
12 individuals and organisations to provide it with
13 evidence and with serious repercussions if they failed
14 to do so. Dr Strathdee stood down as chair in this
15 time.
16 In September 2023, I was asked by Mr Barclay to take
17 on the role of chairing this Inquiry and I was formally
18 appointed as chair on 26 October 2023. The following
19 day the Department of Health and Social Care issued
20 a formal notice of conversion, confirming the Inquiry's
21 statutory status. The Inquiry then relaunched as the
22 Lampard Inquiry on 1 November 2023.
23 When the non-statutory Inquiry was first launched,
24 Dr Strathdee made a commitment to put families and
25 former patients at the heart of our work. I firmly

1 stand by that commitment. I will ensure that the
2 experience of family, friends, patients and former
3 patients remains central to the Inquiry's work.
4 My key concern is properly and fully to understand
5 all the issues I'm required to address and to make
6 meaningful recommendations. This is to ensure that any
7 necessary improvements in mental health care are made
8 here in Essex but also nationally and to do this within
9 a reasonable period of time. There is urgency to my
10 task. A number of the issues that have been identified
11 remain of current concern and I need to address those
12 quickly.
13 This Inquiry was not established on the back of
14 a single incident. Instead it was the accumulation of
15 a number of tragic deaths which have led to a series of
16 investigations, key reports from regulators and other
17 relevant bodies and awareness-raising by
18 parliamentarians.
19 In my statement of approach to the Terms of
20 Reference, I referred to the courage, resilience and
21 strength that the families have demonstrated in these
22 most tragic of circumstances, including in bringing to
23 light some of the matters I will be looking into.
24 I again acknowledge the instrumental role of the
25 families in the creation of this independent statutory

1 Inquiry. Without their dedicated and tireless
2 campaigning, it is unlikely that we would be here today.
3 I am grateful to have met with a number of families to
4 hear about their experiences, their concerns and, most
5 importantly, about the person they lost.
6 I think it's important that I should say a little
7 about my own background. After spending a number of
8 years practising as a barrister, I gained an in-depth
9 understanding of our health systems through holding
10 various senior non-executive roles within the
11 National Health Service. During my career, I have led
12 independent reviews into matters of serious public
13 concern. These include being appointed by the
14 Department of Health and Social Care to oversee its
15 investigations into the allegations of sexual abuse by
16 the late broadcaster Jimmy Savile, taking place in NHS
17 hospitals.
18 I have had a role considering deaths in a closed
19 setting as interim chair of the Independent Advisory
20 Panel On Deaths in Custody. I also conducted
21 independent reviews of allegations of the mistreatment
22 of detainees at Yarl's Wood Immigration Removal Centre
23 and then later at the Brook House Immigration Removal
24 Centre. This led, in 2019, to my being appointed by the
25 then Home Secretary to conduct a review of the Borders,

1 Immigration and Citizenship Service. I therefore have
2 significant experience of the conduct of major
3 investigations and reviews. I intend to apply that
4 experience to my work as chair of this Inquiry.
5 The role of chair comes with deep responsibility and
6 is one I've not stepped into lightly. I and my Inquiry
7 team will be investigating matters of grave importance
8 relating to life and death, which are of course the most
9 serious issues that we can find ourselves dealing with.
10 I will ensure that this Inquiry is fair, objective,
11 thorough, rigorous and balanced. It's important to
12 stress that I am independent. As chair, I will act
13 without fear or favour and without interference from
14 government, health bodies or others to get to the truth.
15 You have my full commitment to establishing the key
16 facts and issues at the heart of this Inquiry, to probe,
17 to examine the evidence critically and to ask the
18 difficult questions.
19 This Inquiry is not a trial in court. It's not
20 about finding guilt, although wrongdoing is likely to be
21 uncovered. I do not have the power to make findings of
22 criminal or civil liability. Instead, this, like other
23 inquiries, is a process independent of Government and
24 politicians, stakeholders and all interested parties,
25 with the key aim of getting to the truth.

1 I must approach the Inquiry proportionately and
2 efficiently and deliver my findings and recommendations
3 in as swift a manner as possible. People have waited
4 too long for answers and, as I've already said, we need
5 to make sure that matters that need remedying are put
6 right urgently to limit any further unnecessary
7 suffering.
8 I'm not going to be opening up and determining cause
9 of death in every single case. In many cases the cause
10 of death has already been determined by legal processes.
11 In others the passing of time and lack of evidence make
12 it impossible to do so. In any event, this Inquiry is
13 concerned with and has been set up to identify the
14 systemic issues that have given rise to the deaths and
15 serious harm we're concerned with. This Inquiry will
16 uncover what went wrong, but, in doing so, I also want
17 to investigate what went right, what good practice looks
18 like and how things can be improved. Indeed I accept
19 that there were many dedicated members of staff on the
20 wards during the time in question who were carrying out
21 their work to the highest standards. The importance of
22 this Inquiry is to learn lessons of general application
23 so that we can ensure that the identified failings are
24 never able to happen again, in Essex or beyond, in
25 mental health facilities across the country.

1 The Secretary of State for Health set the Inquiry's
2 Terms of Reference in their current form in April this
3 year. They outline the matters this Inquiry will
4 investigate. You can find them on the Inquiry's website
5 along with an explanatory note which indicates how
6 I propose to interpret them.
7 The Inquiry is investigating "the circumstances
8 surrounding the deaths of mental health inpatients".
9 The focus is accordingly on those who died as
10 inpatients rather than those who were being treated in
11 the community. However, my proposed definition of
12 inpatient deaths enables me to examine the circumstances
13 of those who died up to three months post-discharge,
14 including the support provided on discharge as well as
15 the circumstances surrounding assessments and admissions
16 to inpatient wards. This means that some aspects of
17 care received in the community will inevitably fall
18 within the Inquiry's investigations.
19 The Inquiry will look into serious failings in
20 inpatient treatment and care, including serious harm
21 that did not end in a death. It will also be
22 considering how the NHS engaged with patients and their
23 families, matters relating to physical and sexual
24 safety, the actions of staff as well as the Trusts'
25 approach to staffing, the relevant leadership, culture

1 and governance within the Trust, the quality of the
2 Trusts' investigations and how they responded when
3 things went wrong and the interactions between the
4 Trusts and other bodies, such as coroners' courts.
5 I am satisfied that the scope of this Inquiry
6 provides the breadth needed to thoroughly address the
7 significant areas of concern identified, but the terms
8 are also appropriately focused and proportionate,
9 allowing me to report and make recommendations within
10 a reasonable period of time.
11 My hope and expectation is that any witness I call
12 to give evidence at a hearing or to whom a request is
13 made to provide documents or a written statement will
14 cooperate voluntarily with the Inquiry. Where NHS staff
15 in Essex have relevant information, I will expect them
16 to come forward to the Inquiry with it. I expect
17 the Inquiry's requests for evidence to be met promptly
18 and with complete candour. My strong wish is to work
19 collaboratively with core participants and others
20 engaging with the Inquiry to achieve my objectives.
21 I should, however, make clear from the outset that,
22 where relevant evidence is not provided or is not
23 provided appropriately promptly, I will not hesitate to
24 use my statutory powers to the fullest extent necessary
25 to compel its production. I will also expect the

1 organisations at the heart of the Inquiry's
2 investigations to be appropriately resourced so that
3 they engage effectively and efficiently with
4 the Inquiry.
5 I'd like to turn now to speak about the Inquiry
6 team. It's made up of the secretariat, solicitor and
7 counsel teams, who work closely together to support me
8 and advance the Inquiry's work. Kate Ward is the
9 secretary to the Inquiry. Her role is to support and
10 advise me and to act as Chief of Staff to the Inquiry.
11 She is a member of the Senior Civil Service and has
12 wide-ranging experience highly relevant to this Inquiry.
13 She has also worked on the front line as a nurse. She
14 is supported by a highly skilled secretariat team.
15 Catherine Turtle is lead solicitor to the Inquiry.
16 Her role includes advising me and the Inquiry team on
17 any legal issues which may arise. She has extensive
18 experience of working with inquiry teams, stakeholders
19 and witnesses. She is supported by a team of solicitors
20 with significant inquiry experience.
21 Nicholas Griffin KC is lead counsel to the Inquiry
22 and you will be hearing from him after me. He has
23 practised extensively as a barrister in major public
24 inquiries. His role includes the presentation of
25 evidence at this Inquiry, which he will do with his team

1 of experienced barristers.

2 I am also in the process of appointing assessors.
3 They will have a background and expertise in certain of
4 the areas into which I am looking. They will provide me
5 with additional assistance during the course of the
6 Inquiry. For example, they'll help me to understand key
7 clinical, managerial, governance and regulatory aspects
8 of mental health care. In all of these ways, I will be
9 supported by a highly skilled, dedicated and experienced
10 group of people.

11 I will, separately, instruct experts in certain
12 areas, for example healthcare statistics, to analyse or
13 explain particular issues and to present their evidence
14 to me in the form of written reports and possibly also
15 at the Inquiry's hearings. I'll provide more details of
16 my approach to assessors and experts as the Inquiry
17 proceeds.

18 This Inquiry will be considering matters of the
19 gravest sensitivity in relation to people who were, at
20 the time, very vulnerable. I take that seriously.
21 The Inquiry's processes will be set up to ensure that
22 special allowances are made to help people who find
23 talking about these matters difficult and to safeguard
24 highly personal and medical information that doesn't
25 need to be made public. I know that there will be

1 members of staff who have also found the events under
2 consideration to be challenging and who wish to do their
3 best to assist the Inquiry to get to the truth. I will
4 do all that I can to help them to give important
5 evidence.
6 I recognise that this Inquiry is dealing with issues
7 that are deeply personal. Everyone involved will have
8 certain words and expressions that they feel right for
9 them to use when explaining their thoughts and
10 experiences connected to mental health and the matters
11 which this Inquiry is looking into. These may differ
12 from person to person. I ask that everyone is
13 respectful of that.
14 I and my Inquiry team have carefully considered the
15 language we plan to use and we've published on our
16 website a list of the terms the Inquiry proposes to use,
17 which is available for all to read. If we use terms
18 that are not your preferred language or if we
19 accidentally deviate from our own intended language,
20 please be assured that we do not mean any disrespect.
21 The Inquiry's list of terms is for us but it doesn't
22 need to be for you. You're obviously free to use the
23 language of your choice. I wish to hear your experience
24 in your own words and I reiterate my ask that people are
25 respectful of those who, in describing very personal

1 experiences or talking about difficult issues, choose to
2 adopt language that you might not use yourself.
3 As I've said, this Inquiry is dealing with the most
4 sensitive of subjects and it's understandably
5 distressing to many. I encourage us all to remember
6 this and ask that we treat each other with courtesy at
7 all times. I recognise that there may be parts of the
8 hearings that could be extremely difficult to hear. In
9 order for the Inquiry to obtain the best information and
10 evidence possible, however, everyone speaking at these
11 hearings must be given the opportunity to be heard and
12 everyone attending or engaged in these hearings must be
13 afforded respect throughout. I therefore ask that those
14 attending listen quietly to the opening statements and
15 the commemorative and impact evidence being given.
16 There are to be no disruptions, shouting out or
17 disturbances of any kind. Mobile phones must be
18 switched off within the hearing room and no recording or
19 filming devices of any kind may be used. I thank you
20 all in advance for your co-operation with this.
21 The Inquiry places the well-being of those engaging
22 with it at the centre of its work. You can find further
23 details of the support available on the website or do,
24 please, speak to one of the Inquiry's team if you feel
25 you may need support. Today, emotional support

1 services, which consist of confidential one-on-one
2 support, are available. Anyone who needs assistance
3 during a hearing should please leave the room quietly
4 and alert a member of the Inquiry team, who will help
5 them to access this support.
6 Raising awareness of mental health and expectations
7 around the care given to those living with mental
8 ill-health is of critical importance. For too long the
9 subject of mental health has not been spoken about with
10 the same candour and openness as physical health.
11 Thankfully times are changing and I hope that this
12 important Public Inquiry into mental healthcare, the
13 first of its kind, will further support this shift.
14 One of the best ways to shine a light on the matters
15 under investigation in this Inquiry is through media
16 reporting. The media are able to disseminate the
17 findings, learnings and in due course the
18 recommendations to a wide and varied audience. I'd like
19 to thank our press and media colleagues for all the work
20 they've done and will continue to do in encouraging
21 a sensitive, respectful and informed debate about mental
22 health and care.
23 I know that journalists will be accustomed to the
24 guidance on reporting of suicide but I would ask
25 everyone watching these hearings to be mindful about

1 what they say online about any of the information they
2 hear in this Inquiry. Care should be taken to limit the
3 risk of vulnerable people being influenced by discussion
4 of suicide and choosing to end their own lives.
5 Particular care should be taken when mentioning unusual
6 methods of suicide or the inclusion of any unnecessary
7 details. It's a matter of the utmost importance to be
8 sensitive to the needs and feelings of the bereaved.
9 I would also ask that no photography, filming, media
10 interviews, including for social media, take place in or
11 around any hearing venue. This is to protect and
12 respect the privacy of all those who are watching and
13 participating in person.
14 Turning now to the outcome to be achieved from this
15 Inquiry. Following my thorough investigations of the
16 issues in scope, I will set out in a report the key
17 factual background, analysis, my findings and
18 recommendations. The report will be written in clear
19 and straightforward language. My current intention is
20 not to provide interim reports, but I will keep an open
21 mind on this point as the Inquiry develops. Where
22 I identify systemic matters that require urgent
23 attention, I may issue an urgent statement and I will
24 alert the relevant organisations as appropriate.
25 Matters which relate to keeping people safe from harm,

1 current threats to health or safety and any criminal
2 offending will be communicated immediately to the
3 relevant authorities.
4 I will not be afraid to be critical or challenging
5 in my findings or to make bold and meaningful
6 recommendations for change. When making
7 recommendations, I will direct them to particular
8 individuals or organisations, provide a timeframe for
9 expected implementation and set out the way in which
10 I would expect that implementation to be monitored.
11 Although the Inquiry is focused on Essex, my
12 recommendations will be made national wherever
13 appropriate, helping to ensure improvements to mental
14 healthcare across the whole country.
15 I wish to finish by underlining the importance of
16 this Inquiry to families, friends, patients and former
17 patients who have experienced trauma and loss because of
18 the mental healthcare provided in Essex. For my part,
19 I wish to conduct this Inquiry in a way that both
20 recognises these experiences and allows everyone to have
21 their say in order to get to the real heart of the
22 issues. I hope that through this Inquiry we can make
23 recommendations for real and lasting change in memory of
24 those who have lost their lives as mental health
25 inpatients in Essex.

1 Mr Griffin.
2 MR GRIFFIN: Thank you, Chair. May I just check first that
3 everyone can hear me all right? It's a little bit
4 low -- is the volume a little bit better now? Okay,
5 thank you.
6 Opening statement by MR GRIFFIN
7 MR GRIFFIN: We will today and during the course of this
8 hearing be addressing distressing and difficult matters.
9 Chair, you have referred to the emotional support
10 service that is available. It is overseen by
11 the Inquiry's chief psychologist. Counsellors are
12 present here today -- and I think they're wearing black
13 lanyards -- and information about further services is
14 available on the Support Services page of the Inquiry's
15 website or by asking a member of the Inquiry team. As
16 you heard, we are wearing purple lanyards. We want all
17 those engaging with the Inquiry to feel safe and
18 supported.
19 Chair, we have a number of lawyers here representing
20 core participants. On behalf of the family, friends and
21 patients represented by Hodge Jones & Allen,
22 Steven Snowden King's Counsel, Dr Achas Burin and
23 Rebecca Henshaw-Keene; on behalf of INQUEST,
24 Lilian Lewis; on behalf of the Essex Partnership
25 University Trust, Adam Fullwood. Chair, Eleanor Grey

1 King's Counsel will be here on Wednesday to give their
2 opening statement; on behalf of North East London NHS
3 Foundation Trust, Valerie Charbit; on behalf of the
4 three core participant integrated care boards, Mid and
5 South Essex, Hertfordshire and West Essex, Suffolk and
6 North East Essex, Zeenat Islam; on behalf of the
7 Care Quality Commission, Jenni Richards King's Counsel;
8 and on behalf of the Department of Health and Social
9 Care, Anne Studd King's Counsel.
10 I am assisted at this hearing by further members of
11 the counsel to the Inquiry team. They are Rachel Troup,
12 Rebecca Harris and Dr Tagbo Ilozue. I am grateful for
13 all of their help. As you have said, Chair, the counsel
14 team works closely with the Lampard Inquiry solicitor
15 team under Catherine Turtle -- the Inquiry would not be
16 able to operate without them -- and we also rely heavily
17 on the work of the professional and experienced
18 secretariat team and the Inquiry's engagement team,
19 which is part of the secretariat and with whom many
20 families and patients may have already been in contact.
21 I've already referred to the Inquiry's website and
22 I will throughout this opening statement be referring to
23 other documents and information that are available on
24 it. It's an important resource and the Inquiry will
25 regularly post updates on it. It is at

1 lampardinquiry.org.uk and it contains a wealth of
2 material, including a series of helpful FAQs.
3 It will be helpful to provide some background about
4 how this Inquiry came to be set up, although I don't
5 intend to provide a comprehensive account. In June 2019
6 Rob Behrens CBE, who was then Parliamentary and Health
7 Service Ombudsman, published his report entitled "Missed
8 Opportunities", which found that there had been a series
9 of significant failings in the care and treatment of two
10 vulnerable young men who died shortly after being
11 admitted to North Essex Partnership University NHS
12 Foundation Trust, which was subsequently subsumed into
13 the Essex Partnership University NHS Foundation Trust.
14 The report considered the death in 2008 of a person
15 referred to as "Mr R" and the death in November 2012 of
16 Matthew Leahy. It identified multiple failings
17 surrounding both deaths. The report also identified
18 systemic issues at the Trust, including a failure over
19 many years to develop the learning culture necessary to
20 prevent similar mistakes from being repeated.
21 Mr Behrens noted that the families of both young
22 men -- and I quote:
23 "... suffer the ongoing injustice of knowing that
24 their sons did not receive the standard of care they
25 should have done. This has caused them unimaginable

1 distress."

2 He also said -- and I quote:

3 "Serious failings by organisations providing mental
4 health services can have catastrophic consequences for
5 patients. NHS Trusts must ensure timely improvements to
6 ensure patient safety and protect patients who are at
7 risk of taking their own life."

8 In 2021, Essex Partnership University NHS Foundation
9 Trust, which I will sometimes refer to as "EPUT", faced
10 criminal proceedings and was fined for safety failings.
11 This was for over a period exceeding ten years, from
12 2004 to 2015, concerning the deaths of patients at the
13 North Essex Partnership University Trust. The
14 prosecution was brought by the Health and Safety
15 Executive and I will refer to the sentencing remarks of
16 Mr Justice Cavanagh. That was at the Crown Court here
17 in Chelmsford on 16 June 2021. Some of what he said is
18 distressing to hear.

19 He noted that, on 20 November 2020, at Chelmsford
20 Magistrates' Court, EPUT had pleaded guilty to a charge
21 that during the period from 1 October 2004 to
22 31 March 2015 it had failed, so far as was reasonably
23 practicable, to manage the environmental risks from
24 fixed ligature points within its inpatient mental health
25 wards across various sites under its control in Essex,

1 thereby exposing vulnerable patients in its care to the
2 risk of harm by ligature. The risk of harm was that
3 patients would end or attempt to end their lives by
4 hanging, using such ligature points as were available to
5 them in the inpatient wards.
6 During this period, 11 inpatients hanged themselves
7 using ligature points and at least one other and
8 probably more tried unsuccessfully to do so. The judge
9 added this -- and I quote:
10 "At the heart of this case are a number of
11 interconnected failures by the Trust. In summary, these
12 are that there was a consistent failure to comply with
13 national standards and guidance involving ligature risks
14 (these are sometimes referred to as 'environmental'
15 risks); failure to act in a timely manner when
16 environmental risks were brought to the Trust's
17 attention, and failure to act in a timely manner on
18 recommendations made by the Trust's own internal Audits;
19 and failure to act appropriately after serious incidents
20 had occurred, by failing to make appropriate
21 environmental changes to reduce suicide risks, so as to
22 remove the environmental risks from the same or similar
23 locations. These failings often persisted for a number
24 of years and meant that dangers resulting from ligature
25 points on wards ... were not identified and dealt with."

1 Dedicated family members, with the strong support of
2 a number of MPs, raised awareness of these issues within
3 Parliament and, on 16 October 2020, during a debate on
4 deaths in mental health facilities, James Cartilage MP
5 spoke about the circumstances of the death of a young
6 man named Richard Wade in 2015 in the Linden Centre here
7 in Chelmsford. The debate highlighted concerns over the
8 Care Quality Commission's handling and investigations of
9 deaths in a mental health inpatient setting.
10 Ed Argar MP, who was then Minister of State for Health,
11 told the House of Commons that fellow Health Minister,
12 Nadine Dorries MP, intended to commission an independent
13 review into the serious questions raised by a series of
14 tragic deaths of patients at the Linden Centre between
15 2008 and 2015. At around the same time, a petition
16 created by Matthew Leahy's mother, Melanie, was signed
17 by over 100,000 people, calling for a statutory inquiry
18 to cover all Essex mental health services. This
19 extraordinary effort secured a second Parliamentary
20 debate on 30 November 2020.
21 During this debate, Nadine Dorries announced that
22 there would be an independent inquiry covering the
23 period from 2000 to the present day. The Essex Mental
24 Health Independent Inquiry was established by the
25 Government in April 2021 and Dr Geraldine Strathdee CBE

1 was appointed as its chair. This was a non-statutory
2 inquiry. Significant concerns were raised by some
3 families from the outset about it being a non-statutory
4 inquiry and calls were made for it to have the full
5 force and powers of a statutory inquiry.
6 In November 2021 the Inquiry launched a call for
7 evidence from families and carers of inpatients who
8 died in Essex NHS Trusts between 2000 and 2020 as well
9 as anyone with experience of mental health inpatient
10 services across Essex during the 21-year period.
11 In March 2022 the Inquiry put out a wider call for
12 evidence. In July 2022 the Inquiry's chair issued an
13 urgent appeal to staff to come forward to share their
14 experiences with the Inquiry. The response to this was
15 extremely poor. On 12 January 2023, Dr Strathdee
16 published an open letter setting out her belief that
17 the Inquiry could not deliver as a non-statutory inquiry
18 with the current response from staff.
19 After further efforts to engage staff, the chair
20 informed Steve Barclay MP, who was then Secretary of
21 State for Health and Social Care, on 17 April that her
22 view remained that the Inquiry could not meet its terms
23 of reference without statutory status to compel
24 witnesses to share evidence. In June 2023 Steve Barclay
25 announced the Statutory Inquiry, saying that -- and

1 I quote:

2 "Due to the challenges faced while running an
3 independent inquiry -- such as engaging former and
4 current staff at the Essex Partnership University Trust
5 ... and in securing evidence from the Trust itself,
6 a statutory inquiry will have legal powers to compel
7 witnesses, including those former and current staff of
8 EPUT, to give evidence."

9 Chair, you have already described how the Inquiry
10 was put on a statutory footing in October 2023, that you
11 took over from Dr Strathdee as chair and that it
12 relaunched on 1 November last year as the
13 "Lampard Inquiry". It is clear that serious issues with
14 mental healthcare in Essex continue and that the matters
15 to be investigated by the Inquiry are as pressing and
16 relevant as when it was first established.

17 On 10 October 2022 Channel 4 broadcast a Dispatches
18 documentary entitled "Hospitals Undercover Are They
19 Safe?". The programme showed footage from a year-long
20 undercover investigation and highlighted concerning
21 practices on various wards run by EPUT. It is a stark
22 but important piece of reporting. It covers issues of
23 great relevance to this Inquiry, including concerning
24 ligatures, the use of restraint and absconding from
25 wards.

1 I turn now to discuss the Inquiry's procedure. The
2 Statutory Public Inquiry is a process that allows for
3 a thorough but ultimately flexible and imaginative
4 approach in pursuit of the truth. I want to speak first
5 about some of the provisions in the Inquiries Act 2005
6 and Inquiry Rules 2006 as they form an important part of
7 the Inquiry's procedure, but I don't intend to enter
8 into an exhaustive discussion of this statutory
9 framework.
10 The Inquiries Act specifically says that the
11 procedure and conduct of an inquiry are to be as the
12 chair directs them to be. That is section 17. It is
13 subject to the Inquiry Rules, which I will come back to
14 in a moment. The law therefore gives the chair a great
15 degree of control about how to proceed. The Act also
16 makes clear that the chair, and I quote, "must act with
17 fairness and with regard also to the need to avoid any
18 unnecessary cost". That is again section 17. The
19 central requirement of fairness is as one would expect
20 and the chair must adopt a proportionate approach, with
21 efficiency and the urgency of the Inquiry's task in
22 mind.
23 Section 2 of the Act states that the chair is not to
24 rule on and has no power to determine any person's civil
25 or criminal liability. Chair, as you have said, that

1 means that the Inquiry is not a trial. The Inquiry's
2 process is inquisitorial and the end results are its
3 report and recommendations. It is not like a civil or
4 criminal case, there are no sides and there is no
5 finding of guilt or innocence.
6 Chair, this does not stop you from reaching strong
7 and clear findings about the facts. On the contrary, it
8 is your duty to do so. And it does not stop you from
9 going on to make robust recommendations for change.
10 This is in part because section 2 also makes clear that
11 the chair is, I quote, "not to be inhibited in the
12 discharge of [her] functions by any likelihood of
13 liability being inferred from facts that [she]
14 determines or recommendations that [she] makes".
15 One of the requirements of the chair's appointment
16 is impartiality. This is addressed in section 9. The
17 chair and this Inquiry will be entirely independent from
18 all of those engaging with the Inquiry and, more widely,
19 from Government or any health body or other
20 organisation. This is a statutory requirement and
21 a matter of fundamental fairness. The Inquiry's
22 findings would be undermined were we to act in any other
23 way. This is a public inquiry. The default position is
24 that Inquiry proceedings shall be public. Section 18
25 covers this. It sets out that the chair must take such

1 steps as she considers reasonable so that, firstly,
2 members of the public are able to attend the Inquiry in
3 person or to view its proceedings virtually via
4 a simultaneous transmission and, secondly, to obtain or
5 view a record of its evidence and documents. But the
6 Inquiry is considering matters of great sensitivity.
7 They involve highly personal information regarding
8 mental health and medical matters in relation to people
9 who may be vulnerable. The Inquiry's Terms of Reference
10 recognise this and include that -- I quote:
11 "Personal and sensitive information provided to
12 the Inquiry will be appropriately handled. It will only
13 be shared or made public as is necessary and
14 proportionate for the Inquiry to fulfil these Terms of
15 Reference."
16 This is where section 19 comes into play. It allows
17 the chair to impose restrictions both on attendance at
18 an inquiry and the disclosure or publication of
19 evidence. In general terms, this means that in certain
20 circumstances the chair may hold hearings in private or
21 hold back certain documents or provide them with
22 redactions. Another aspect of this is that the chair
23 may grant individuals anonymity, allowing them to give
24 evidence without disclosing their identities. In some
25 cases this might be appropriate for those who wish to

1 assist the Inquiry but for various reasons are very
2 apprehensive about doing so in public.
3 Restrictions on the disclosure of identities or
4 other parts of evidence are imposed by making
5 a restriction order. Two different categories of
6 restriction may be contained in an order. They are set
7 out in section 19. The first are those required by
8 a statutory provision or rule of law; the second are
9 those that the chair considers, I quote, "to be
10 conducive to the inquiry fulfilling its terms of
11 reference or to be necessary in the public interest".
12 The system involves careful consideration and
13 balancing of a number of relevant factors. It also
14 requires a clearly set-out proper basis before any
15 restriction may be made.
16 Chair, you have published a note on the Inquiry's
17 website setting out the approach you will adopt in
18 relation to restricting the identities of patients who
19 engage with our investigations. You have decided to
20 apply a presumption in favour of anonymity for those who
21 are living and are currently or have previously been
22 mental health inpatients under the care of NHS Trusts in
23 Essex.
24 I would now like to address the Inquiry's powers of
25 compulsion, which most clearly set it apart from the

1 non-statutory Inquiry. Chair, you have said that the
2 Inquiry expects that those asked to provide documents or
3 to come to give evidence will do so voluntarily.
4 However, where that does not happen, the chair has
5 powers under section 21, by notice, to require a person
6 to give evidence and to produce documents and materials
7 to the Inquiry. It is a criminal offence under
8 section 35 to fail without reasonable excuse to do
9 anything that is required by a section 21 notice. It is
10 also a criminal offence to suppress, conceal, alter or
11 destroy relevant evidence. As we have heard, the
12 importance of the matters being looked into and the
13 difficulties experienced by the non-statutory Inquiry
14 have made a statutory inquiry with powers necessary.
15 I repeat the call for those with relevant
16 information to provide to the Inquiry, whether they are
17 current or former staff members or others, to come
18 forward voluntarily. By doing so and cooperating, they
19 will rightly assist us in uncovering what happened. We
20 recognise that there will be dedicated and committed
21 staff and former staff who do wish to come forward to
22 share their experiences of mental health inpatient care
23 in Essex and to express their concerns about what they
24 have witnessed. They will be supported throughout by
25 this Inquiry, including, where appropriate, through the

1 use of restriction orders. But we will not hesitate to
2 look for those who do not come forward. Chair, you have
3 indicated that you are prepared to use your powers to
4 compel evidence wherever necessary.
5 We recognise, however, that giving evidence at
6 a hearing may be particularly difficult for the family
7 and friends of those who have died and for patients and
8 former patients. The Inquiry's objective is to ensure
9 that each witness is fully supported in a way that
10 allows them to share their experiences to the best of
11 their ability. To achieve that objective and to
12 encourage these witnesses to share their experiences
13 with the Inquiry as safely as possible, Chair, you have
14 confirmed that you will not exercise your powers under
15 section 21 against the family and friends of those who
16 have died or against patients and former patients,
17 unless in exceptional circumstances. This means that
18 they will not at any stage be compelled to give evidence
19 at any Inquiry hearing. They will be invited to do so
20 on a voluntary basis. Further information about this is
21 available in a note that was published in July this year
22 regarding section 21 of the Inquiries Act 2005.
23 This is an appropriate time to make clear that
24 the Inquiry takes its safeguarding responsibilities very
25 seriously. A note about the approach the Inquiry will

1 take in this regard is available on its website.
2 The Inquiry has produced various other notices.
3 They provide additional information about the running of
4 the Inquiry. It's important to mention one of those at
5 this stage: the notice on the prohibition on the
6 destruction of documents which refers to section 35. It
7 makes clear that it is crucial that the Inquiry's
8 investigation is not obstructed by the premature
9 destruction of any material that may be relevant to the
10 matters it is investigating and that anyone holding such
11 material should ensure that it is preserved. It spells
12 out what is meant by "material" here, including all
13 correspondence, emails, recordings, documentation or
14 data of different sorts. The Inquiry has also contacted
15 those it knows or believes to hold relevant documents in
16 similar terms.
17 Chair, you have decided that the Inquiry will also
18 operate under the Inquiry Rules 2006. You were not
19 required to do so as the Inquiry started life as
20 a non-statutory inquiry, but the rules will provide
21 a proper framework for participation by those who wish
22 or are asked to engage with the Inquiry. This was
23 explained in the April 2024 statement of approach you
24 provided with the publication of the Inquiry's Terms of
25 Reference. The rules cover matters such as the

1 designation of core participants. They also cover, in
2 rule 9, the process by which the Inquiry should seek
3 evidence, initially by way of written request, and in
4 rule 10, the framework for the questioning of witnesses
5 who come to an inquiry hearing to give evidence. The
6 rules cover a range of other matters, such as the award
7 of legal and other costs and expenses, that I don't
8 intend to go into now.
9 The Inquiry has further spelt out the procedure it
10 is to follow in a series of protocols. It is important
11 that those engaging with the Inquiry and, where they are
12 represented, their lawyers have regard to these
13 protocols. They cover the Inquiry's approach to a range
14 of matters, including but not limited to obtaining
15 witness statements, the disclosure of documents to the
16 Inquiry and whistle-blowing. I will refer to some other
17 protocols later and further protocols will be added as
18 appropriate as the Inquiry goes along.
19 As we have seen, the Inquiry is not constrained by
20 the strict rules of evidence in adversarial proceedings.
21 Chair, given your commitment to ensuring that all those
22 who engage with the Inquiry can be supported to do so as
23 safely as possible, the Inquiry will consider the
24 processes it adopts and may be flexible about the types
25 of evidence it is prepared to receive. The Inquiry team

1 will continuously consider the most efficient way in
2 which to address the issues being investigated,
3 consistent with the requirements of thoroughness and
4 fairness. We will also consider the views of core
5 participants and others involved in the Inquiry's work
6 about how to achieve this.
7 I have already referred to core participants.
8 I would like now to explain what a core participant is.
9 It is a person or organisation afforded specific rights
10 at the Inquiry. For example, they may have greater
11 access to the Inquiry's evidence; they can make opening
12 statements, as we will be seeing this week, and closing
13 statements in due course; they may suggest lines of
14 questioning for witnesses who come to give evidence at
15 an inquiry hearing. The application process to become
16 a core participant took place in April and May this
17 year. It is still possible to apply, however,
18 particularly for those who may have only recently become
19 involved in the work of the Inquiry.
20 Anyone interested in applying should look at the
21 protocol on core participants, which explains the
22 relevant criteria and includes an application form.
23 They should also look at the chair's statement of
24 approach on determining core participant applications of
25 15 July this year.

1 The Inquiry's core participants fall into the
2 following broad categories: the bereaved family and
3 friends of those who died; living current and former
4 patients; staff members and health bodies and other
5 organisations. The evidence of the family, friends and
6 patients will be key. At its heart, this Inquiry is
7 about people and, most obviously, those who died and
8 those most closely affected by the issues under
9 consideration. The written opening statement provided
10 on behalf of many of the families, friends and patients
11 expresses hope of building rapport and trust with the
12 Inquiry. The Inquiry very much welcomes the opportunity
13 to build those constructive relationships with the
14 people most affected by the issues to be explored.
15 There are various organisations with core
16 participant status in this Inquiry, ranging from
17 government departments and national health bodies
18 through to local NHS Trusts and integrated care boards.
19 A number of these core participants have provided
20 written opening statements which include relevant
21 background. However, it will help if I provide a brief
22 summary about each of them at this stage.
23 The Department of Health and Social Care, also known
24 as the "DHSC", is the Government department which sets
25 overall strategy for funds and oversees the health and

1 social care system in this country. This includes
2 responsibility for overseeing services provided in
3 clinical settings, such as hospitals and GP surgeries,
4 and those provided in the community through nursing,
5 social work and other professional services. The DHSC
6 has a significant role to play in the development of
7 policy in relation to mental health and patient safety.
8 It works with a number of other public bodies, agencies
9 and authorities to provide health and social care.
10 These include public bodies such as NHS England and the
11 Care Quality Commission, who are also core participants
12 in this Inquiry.
13 The DHSC is the Government department sponsoring and
14 funding this Inquiry. It is therefore important to
15 state that the Inquiry requires and will monitor strict
16 separation between the department's sponsorship and core
17 participant roles.
18 NHS England. The National Health Service is
19 a series of interconnected organisations responsible for
20 directing, planning, commissioning, organising and
21 providing healthcare services. NHS England leads the
22 National Health Service in England and has day-to-day
23 responsibility for the provision of health services in
24 England. Its purpose is to deliver high quality
25 services for all users.

1 The Care Quality Commission, also known as the
2 "CQC", established in 2009, is the independent regulator
3 of health and adult social care in England. The CQC
4 regulates the organisations that provide health and
5 social care as distinct from the individuals within
6 them. The CQC's role is to ensure that all health and
7 social care services provided in this country are safe,
8 effective and of high quality. Its remit is
9 wide-ranging. The CQC regulates and scrutinises
10 a variety of providers, from hospitals to care homes.
11 It is an executive, non-departmental, public body
12 sponsored by the DHSC. There is no question that work
13 done by the CQC will be of interest and relevance to the
14 work of the Inquiry; for example, the CQC undertook
15 reviews of the Trusts with which we are concerned.
16 Three integrated care boards, also known as "ICBs",
17 are core participants in this Inquiry: Hertfordshire and
18 West Essex; Suffolk and North East Essex; and Mid and
19 South Essex. ICBs are statutory bodies responsible for
20 planning and funding NHS services in their local area.
21 ICBs allocate the NHS budget and commission services for
22 the population, taking over the functions previously
23 held by clinical commissioning groups and some of the
24 direct commissioning functions of NHS England.
25 ICBs are directly accountable to NHS England. They

1 are a key component of integrated care systems. The
2 three ICB core participants in this Inquiry are those
3 responsible for planning and funding mental health
4 services in Essex. They work with local providers to do
5 so.
6 Essex Partnership University Trust or "EPUT" is the
7 main Trust providing mental health services in Essex
8 which this Inquiry is investigating. EPUT was formed
9 in April 2017 as a result of the merger of two
10 predecessor Trusts in Essex, the North Essex Partnership
11 University Trust and the South Essex Partnership
12 University Trust. EPUT is commissioned to provide the
13 majority of mental health services in Essex but not
14 community outpatient Child and Adolescent Mental Health
15 Services. As the Inquiry's timeframe extends back to
16 the start of 2000, the Inquiry will in addition consider
17 the way in which predecessor Trusts operated.
18 North East London NHS Foundation Trust, also known
19 as "NELFT", provides community Child and Adolescent
20 Mental Health Services across the whole of Essex. NELFT
21 also provided mental health services historically at
22 Mascalls Park, a mental health inpatient unit in Essex
23 which closed in 2011. Furthermore, on occasions,
24 patients from Essex were placed in NELFT units.
25 The Royal College of Psychiatrists is the

1 professional medical body responsible for supporting
2 psychiatrists through their careers. Given its
3 membership, the college works to promote the provision
4 of high quality mental health services and to secure the
5 best outcomes for people with mental illness.
6 The Inquiry expects to hear evidence from and about
7 registered clinicians who work in this speciality.
8 The charity INQUEST is also a core participant in
9 this Inquiry. INQUEST is independent from Government.
10 It provides advice and expertise on state-related deaths
11 to bereaved people, lawyers and others. INQUEST has
12 considerable experience of the deaths of those detained
13 under the Mental Health Act and in psychiatric settings
14 and has worked on a large number of cases involving
15 deaths in mental health settings in Essex.
16 Staff member core participants and witnesses will
17 fall into one of the following categories: doctors,
18 ranging from trainees and specialist psychiatric
19 trainees to consultant psychiatrists; those working in
20 the psychological professions, such as clinical
21 psychologists and CBT therapists; mental health nurses
22 and nursing associates; occupational therapists; other
23 therapists; paramedics; healthcare assistants; and
24 managers. The Inquiry is aware of highly concerning
25 practices that must be brought to light. Staff members

1 must come forward where they have relevant information
2 but, as has already been said, the Inquiry expects also
3 to find examples of professionalism, dedication and good
4 practice from which it wishes to learn.
5 We do not intend to provide a fuller list of family,
6 friend and patient core participants at the moment.
7 This is for various reasons, including outstanding
8 applications to protect the identities of certain
9 individuals. A full list will be provided in due
10 course, which may include ciphers in place of the names
11 of those to whom the Inquiry has granted anonymity.
12 As far as is possible and appropriate, the Inquiry
13 team wishes to collaborate with core participants to
14 advance the Inquiry's important work. Being a core
15 participant does not mean that a person's evidence is in
16 any way more important or given any greater weight.
17 Personal accounts and experiences shared by those who
18 are witnesses but not core participants are of no less
19 value in the eyes of the Inquiry than those provided by
20 persons who are, so it is important to stress that it is
21 not necessary to be a core participant to engage
22 meaningfully with the Inquiry. The Inquiry process is
23 designed so that those engaging with it do not need to
24 be legally represented. Each person or organisation,
25 core participant or not, should decide for themselves

1 whether they require legal representation.
2 Funding is available for legal costs for individuals
3 who meet the relevant criteria. Funding is also
4 available for other expenses connected to assisting
5 the Inquiry as a witness, whether legally represented or
6 not. The protocols on legal costs and on witness
7 expenses explain more about this. Those can be found on
8 the Inquiry's website along with other protocols.
9 Lawyers representing core participants are known as
10 "recognised legal representatives", using the language
11 of the Inquiry Rules. Our hope and expectation is that
12 they will not only provide a high level of
13 representation to their clients but will also engage
14 helpfully with the Inquiry team. We look forward to
15 working with them. The Inquiry counsel team will make
16 itself available to speak with legal representatives and
17 I encourage constructive dialogue during the course of
18 this Inquiry.
19 We are pleased to see many of the core participants
20 and their representatives here today. We are grateful
21 for the written opening statements that they have
22 provided and look forward to the oral opening statements
23 that will follow my own.
24 Moving now to consider the scope of this Inquiry.
25 The Terms of Reference are central to the Inquiry and

1 delineate its scope. I would like to say a little bit more
2 about them now. "Terms of Reference" are defined in
3 section 5 of the Inquiries Act to mean "the matters to
4 which the Inquiry relates", as well as the matters as to
5 which the chair is to determine the facts, whether she
6 is to make recommendations and any other matters that
7 are specified relating to scope. The Inquiry has no
8 power to consider matters outside its Terms of
9 Reference.
10 The Lampard Inquiry terms should be read along with
11 the explanatory note in relation to scope, which
12 indicates how the chair is minded to interpret them.
13 The chair's statement of approach of 10 April this year
14 was provided following the consultation on updated terms
15 of reference to form the basis of the newly statutory
16 Lampard Inquiry. It provides information about that
17 consultation process and its outcome. The Chair's
18 further statement of approach of 15 July this year
19 contains some further information about the Terms of
20 Reference and how they are to be interpreted.
21 In addition, we now have produced a provisional list
22 of issues. It is intended to spell out in further
23 detail the issues under consideration and to help guide
24 the Inquiry's investigative work. It is not intended
25 to, nor would the Inquiry be permitted to, expand or

1 capture issues outside the Terms of Reference.
2 The Inquiry recently invited written submissions
3 about the provisional list and we are grateful for the
4 responses received. We are considering them and will
5 provide a formal list of issues following this hearing
6 to reflect the submissions as appropriate along with any
7 further matters that arise in the written and oral
8 opening statements.
9 The Inquiry team also continues to reflect upon
10 these issues and is minded to add further matters to the
11 list of issues, such as: the demographics of Essex and
12 whether a person's background or ethnicity influenced
13 the treatment they received; the risk of adverse
14 therapeutic outcomes arising from coercive treatment
15 aimed at promoting physical safety, such as confinement;
16 how an appropriate balance was reached between medical
17 and psychological treatment options and the extent to
18 which there was any practice or culture of
19 over-medication; wider beliefs held by those working in
20 psychiatric care, which may influence the care given,
21 for example, whether or not they consider suicide to be
22 preventable; and the extent to which mental health has
23 been prioritised by politicians and those in leadership
24 positions in the major health bodies nationally and in
25 Essex. The list of issues may further evolve as

1 the Inquiry receives further evidence and undertakes its
2 investigations, with issues being added, removed or
3 amended as appropriate.
4 I would like now to turn to look at key points
5 arising from the Terms of Reference themselves. What
6 I would like to do is to ask the evidence handler to
7 please put up the Terms of Reference, page 1. That's
8 perfect. Thank you. The Terms of Reference, as we can
9 see, start by encapsulating the Inquiry's task, namely:
10 "To investigate the circumstances surrounding the
11 deaths of mental health inpatients under the care of
12 NHS Trust(s) in Essex ... between 1 January 2000 and
13 31 December 2023."
14 We can see that they then say:
15 "1. The Inquiry will investigate the circumstances
16 surrounding the deaths of mental health inpatients
17 within this timeframe.
18 "2. To the extent necessary to investigate the
19 deaths and fulfil these Terms of Reference, the Inquiry
20 will consider ..."
21 And we there then see a series of specified issues.
22 So we can see from the start of the Terms of
23 Reference that the focus of the Inquiry is on the deaths
24 of mental health inpatients under the care of Essex
25 Trusts. This is not therefore an inquiry into community

1 mental health -- but I will come back to this -- nor
2 is it into mental health services outside of Essex with
3 certain limited exceptions. The timeframe under
4 consideration is approaching a quarter of a century, the
5 24 years from the start of 2000 to the end of 2023,
6 during which there were significant changes, for
7 example, as to the applicable legislation and policy and
8 as to the structure of the relevant health bodies that
9 the Inquiry will need to understand and take into
10 account.
11 The Inquiry will adopt a proportionate approach. It
12 is required to investigate a series of issues but only
13 to the extent necessary to fulfil the terms.
14 The Inquiry will be rigorous and thorough but it will
15 also act with expedition to provide answers to these
16 important issues within a reasonable period of time. It
17 will be for the chair to judge to what extent it will be
18 necessary to investigate each of the matters that are
19 then listed from (a) to (k) in the Terms of Reference,
20 remembering that the Inquiry's focus is mental health
21 inpatients' deaths.
22 What constitutes an inpatient's death is addressed
23 in the explanatory note and also in the July 2024
24 statement of approach. It includes, for example, not
25 only those who died on relevant wards or units but also

1 those who died in a range of other circumstances. They
2 include but are not limited to deaths within three
3 months of discharge or, at the other end of the
4 spectrum, within three months of a mental health
5 assessment provided by the Trusts where the decision was
6 not to admit. In this way certain deaths outside mental
7 health inpatient units and in the community will be in
8 scope and we will greatly value evidence about them.
9 The provisional list of issues covers in greater
10 detail important background issues, such as the
11 landscape to NHS-funded mental health inpatient care in
12 Essex, the care and treatment pathway of those who died
13 and discharge and continuity of care to those returning
14 to the community. That's at sections (a) to (c).
15 Specific issues for investigation in the terms
16 include at 2(a):
17 "Serious failings related to the delivery of ...
18 inpatient treatment and care ..."
19 The draft terms were extended to reflect responses
20 received during the November consultation. This was to
21 make clear that serious failings may include, as we can
22 see, consideration of circumstances where serious harm
23 short of death occurred. It is recognised that such
24 incidents may raise the same or similar issues as
25 incidents that resulted in deaths.

1 Chair, as you said in your July statement of
2 approach, you have defined "serious harm short of death"
3 to apply to incidents and events that are serious in
4 nature and which had a reasonable prospect of leading to
5 death. They include but are not limited to attempted
6 suicide, serious physical and/or sexual assault and
7 serious failure to look after patients' well-being.
8 The terms also address, at 2(b) and (c), how the NHS
9 engage with patients and their families. The Inquiry
10 knows that these are issues of grave concern to patients
11 and families alike and they are further outlined in the
12 provisional list of issues at section D.
13 The Inquiry has received serious allegations about
14 the way in which various Trusts and staff members have
15 acted. Accordingly, the terms expressly extend to
16 matters relating to physical and sexual safety within
17 the relevant units at 2(d) and this is covered further
18 within the provisional list of issues at section E.
19 Could you please expand the bottom half of this
20 page? Perfect, thank you.
21 Paragraphs 2(e) and (f), as we can see, cover the
22 actions of staff more generally as well as the Trusts'
23 approach to staffing. This will be a major area of the
24 Inquiry's investigations and the issues are further
25 broken down in the provisional list of issues at

1 sections B, G and elsewhere.
2 The leadership culture and wider governance within
3 the Trusts is also a major area of investigation. It is
4 covered at 2(g) and (h) and in the provisional list of
5 issues at sections H to J.
6 The Inquiry will consider next in the terms at 2(i)
7 and (j) the quality of the Trusts' investigations and,
8 separately, how they responded to concerns and
9 complaints that were raised with them. These issues are
10 addressed further in the provisional list of issues at
11 sections K and L.
12 Could you please put up the top half of the next
13 page? Thank you.
14 Finally, as far as specific issues are concerned,
15 the Inquiry will investigate how the Trusts interacted
16 with other public bodies, such as coroners and
17 professional regulators. What I'm going to suggest is
18 could you expand the top half of the page so that people
19 can see the screen? Thank you.
20 I was talking about 2(k), covered further in the
21 provisional list of issues at section M.
22 As the focus of this Inquiry is on the actions of
23 the Trusts in the context of the treatment of mental
24 health inpatients, we will not, other than in the way
25 I have just described, be considering the operation of

1 these other public bodies. This means that it's not the
2 place of the Lampard Inquiry to consider the workings
3 and effectiveness of, for instance, the coronial or
4 healthcare regulatory systems in their own right.
5 We can see at paragraph 4 of the terms that
6 the Inquiry is indeed required to go on to make
7 recommendations to improve the provision of mental
8 health inpatient care. The Inquiry wishes to give
9 a great deal of thought from an early stage to any
10 recommendations it may make. The recommendations must
11 be evidence-based, clearly expressed and, of course,
12 implemented by the responsible bodies. The Inquiry will
13 also consider the ways in which the implementation of
14 those recommendations could be monitored.
15 Chair, I've been talking for a while and this might
16 be a moment for a brief break. Can I say ten minutes
17 only?
18 (12.25 pm)
19 (A short break)
20 (12.45 pm)
21 THE CHAIR: Mr Griffin, do you want to carry on?
22 MR GRIFFIN: Chair, I plan to finish my opening statement
23 this morning, which will probably mean going beyond
24 1 o'clock but not hopefully too much. In that way,
25 Mr Snowden will have a clear start this afternoon and

1 will ensure that people have a full hour for their lunch
2 in the middle of the day.
3 Can the evidence handler please put up the first
4 page of the explanatory note? Thank you.
5 This is the explanatory note in relation to scope to
6 which I referred before the break. As we can see at the
7 top there, it:
8 "... does not form part of these Terms of Reference
9 but indicates how the Chair is minded to interpret
10 them."
11 Would you mind going to the second page, please?
12 Could you expand from "Further points to note"? Can
13 people see that all right? Yes.
14 At this stage I would like to draw attention to two
15 paragraphs in the explanatory note. The first is the
16 paragraph which starts:
17 "In undertaking her investigations ..."
18 This explains that the chair will consider the
19 particular circumstances relevant to those who have
20 died. This may include a range of factors, such as
21 "neurodiversity, learning disabilities, dementia,
22 co-existing physical health issues, drug and alcohol
23 addiction, and other social and economic factors".
24 Taking neurodiversity as an example, the issue of
25 the adequacy of treatment of people who are neurodiverse

1 in the context of mental health inpatient care emerged
2 as a serious matter of concern in the responses to the
3 Terms of Reference consultation. It is therefore
4 important to reflect this within the work of the Inquiry
5 and I know it is very important to a lot of people.
6 The second paragraph I want to look at comes next.
7 It says:
8 "The Chair is minded to identify a sample of cases,
9 representative of the issues, that will be investigated
10 in detail in order to draw wider conclusions."
11 The approach will provide a sensible and
12 proportionate way forward as it will unfortunately not
13 be possible to investigate in depth each of the very
14 many deaths that are potentially within scope.
15 The Inquiry is acutely conscious of the fact that many
16 of the issues it is investigating remain of ongoing
17 concern and that it must therefore work efficiently to
18 identify those issues as a matter of urgent importance.
19 The Inquiry is considering which cases should fall
20 within the sample and no doubt further cases will be
21 added as we proceed and more information becomes
22 available. However, I can indicate now to all existing
23 core participant families and friends that we will be
24 looking into the death of their relative or friend and
25 the issues or concerns arising to the extent possible

1 and appropriate.

2 Thank you. Can you take down the explanatory note?

3 It is important to say that the Inquiry will
4 consider the totality of the information and evidence it
5 obtains and its focus will not be limited to individual
6 cases. Chair, the Terms of Reference provide the basis
7 for a full investigation of the issues of major public
8 concern giving rise to this Inquiry. They will allow
9 the Inquiry to get to the heart of these issues and to
10 make findings about what actually happened. This will
11 form the basis for significant recommendations to ensure
12 to the greatest extent possible that they will not
13 happen again. That is the mission of the Inquiry. The
14 starting point must be recognition of the rights and
15 expectations of patients and their families in
16 connection with care, treatment, dignity and respect.
17 There must also be recognition of the tragedies
18 experienced by so many and agreement that lessons must
19 now finally be learnt and acted upon.

20 At this stage I note the following from the written
21 opening statements of the health bodies. The Department
22 of Health and Social Care states that "every patient
23 deserves to be treated in an environment where they
24 receive high quality care and are treated with dignity
25 and respect"; that it is "determined to work with others

1 to transform and improve mental healthcare"; and that it
2 "looks forward to assisting the Inquiry" in this regard.
3 NHS England, again, in their written opening,
4 "recognises the incredibly important role for this
5 Inquiry in identifying lessons that can be learned from
6 the events that led to these tragic deaths in order to
7 improve NHS mental health services both in Essex and
8 nationally"; and that it is "committed to assisting
9 the Inquiry".
10 And the three integrated care boards are "committed
11 to engaging with the Inquiry in full openness and
12 transparency" and "highlight their willingness to
13 reflect on key learning".
14 And EPUT apologises to all those who have been
15 failed by NHS mental health services in Essex and
16 acknowledges that safe services were not always
17 provided. It vows to learn and to implement change and
18 states that it is committed to engage candidly with the
19 Inquiry.
20 The Inquiry will hold these health bodies to their
21 promises of engagement and assistance.
22 It is important to say a little more about the
23 geographical scope of the Inquiry. As the Terms of
24 Reference make clear, the Inquiry is investigating the
25 deaths of mental health inpatients "under the care of

1 NHS Trust(s) in Essex". The explanatory note says
2 further that these include "[EPUT] and [NELFT] and their
3 predecessor organisations where relevant".
4 The July statement of approach explains that "Essex"
5 has been defined in accordance with Schedule 1 of the
6 Lieutenancies Act 1997 as being comprised of the local
7 government areas of Essex, Southend-on-Sea and Thurrock.
8 This is the administrative county of Essex and does not
9 include areas of Greater London.
10 However, the Inquiry will need to consider matters
11 outside Essex in two ways. Firstly and as the July
12 statement of approach explains, the Inquiry's definition
13 of "inpatient" includes mental health inpatients who
14 were under the care of NHS providers in Essex but who
15 were placed outside Essex. This was either because
16 there was not enough bed space in Essex or due to
17 needing specialist services that were not, at the
18 relevant time, available in Essex.
19 Secondly, the Terms of Reference state at
20 paragraph 5 that while the investigations will focus on
21 the Essex Trusts -- I quote:
22 "The Chair may make national recommendations as she
23 considers appropriate. To do so, she may seek evidence
24 from individuals, organisations or from Trusts who are
25 either involved in the provision of mental health

1 inpatient healthcare in other areas or [who] have
2 evidence which may be relevant to the issues which
3 the Inquiry is investigating."
4 The evidence obtained in this way may provide useful
5 comparators to the approach in Essex but it could also
6 address, to a certain extent at least, whether the
7 practices of concern revealed in Essex are specific to
8 this county or whether they actually reflect the
9 approach in other parts of the country.
10 The Inquiry's intention is to address the issues
11 under investigation on a Trust-by-Trust basis. We will
12 start with a consideration of North Essex Partnership
13 University Trust and the South Essex Partnership
14 University Trust and we'll then move on to EPUT. We
15 will also consider NELFT and the private providers, to
16 the extent that they are in scope.
17 As well as matters connected to the management of
18 and leadership of the Trusts, we will consider events
19 and issues as appropriate on a ward-by-ward basis within
20 each Trust and broadly on a chronological basis within
21 each ward.
22 We will of course be looking at other matters too,
23 including other local and national bodies such as those
24 that I have named, to the extent necessary. Further
25 information about the Inquiry's approach will be

1 provided shortly.
2 I move now to consider evidence and disclosure.
3 Important information was obtained during the
4 non-statutory phase of this Inquiry, when it was the
5 Essex Mental Health Independent Inquiry. This included,
6 for instance, transcripts and recordings of evidence
7 sessions with family members and others. The
8 information is being reviewed and will be incorporated
9 as appropriate into the statutory Inquiry, so in many
10 cases members of the Inquiry team are working with
11 families who attended evidence sessions with the
12 non-statutory Inquiry to use the transcripts of those
13 sessions to form the basis of their witness statements
14 to this Inquiry.
15 As a general principle, the Inquiry will only
16 request, review and store material which is potentially
17 relevant to the Terms of Reference. The Inquiry will
18 review the evidence it obtains prior to making
19 disclosure of documents that it is relevant and
20 necessary to provide to core participants and witnesses.
21 Given the nature of this Inquiry, much of the evidence
22 we receive will be highly sensitive. As I have said,
23 the Inquiry will handle all the material it receives
24 with extreme caution and will ensure that it is
25 processed and stored in accordance with all relevant

1 data protection laws.
2 In order to meet its Terms of Reference, the Inquiry
3 will be looking to obtain and hear evidence from a wide
4 variety of sources. The Inquiry is working very hard to
5 obtain full information in relation to those who have
6 died. As the chair said, we have asked the relevant
7 healthcare providers to provide us with the details of
8 those who fall within the Inquiry's definition of
9 inpatient deaths and who died whilst in their care.
10 As the chair has already said, this is proving to be
11 a difficult exercise. This is in part because there are
12 issues with the availability of data. Very sadly we may
13 never know the precise number of those who died and come
14 within the Inquiry's scope, but we will continue to work
15 with and require information from the providers and
16 intend to provide the best estimate possible. The
17 further work done has already demonstrated that the
18 figure previously given of 2,000 deaths will rise
19 substantially. We will provide an update about this at
20 the November hearing.
21 The evidence from the families and friends of those
22 who have died and from patients with lived experience
23 will be at the heart of this Inquiry. We are very
24 grateful to those who have engaged with the Inquiry
25 already and we will do all that we can to support others

1 who may wish to engage in due course. The Inquiry also
2 understands, however, that there may be some for whom
3 such engagement is simply too difficult. We will
4 continue to look for answers on their behalf.
5 As well as the powerful and moving commemorative
6 evidence that we will hear over the next two weeks,
7 the Inquiry will hear evidence from a number of patients
8 about the impact on them of their experiences. We have
9 already received courageous and compelling accounts from
10 former patients. The vital importance of that evidence
11 is best illustrated by some excerpts from one of these
12 accounts which I would like to read at this stage.
13 A former patient has told the Inquiry -- and I quote:
14 "I became ill when I was at university. I was
15 a high achiever and like many young people I was
16 overwhelmed with the pressures of university and this
17 led to a real deterioration in my mental health and
18 a number of suicide attempts that led to my eventual
19 admission. What should have been a relatively
20 straightforward encounter with services to develop
21 mechanisms to cope with life turned into a very
22 traumatic experience and I am both physically and
23 emotionally scarred from that experience. The point
24 I would make is that I was just a relatively typical
25 person who had a mental health crisis, something that

1 could happen to anyone.
2 "When I first heard about the possibility of an
3 inquiry into a number of deaths within inpatient
4 settings, the aspect that affected me most was the
5 sudden difficult realisation that a number of the things
6 I had experienced whilst an inpatient were wrong. They
7 had also happened to a lot of other people and the thing
8 that probably upset me most was a realisation that I was
9 not to blame for my presentation whilst unwell. I feel
10 terrible that so many people have lost loved ones and
11 have experienced the same kinds of trauma that I did in
12 a place where I should have been safe and supported to
13 recover.
14 "Whilst I have long since recovered from my mental
15 illness, it was still very difficult to talk about what
16 happened to me. However, I felt, and still feel, that
17 I have a moral duty to speak up as there are so many
18 people who cannot. Today I am well but I am well
19 despite my treatment from Essex mental health services,
20 not because of it. No one should have to say that they
21 are a survivor of a system that completely failed to
22 keep them safe [as read]."
23 That is the end of the quote and we are very
24 grateful for that account.
25 From next year the Inquiry will hear evidence from

1 families, friends and patients about the detail of the
2 care and treatment that was or was not provided as part
3 of inpatient mental health services in Essex.
4 The Inquiry will also seek evidence from those
5 employed or engaged in the provision of this care. I've
6 outlined the relevant categories of staff from whom we
7 shall hear, from those on the front line through to
8 clinical managers and those in executive roles at the
9 relevant healthcare providers. The Inquiry has
10 identified many such individuals and it is in the
11 process of approaching them for assistance. The Inquiry
12 is pleased to note EPUT's assurance that it is doing all
13 it reasonably can to ensure that staff members engage
14 fully with the Inquiry.
15 The Inquiry will examine all relevant information
16 available to it; for example, serious incident reviews,
17 investigative work undertaken by regulators, the police
18 and the Health and Safety Executive, and material from
19 inquests in order to understand the extent to which
20 mental health services were being provided to an
21 appropriate standard during the period with which we are
22 concerned.
23 The Inquiry will rigorously scrutinise the
24 management and governance of mental health services
25 during the relevant period. It will look not only at

1 the way those services were being run but also at how
2 those in charge were learning lessons and implementing
3 changes where necessary. These are just examples of the
4 investigative work the Inquiry intends to undertake.
5 Put shortly, the Inquiry will be robust and unafraid in
6 its pursuit of evidence to enable it to meet its Terms
7 of Reference.
8 The Inquiry recognises the importance of the data it
9 will capture from the Trusts and others. Data has the
10 potential to provide insight to reveal trends and to
11 expose further areas of concern. The Inquiry will
12 instruct an expert statistician, as the chair said, of
13 appropriate standing and experience to assist it with
14 its work.
15 Issues of relevance to data collection are addressed
16 in the provisional list of issues at section F. This
17 identifies relevant lines of enquiry, including about
18 the data that was captured during an inpatient's stay on
19 a ward and how it was recorded and analysed at the time.
20 Issues concerning data adequacy, accuracy and
21 availability have also been raised in core participants'
22 responses to the provisional list of issues as well as
23 in the written opening statements. We will consider
24 what they have said with care.
25 The Inquiry also intends to hold seminars this

1 autumn and winter. They will provide an early and
2 efficient way to provide uncontroversial but important
3 background information. The intention is that they will
4 provide necessary context to the hearings that will take
5 place next year and will cover areas such as the
6 structure and organisation of NHS mental health services
7 on a national basis and in Essex over the period under
8 consideration as well as the legal and policy
9 background. We hope shortly to be able to give more
10 information about the seminars we have planned.
11 I now turn to speak about two different types of
12 undertakings. First, confidentiality undertakings.
13 The Inquiry will make disclosure of certain of the
14 documents in advance of hearings to core participants
15 and witnesses so they can prepare and provide witness
16 statements and other information as necessary. The
17 documents may well contain sensitive information or
18 otherwise be confidential. Those involved with the
19 Inquiry are entitled to expect that the Inquiry itself
20 and those to whom it provides disclosure will treat that
21 disclosure responsibly and securely. That is why
22 the Inquiry requires everyone to whom it provides
23 documents to sign a confidentiality undertaking. The
24 undertaking requires that the documents that have been
25 disclosed are kept secure and confidential, can only be

1 used for the purposes of the Inquiry and directly
2 related legal proceedings and can only be discussed with
3 the Inquiry or others who have signed an undertaking.
4 The Inquiry takes the confidentiality of its material
5 extremely seriously and there will be grave consequences
6 for anyone breaching an undertaking.
7 The second type of undertakings are those from
8 Trusts and regulators. The Inquiry intends to use all
9 means at its disposal to ensure that important evidence
10 is heard. Where necessary, it will deploy its statutory
11 powers to compel evidence. In addition, the Inquiry
12 wishes to take all appropriate steps to encourage people
13 to come forward with relevant evidence. It therefore
14 considers it necessary to seek limited undertakings from
15 the relevant healthcare providers and regulators that
16 are designed to facilitate the flow of evidence to the
17 Inquiry. What this means is that the Inquiry is asking
18 the healthcare providers and regulators to agree that
19 they will not take action against individuals such as
20 staff members in certain limited circumstances relating
21 to their provision of information to the Inquiry or
22 their failure to have come forward to provide it in the
23 past. Such undertakings would mean that a staff member
24 does not need to worry about being held accountable for
25 breaching confidences if they provide sensitive

1 information to this Inquiry or if they come forward now
2 with information about an incident occurring some time
3 ago and which they should have reported at the time.
4 The Inquiry has been in talks with the relevant
5 healthcare providers and regulators on this issue. We
6 reiterate that staff are encouraged to come forward to
7 share their experiences and that they have the support
8 of the Inquiry in doing so.
9 Turning now to the Inquiry's hearings, I hope that
10 those attending will now be aware of the protocol and
11 code of conduct for this September hearing. Both are on
12 the website. We will be hearing core participant
13 opening statements this week, followed, as I've said, by
14 two weeks of commemorative and impact evidence. There
15 will be no hearing tomorrow afternoon. This short pause
16 has proved necessary in order to enable legal
17 representatives of core participants to be present and
18 fully engage in the opening statements section of the
19 hearing. Opening statements will conclude on Wednesday
20 morning.
21 I would like to say something now about the
22 commemorative and impact evidence commencing on Monday,
23 16 September. I have had the great privilege of reading
24 the statements that have been provided and viewing the
25 videos and photographs too. On behalf of the Inquiry

1 team, I would like to stress three particularly
2 important points.
3 First, next week, when we start to hear this
4 evidence, will mark the most important stage in the
5 Inquiry so far. It is when we will hear about the lives
6 of those who have died from their families and friends.
7 Second, we will be hearing about people who were
8 deeply loved, from people giving evidence with dignity
9 and pride.
10 And, third, those coming forward are doing so with
11 immense courage. We do not underestimate the difficulty
12 of doing this and I want them to know that we thank them
13 and we will support them.
14 A further virtual hearing is planned from
15 25 November to 5 December this year. The Inquiry
16 recognises that not everyone who might wish to would be
17 ready to give commemorative and impact evidence at
18 this September hearing. The November hearing provides
19 another important opportunity for the Inquiry to hear
20 from them. We will provide details about the November
21 hearings shortly.
22 We then move on to 2025 and 2026. This is the stage
23 when the Inquiry will hear further evidence from the
24 families and friends of those who have died, from
25 patients and former patients, from those who work in

1 mental health settings and from a range of other
2 witnesses who can help us understand what has been
3 happening in inpatient mental health services in Essex
4 and how things need to change. These future hearings
5 will be evidential hearings to address the issues raised
6 in the Terms of Reference.
7 There will be hearings throughout 2025 and into 2026
8 as follows: in 2025, from April 28 to May 15, July 7 to
9 the 24th, October 6 to the 23rd; in 2026, from
10 February 2 to the 19th, April 20 to May 7, July 6 to the
11 23rd.
12 The Inquiry will provide details of what each
13 hearing will cover well in advance. We intend to fix
14 the schedule of witnesses as far in advance of each
15 hearing as possible. Our current intention is also to
16 circulate an electronic bundle of evidence of relevance
17 to each specific hearing to core participants.
18 We wish to provide as much certainty as possible
19 about the Inquiry's hearings and arrangements. In this
20 way, we hope to assist those involved with their own
21 planning. These dates are therefore fixed, barring
22 unforeseen circumstances.
23 The Inquiry considered that an inquiry which has an
24 Essex focus should hold its opening hearing in Essex.
25 However, we are aware of the real sensitivities

1 concerning a number of locations in this county. In
2 short, they include locations where individuals took
3 their own lives or which have connections to Government,
4 health or other bodies that may be involved in the
5 matters that may be investigated by the Inquiry. In
6 securing a venue for the hearings in 2025 and 2026 we
7 have borne this in mind.
8 In addition, we have been determined to find
9 a hearing centre that is suitable for holding an
10 investigation into matters of such sensitivity which
11 will, as far as possible, be conducive to receiving the
12 best evidence from a full range of witnesses. It needs
13 to be neutral with sufficient and appropriate space.
14 This must include trauma-informed space. In other
15 words, a venue allowing access to emotional support and
16 that is considerate of those who have experienced or
17 continue to experience trauma, avoiding links that may
18 be triggering for witnesses and attendees.
19 The Inquiry has therefore decided on a venue in
20 London, with good transport links to Essex, with the
21 set-up and facilities that are required to ensure that
22 this Inquiry supports those engaging with it and runs
23 efficiently. It is a neutral venue with ample space,
24 good facilities and natural light. It is Arundel House,
25 near Temple Underground Station, and we will provide

1 further information about it and indeed about the
2 hearings in due course.
3 It will not be necessary to attend hearings to view
4 what is taking place. Hearings will be filmed and
5 a live feed will be available for those wishing to
6 follow proceedings in that way. A secure link will be
7 made available to core participants and their legal
8 representatives should they wish to access the hearings
9 in that way.
10 Finally, on the question of venues, I'd like to say
11 that the Inquiry may hold a further hearing or hearings
12 in Essex. We will liaise closely with core participants
13 and others about this. We intend to ensure that we
14 create the right environment for this Inquiry. We place
15 the well-being of those involved in the Inquiry's work
16 at the centre of the evidence-gathering process and
17 acknowledge that the giving of evidence may be
18 challenging. Our aim is that the Inquiry and its
19 hearing spaces are safe spaces. Every person engaging
20 with the Inquiry should be able to share their
21 experiences to the best of their ability. We will wish
22 to engage with core participants and their legal
23 representatives about the best way to achieve this.
24 The Inquiry will put in place special measures and
25 support to ensure that those who are vulnerable are

1 looked after properly. Special measures are adjustments
2 at hearings which may be made for witnesses to ensure
3 they are able to provide their best evidence. Further
4 information about this can be found in the Inquiry's
5 vulnerable witness and restriction orders protocols.
6 The terms of reference require, at paragraph 9,
7 that -- and I quote:
8 "Those engaging with the Inquiry are to be treated
9 by all parties with courtesy."
10 We ask that Inquiry participants respect the right
11 of all witnesses to be heard. We understand how
12 difficult it may be to hear some of the evidence and the
13 anger and the distress to which it may give rise,
14 particularly in the hearings from next year. But all
15 witnesses must be heard and treated with courtesy, no
16 matter what subjects they are addressing, if the Inquiry
17 is to be able properly to fulfil its role.
18 Chair, you have referred already to the terminology
19 the Inquiry team plans to use in connection with the
20 deaths and other matters you are considering. The
21 Lampard Inquiry document on terminology and
22 abbreviations is available on the website. It will be
23 reviewed and expanded after this hearing. Although the
24 language set out in the document is not mandatory, as
25 witnesses are free to express themselves as they choose,

1 it is helpful to have a reference document explaining
2 the terms the Inquiry will be adopting. We will keep
3 this document under review and would be happy to engage
4 with core participants and others who have suggestions
5 for its development.
6 Chair, a written version of this opening statement,
7 my opening statement, will go on to the website with
8 hyperlinks to most of the documents to which I have
9 referred.
10 I conclude by saying that the Inquiry's legal team
11 recognises the urgency and importance of the task upon
12 which we are embarking. We will be dedicated,
13 determined and thorough in our pursuit of the truth. We
14 look forward to working with core participants and
15 others to advance the work of the Inquiry. We look
16 forward to assisting you throughout so that you are able
17 to meet your terms of reference and to deliver a strong
18 report with robust recommendations.
19 Chair, that is all for this morning. The hearing
20 will resume this afternoon with Mr Snowden's opening
21 statement. Should we say at 2.20 pm to allow people
22 a full hour over lunch? 2.20 pm.
23 THE CHAIR: Thank you. Thank you very much, Mr Griffin.
24 (1.18 pm)
25 (The short adjournment)

1 (2.23 pm)

2 THE CHAIR: Mr Snowden, thank you.

3 Opening statement by MR SNOWDEN

4 MR SNOWDEN: Thank you. Chair and all those present here
5 and those watching online, good afternoon. I'm
6 Steven Snowden. I'm leading counsel, instructed with
7 a small team of barristers by Hodge Jones & Allen and
8 the team there, led by Nina Ali, the partner leading
9 this case, to represent 52 core participants who
10 instruct them. We also represent other clients who are
11 not or not yet afforded core participant status.
12 Speaking on behalf of a large group is never easy
13 but we do our best and we trust, Chair, that you will,
14 so far as possible, allow each to have their own voice,
15 expressed through their witness statements and evidence,
16 as and when they are called to give it as this Inquiry
17 proceeds. We are very grateful for the opportunity to
18 speak first after your Counsel to the Inquiry.
19 Some of my thunder has been stolen, but I was going
20 to start with two numbers: first, 24 years, 2000 to the
21 end of 2023, and, second, the fact that this Inquiry is
22 investigating up to or was believed to have been
23 investigating up to 2,000 deaths which may have been
24 preventable. I'll say that again: 24 years and 2,000
25 deaths which may have been preventable. I said two

1 numbers. There's a third because that translates to
2 almost 100 deaths a year.
3 Now, Chair, we heard what you said this morning and
4 absolutely concur that having the correct numbers and
5 understanding as best we can of whether that 2,000
6 figure is right or not is crucial. It would be helpful
7 to the Inquiry and it would be helpful to carry through
8 the strength of the recommendations you make if we can
9 see the magnitude of the numbers affected. But, having
10 heard, Chair, what you said this morning, that 2,000
11 deaths may or may not be an underestimate, given that
12 your Inquiry covers a greater number of years and
13 a greater constituency, if I can put it that way, than
14 the previous informal Inquiry did, it seems likely it
15 will be at least that number, so I proceed on that basis
16 for now.
17 But those numbers are simply shocking. I say that
18 on behalf of all of our core participants and I'll say
19 it again: shocking that those deaths have occurred.
20 Each death, as we know, leaves a family bereft and,
21 insofar as each death was preventable, needlessly
22 bereft, which is utterly shocking.
23 Our cohort of core participants have said for years
24 that there has been woefully sub-standard, inadequate,
25 unacceptable care, clinical care practice. They've said

1 poor care, poor treatment decisions, statistically high
2 levels of suicide, preventable deaths, lack of
3 continuity between inpatient and outpatient care, abuse
4 and maltreatment.
5 Chair, we recognise and are grateful that the very
6 fact of there being a statutory inquiry being convened,
7 as we set out in writing in our written submissions,
8 which we understand you'll publish shortly, is itself
9 a recognition that there is something of real concern in
10 mental healthcare in Essex and continues to be so.
11 We together say and we believe you will find that
12 each of those deaths was not an accident in the sense in
13 which we use that word. An accident in its true sense
14 is something which is avoidable. It's an avoidable
15 misfortune. These were avoidable deaths, we believe you
16 will find. Inquest juries and coroners have repeatedly
17 said so. Health Ombudsman reports have repeatedly been
18 critical. Many of these deaths were in fact criminal,
19 as established by the guilty plea that your Counsel to
20 the Inquiry referred to earlier, to charges arising from
21 11 deaths. These were preventable deaths.
22 Then we put the context on it, Chair, if you'll
23 allow me to do so in the language my clients would like
24 me to use. In the ordinary course of events, any death
25 naturally brings sorrow and mourning and feelings of

1 loss, but these were preventable. We pause for a moment
2 and imagine how that feels. A parent trusts their
3 child, let's say, to the state, to the NHS. They are
4 devastated at the loss of their child. They are
5 destroyed at the guilt they feel, having trusted their
6 loved one to others and been let down. They are then
7 dehumanised by the way they are dealt with in the
8 aftermath of that death. To those three Ds, we then add
9 that they are universally disgusted by the cover-ups and
10 the failure to learn lessons, with the result that
11 others suffer the same avoidable loss later.
12 They universally encourage me to say to you that the
13 complete trust they placed -- these families and these
14 patients -- in the state and in the NHS bodies, which
15 are the emanation of the state, and in the clinicians
16 and in the mental health staff has been broken. So we
17 welcome this Inquiry, I say on their behalf, but at the
18 outset I am going to give an illustration of that broken
19 trust because this, we say, is the Inquiry that almost
20 did not happen. I have a graphic to illustrate.
21 Chair, you may or may not have seen that on
22 Saturday, at the weekend, The Daily Telegraph and
23 The Times and then other media bodies picked up and ran
24 the story which I'm showing on the screen now.
25 A special report:

1 "Revealed: how Dorries tried to isolate mother
2 seeking justice for her dead son."
3 Chair, you will see that those who are in the room
4 and I hope those who are watching online, whom
5 I represent, can see that we're not afraid to take you
6 to this. The Telegraph report says this:
7 "A Health Minister attempted to block a full public
8 inquiry into suspicious deaths in mental health
9 hospitals, The Telegraph can reveal. Leaked WhatsApp
10 messages revealed that Nadine Dorries, a Conservative
11 Health Minister under Boris Johnson, sent a message to
12 Matt Hancock, then Health Secretary, saying she was
13 picking off families whose relatives had died as a way
14 to ensure that a full public inquiry into suspicious
15 deaths was not launched [as read]."
16 Chair, if we look at the second page, please, you'll
17 see there the Daily Telegraph, in its graphic way --
18 thank you for highlighting -- has picked out WhatsApp
19 messages in a manner you'll see them on a telephone.
20 You'll see attributed to -- as I say, this was run in
21 both The Times and The Telegraph -- to Nadine Dorries
22 MP, writing to Mr Hancock:
23 "Sorry to bother you about this on a Saturday but
24 I have a petitions debate [there's an explanation for
25 what that is] on Monday [as read]."

1 And these messages are, Chair, you will note, in
2 November 2020, which is the stage at which so many of my
3 clients and others had been campaigning and campaigning
4 and campaigning for a public inquiry and a debate was
5 about to be held in Parliament. You will see that
6 Ms Dorries' WhatsApp carries on:
7 "The Linden Centre Inquiry, the scope was very
8 narrow, half a dozen cases, but as a young boy died
9 there two weeks ago, I'd like to extend the scope to the
10 present day [as read]."
11 Now, that's laudable. But we carry on beneath that,
12 and if we move just a couple of lines down:
13 "Melanie Leahy, one of the mums, has the weight of
14 the media behind her and I'm sure she's being advised by
15 a journalist as she is still calling for a full public
16 inquiry [as read]."
17 Pause and digest what comes next:
18 "We aren't going there and I'm picking off the other
19 families and speaking to them one by one to get them on
20 side to isolate her. But it's incredibly sensitive and
21 difficult as all of these young boys died in very
22 suspicious circumstances [as read]."
23 Mr Hancock replies:
24 "Okay, I will back your judgment on all of these
25 sorts of cases [as read]."

1 Ms Dorries replies, and again we see at the end of
2 a WhatsApp message, "MH [shorthand for mental health] is
3 so effin political [as read]".
4 We can see further -- if we close the zoom-out box
5 for a moment, if that's possible -- the final lines of
6 the report immediately above:
7 "Ms Dorries says [three lines up from the end of the
8 paragraph above], 'I want this on the road before recess
9 so that the Government keeps control'. Mental health is
10 so effin political'. She also writes, 'I want out of
11 mental health asap. It's demoralising' [as read]."
12 Now, Chair, I hope you'll forgive me if, at the
13 request of those families I represent, I say just
14 a couple of things about that. First, those who
15 campaign and campaign and campaign against what they see
16 as iniquities perpetrated on them by the state are often
17 caricatured as conspiracy theorists. They're often
18 caricatured as those who say, "Somebody is trying to
19 stop me getting what is right". Chair, we say that is
20 part of what's occurred here. We trust our politicians
21 and agencies of the state to look after us, so those
22 families I represent feel disgust and revulsion at this
23 dreadful betrayal of their trust. They campaigned for
24 years to get a full proper statutory inquiry and it
25 seems behind the scenes politicians are agitating and

1 turning one against the other to achieve a different
2 result.
3 Now, our belief, Chair, and we fear that you will
4 find, is that failures are continuing, lives are
5 continuing to be lost. Chair, you and your Counsel to
6 the Inquiry have correctly talked about the need to
7 proceed with all due speed to ensure thoroughness
8 because we believe lives continue to be lost. So we
9 pause for a moment and wonder whether, by denying a full
10 proper statutory inquiry in late 2020 and the fact that
11 at least three years have now passed before we have the
12 first hearings in this full statutory Inquiry -- quite
13 what effect those three years of delay have had in terms
14 of further harm, suffering, injury and loss, and that
15 those I represent invite you to consider as disgraceful.
16 Oddly, Nadine Dorries at the time held a post of
17 Minister for Patient Safety, Mental Health and Suicide
18 Prevention. What she did, we say, is a classic example
19 of cover-up. It's a classic example of campaigners
20 being actively undermined, a deliberate divide and
21 conquer strategy, when all these families sought was the
22 truth.
23 So we do welcome your and your Counsel to the
24 Inquiry's statement that families and patients will be
25 at the heart of this Inquiry, but the story broken at

1 the weekend demonstrates that others have professed
2 similar sentiments which turn out to be empty. So we
3 emphasise again that we look forward to building trust
4 with this Inquiry to ensure that things can be different
5 in the future.
6 We do ask in due course -- we'll perhaps make
7 a formal request in due course -- that Ms Dorries and
8 Mr Hancock be called to give evidence, but that's
9 a matter for another day.
10 I'm going to move on to talk about something else.
11 Part of this is the history of how we came to be here,
12 and again your Counsel to the Inquiry, Chair, has
13 explained the campaigning and the steps that were taken
14 to bring us to this point. The start of these public
15 hearings is, we recognise, one more step in what has
16 been a long and arduous road for the patients of the
17 Essex Trusts and for the families of those who died.
18 You, Chair, understand -- I know you do -- that the call
19 for an inquiry followed repeated serious concerns raised
20 about the standards of care in Essex NHS Trusts by
21 coroners, by the CQC, by the Parliamentary and Health
22 Service Ombudsman amongst others.
23 Now, it seems to us extraordinary in the
24 21st century that an NHS Trust should have been
25 prosecuted in a criminal court, as described by your

1 Counsel to the Inquiry, for failing sufficiently to
2 manage environmental risks in its mental health wards,
3 with the results that 11 patients died by using ligature
4 points, but that is exactly what happened. The Trusts
5 were prosecuted, pleaded guilty and sentenced in the
6 summer of 2021.
7 For the avoidance of doubt, we and the families
8 I represent say that avoidable deaths by use of ligature
9 points is only one aspect of the many shortcomings of
10 the Essex Trusts in the period you will be
11 investigating. A number of the others were graphically
12 illustrated in the Channel 4 Dispatches documentary
13 which aired in October 2022, which, we say, shows
14 dreadful, brutal treatment.
15 It further seems extraordinary in the NHS in the
16 21st century that, when a non-statutory inquiry into the
17 shortcomings of the Essex Trusts begins, rather than
18 there being full wholehearted co-operation to allow
19 a swift successful investigation for things to be put
20 right, instead that Inquiry is thwarted by lack of
21 co-operation and lack of engagement. We've given you
22 three examples of that in our written submissions, our
23 written opening, but as those haven't yet been
24 published, you will forgive me illustrating them and
25 reading out loud three examples of those on the issue of

1 engagement. The Trust did email a number of current
2 employees, but surprisingly, with a number of former
3 employees for whom it didn't have a current email
4 address, it didn't send letters by post.
5 We understood from a report of a Westminster Hall
6 debate that, of the many thousands of current and former
7 employees contacted by the previous iteration of this
8 Inquiry, it is understood that only 11 had agreed to
9 give evidence by January 2023.
10 Finally, Dr Strathdee, as your counsel has reminded
11 you and reminded us all, Dr Strathdee, chair of the
12 non-statutory Inquiry, considered a statutory inquiry,
13 such as yours, was necessary due to the lack of
14 engagement and the lack of powers of compulsion. She
15 described that fewer than 30% of what she thought were
16 essential witnesses had agreed to attend evidence
17 sessions.
18 Before I proceed further, though, we're going to
19 take a sidestep. I would like to set the scene because
20 the evidence the families have given and will give of
21 being let down badly by institutions of the state is not
22 new. So taking a sidestep from our written opening, in
23 this oral opening I'm going to emphasise two words which
24 we hope will resonate throughout the rest of this
25 Inquiry. The first is "candour", which is not a word in

1 usual usage but it is the quality of being open, honest
2 and frank, and that we invite you to find -- we will
3 invite you to find -- is what was lacking in the
4 responses of the Trusts towards the concerns of the
5 patients, towards the concerns of the families.
6 The second word I'm going to invite you to consider
7 and think about for a moment or two is the word
8 "justice". Again not common usage. Lawyers use it, we
9 use it. I'm going to ask you to go back some distance
10 in time to 2017 to Bishop Jones, the Bishop of
11 Liverpool, and his report into the Hillsborough tragedy.
12 What I invite you to consider is that those I represent
13 can be described as seeking justice, and the purpose of
14 this Inquiry is to achieve justice, not through the
15 courts but through the statutory inquiry process.
16 Our core participants have fought and fought and
17 campaigned and asked and enquired and sought clarity and
18 sought redress and demanded an inquiry after doors are
19 slammed in their faces, and their overwhelming common
20 experience is of having been ignored, sidelined and
21 belittled by those in authority. Without exception,
22 they are all individuals who have placed their trust in
23 medical professionals and then placed their trust in
24 other authorities and in Government to get it right and
25 their trust has not been met. Individuals have been

1 disempowered.

2 So I'd like to take you back to the Hillsborough

3 story for a moment and, as I say, the former Bishop of

4 Liverpool, the Right Reverend James Jones, was

5 commissioned in the wake of the final Hillsborough

6 inquest by the then Home Secretary to report on the

7 experience of ordinary members of the public who had

8 been the victims of the Hillsborough tragedy. He

9 produced a report in November 2017 entitled "The

10 patronising disposition of unaccountable power", which

11 is a very wordy title but we'll explore what it means in

12 a moment. I'd like, if I may, to quote two paragraphs

13 from his introduction. He writes of his exploration

14 with the Hillsborough families. He says:

15 "Over the last two decades, as I've listened to what

16 the families have endured, a phrase has formed in my

17 mind to describe what they have come up against every

18 time they have sought to challenge those in authority:

19 the patronising disposition of unaccountable power.

20 Those authorities have been in both the public and the

21 private sectors [as read]."

22 He goes on to say:

23 "The Hillsborough families are not the only ones who

24 have suffered from that patronising disposition of

25 unaccountable power. The families know there are others

1 who have found that when, in all innocence and with all
2 good conscience, they have asked questions of those in
3 authority on behalf of those they love, the institution
4 has closed ranks, refused to disclose information, has
5 used public money to defend its interests and has acted
6 in a way which is both intimidating and oppressive. And
7 so the Hillsborough families' struggle to gain justice
8 for 96 [he says] has a vicarious quality so that
9 whatever they can achieve and call into account those in
10 authority is of value to the whole nation [as read]."
11 That we invite you, Chair, to consider is very much
12 the sense of what we have been told and we believe you
13 will be told time and time again by those I represent.
14 That has been their experience too.
15 We emphasise, using the words they'd like me to use,
16 that that is simply wrong. It's not a lawyer's
17 definition of a crime or of negligence, but to any
18 right-thinking person it is wrong that that can happen.
19 It shouldn't have happened.
20 So how do we describe the justice that our families
21 are looking for? First, it needs to be based on
22 knowledge. We are grateful that you and your team of
23 counsel recognise that full access to the facts and
24 information must be the foundation of achieving justice
25 in this case. Those I represent are demanding to know

1 what actually happened -- in some, it's individual
2 cases. For all, it is on the wider stage of the
3 structure and the organisation and the response of the
4 Trusts -- and then what happened or how it came to be
5 that things were covered up afterwards when they began
6 to ask perfectly proper questions.
7 They want to see and hear the truth, the unvarnished
8 full truth, of what happened to their loved ones. They
9 want to know why and how it was allowed to happen to
10 their loved ones. There needs to be recognition and
11 accountability and, again, there needs to be no way that
12 this can happen again. By "this", we mean not only the
13 horror of each individual's case but the inaction and
14 inertia and failure to learn that has followed each.
15 I'm going to come back to the Reverend James Jones
16 now just for a moment. In his report he recommended
17 a charter for families bereaved through public tragedy
18 and since 2017 various public bodies have signed up to
19 it as a code of how to behave when their own behaviour
20 is called into question. And we would like to hear from
21 each of those who follow me in their opening submissions
22 that each of the public bodies here has committed to
23 that charter and will follow through its advice, because
24 this should not be an inquiry that deals with bodies who
25 are closing doors in our faces, but with public bodies

1 who positively welcome the opportunity to engage and to
2 be frank and who welcome it genuinely rather than paying
3 it only lip service.
4 This Inquiry is investigating a public tragedy in
5 exactly the same sense as Bishop Jones has been
6 describing, so the things he says about the perspective
7 of the bereaved, the injured, must not and cannot be
8 lost. So his charter contains six points. The first is
9 this:
10 "In the event of a public tragedy, the body is to
11 activate an emergency plan to deploy its resources to
12 rescue victims [as read]."
13 Now clearly what we mean here is to remedy so far as
14 possible. But it carries on:
15 "... to support the bereaved and to protect the
16 vulnerable [as read]."
17 We pause and we comment and we wonder whether that
18 in fact will be established as ever having happened in
19 many of the cases that you will investigate.
20 Second, point 2:
21 "Place the public interest above your own reputation
22 [as read]."
23 So, again, we encourage those public bodies, as,
24 Chair, I know you do, and we hope we will hear words
25 that say they will. Not to be defensive, not to

1 obstruct this process, not to withhold documents, not to
2 be slow; to comply, to volunteer, to be proactive and to
3 be helpful.
4 Point 3 of Bishop Jones' recommendations:
5 "Approach all forms of public scrutiny, including
6 public inquiries [he says], with candour, in an open,
7 honest and transparent way, making full disclosure of
8 relevant documents, material and facts. Our objective
9 should be to assist the search for the truth, to say we
10 accept that we should learn from the findings of
11 external scrutiny and from past mistakes [as read]."
12 So, again, we invite absolute clarity from those
13 public bodies involved in this Inquiry that they will
14 indeed assist the search for the truth and actively do
15 so.
16 Bishop Jones' fourth point:
17 "Avoid seeking to defend the indefensible or to
18 dismiss or disparage those who may have suffered where
19 we've fallen short [as read]."
20 Let me read that again. I'm sorry, I stumbled over
21 the words:
22 "Avoid seeking to defend the indefensible or dismiss
23 or disparage those who may have suffered when we have
24 fallen short [as read]."
25 Again, Chair, we believe you will hear reams of

1 witness evidence that public bodies have sought to
2 defend the indefensible and they have sought to dismiss
3 and disparage -- we saw an example five minutes ago --
4 those who suffered.
5 Bishop Jones' fifth point:
6 "Ensure all members of staff treat members of the
7 public and each other with mutual respect and with
8 courtesy. Where we fall short, we should apologise
9 straightforwardly and genuinely [as read]."
10 Again, we don't believe that's happened. We look
11 forward to your Inquiry, Chair, and to seeing that
12 co-operation from the public bodies here.
13 Point six, the final one of his six:
14 "Recognise that we are accountable [so this is
15 speaking to the public bodies] and open to challenge.
16 Say that we'll ensure that processes are in place that
17 allow the public to hold us to account for the work we
18 do and the way in which we do it and that we will not
19 knowingly mislead the public or the media [as read]."
20 We pause there because an inquiry which makes no
21 change is pointless and, Chair, we know that you and
22 your counsel team are committed to achieving change
23 insofar as it's possible. We do say that public bodies
24 recognising that they are accountable and the process of
25 being held to account by you is going to be the first

1 step in learning and changing and in putting right.
2 So, against that background of Bishop Jones, what do
3 the families and the bereaved who I represent want?
4 It's very simple: no more unnecessary deaths.
5 Articulated in different words in different evidence
6 from different witnesses, they want good care for the
7 next generation of mental patients. An expression,
8 "I don't want to see this happening to any other family
9 ever"; and from another one, "I want change. I want my
10 answers but I want meaningful change. The whole system
11 needs a radical shake-up [as read]". These families
12 have to have their voices heard. They want good, safe
13 hospitals with staff that care. And that seems so
14 simple and so obvious to say, but I juxtapose that for
15 one moment with the finding of an inquest jury that the
16 young man concerned was subject to a series of multiple
17 failings and missed opportunities over a period of time
18 by those entrusted with his care. We look forward to
19 the day when inquest juries in Essex won't say that
20 anymore.
21 And the families want accountability. There are,
22 they believe, a number of individuals who have fallen
23 below acceptable standards by any stretch of the
24 imagination. We recognise, as your counsel recognises,
25 as you recognise, Chair, that it's no part of a public

1 inquiry to find criminal or civil blame, fault, but,
2 Chair, we endorse what your counsel reminded you of,
3 which is that you can be strongly critical, short of
4 finding criminal or civil blame, and we will encourage
5 you to do so.
6 Now, Chair, if you'll forgive me, I am I hope not
7 going to take long, but as our written opening is not
8 yet up on the Inquiry's web page and many in the room and
9 many watching online will not have read it, I'm going to
10 briefly summarise it.
11 We have appended to the back of it a chronology,
12 a long list of dates and events, where we have begun,
13 from what we know, from the limited resources we have,
14 to list this catalogue of catastrophic failings. But it
15 is only based on what we know. It's based on
16 information that is in the public domain and it is only
17 the beginning. We've hardly scratched the surface in
18 what we, as the collective knowledge of a body of
19 52 core participants and others, currently know.
20 We recognise that the job of this Inquiry will
21 include, as your counsel recognises, exploring and
22 understanding the background material that we don't know
23 and we expect a much more full timeline of failures --
24 of some good practice. Chair, you're entirely right,
25 you may well find good practice -- but a failure upon

1 failure upon failure, which of themselves evidence an
2 inability to learn, an inability to recognise what's
3 gone wrong and an inability properly to correct it so
4 that the failures continue.
5 Chair, with your permission, what I'm going to do
6 briefly is outline three things: first, what our clients
7 expected and what we believe anyone who uses NHS
8 services expects from the Essex Trusts; second, I'm
9 going to very briefly outline what they in fact got,
10 what actually happened contrary to their expectations;
11 thirdly, I'm going to give an indication of what we hope
12 for from this Inquiry, which chimes with, Chair, what
13 you yourself have said and with what your counsel said.
14 First, what do we expect? What did my clients and
15 the core participants I represent expect and what were
16 they entitled to expect from these Trusts? We put it
17 this way: when we entrust our health and that of our
18 loved ones to the care of an NHS hospital, we are
19 expecting to be taken care of and we are expecting to
20 recover. We expect to recover because mental illness is
21 not a terminal diagnosis. Even if it carries risk to
22 life or may have a life-long impact, fundamentally we do
23 not expect our loved ones to die while undergoing
24 treatment for psychiatric illness. Instead we expect
25 their symptoms to get better and, ideally, to resolve.

1 We do not expect them to be traumatised or
2 retraumatised by ill-treatment and abuse they suffer or
3 that which they witness while under NHS care. We do not
4 expect their physical health to be poorly treated or for
5 them to suffer avoidable injury while on an NHS ward.
6 Yet they say and will say in evidence to you that this
7 happened again and again to patients in the care of the
8 Essex Trusts. What is more, every time it's happened,
9 there was an opportunity to prevent further death and
10 ill-treatment, but lessons weren't learned, practices
11 didn't change, poor decisions were repeated, the
12 tragedies continued and they continue to this day.
13 The expectation of our clients: the first one worth
14 highlighting is the entitlement to be treated
15 competently and with dignity, and the law, the common
16 law, entitles us to that, to be treated with medical
17 treatment of a standard that a reasonably competent
18 medical professional would provide. It's called a "duty
19 of care". Chair, we know that. Your counsel knows
20 that. It's a phrase that's bandied around more widely
21 now, but it's helpful, in part because it resonates with
22 a sense of care and compassion for mental treatment of
23 patients. So it's both a moral duty and a legal duty,
24 and that duty has to be discharged by the NHS Trusts
25 broadly but by individual healthcare workers too.

1 On top of that, Chair, as we've set out in our
2 written opening for you, there are a number of duties
3 imposed and expectations arising from the European
4 Convention on Human Rights. The first of those of
5 course and the most significant in this context is the
6 right to life. As long ago as 2009 a case went to the
7 House of Lords, a case called Savage v South Essex
8 Partnership NHS Foundation Trust, and I'll say very
9 little more about it given that one of the counsel
10 involved in that case is present and representing
11 another body in this Inquiry. But the House of Lords in
12 that case found that a state is under an obligation to
13 adopt appropriate measures for protecting the lives of
14 patients in hospitals.
15 It will involve ensuring that competent staff are
16 recruited, that high professional standards are
17 maintained and that suitable systems of work are put in
18 place. We anticipate this Inquiry will find that many
19 of the relevant systems of work simply were not properly
20 implemented in the years you're looking at in the Essex
21 Trusts; either accessing patient data, communicating
22 within the Trust, communicating between the Trusts and
23 other agencies -- from those more systemic issues right
24 down to fundamental ones of staff being asleep while on
25 duty.

1 We think the Inquiry is likely to find -- we will
2 encourage you in due course to find -- that some of
3 these systems of work probably weren't even suitable to
4 begin with. The House of Lords is particularly aware of
5 the position of patients in mental health Trusts, saying
6 as follows:
7 "Plainly, patients who have been detained because of
8 health or safety demands that should receive treatment
9 in hospital are vulnerable. They are vulnerable not
10 only because of their illness, which might affect their
11 ability to look after themselves, but also because they
12 are under the control of hospital authorities. Like
13 anyone else in detention, they are vulnerable to
14 exploitation, abuse, bullying and all the other
15 potential dangers of a closed institution [as read]."
16 Those, we say, are the very dangers that manifested
17 themselves in many of the cases we believe you will be
18 looking at.
19 The House of Lords continued, identifying that there
20 is an obligation on health authorities and hospital
21 staff to do all that can reasonably be expected to
22 prevent patients from committing suicide.
23 The second right under the European Convention that
24 we would refer you to and we have referred you to in
25 writing -- and I'll skip briefly through these because

1 nobody is terribly interested in the law -- but these
2 are setting out the standards that most rational people
3 would expect for their patients, for their loved ones,
4 when they go to hospital: a right to freedom from
5 inhuman and degrading treatment and suffering.
6 We pause there and we will say that you, Chair, will
7 be able to discern what we will characterise as cruel
8 and inhuman treatment of inpatients being seen, for
9 instance, in the Channel 4 Dispatches documentary. We
10 anticipate you will find instances of that sort of
11 treatment being imposed on patients who are vulnerable
12 for all the reasons identified by the House of Lords in
13 the case I've just mentioned. Those reasons, that
14 vulnerability, ought to have led to those patients being
15 treated with more sensitivity rather than with less.
16 There are other aspects that we've identified in our
17 written opening and I won't mention them now, but we
18 move from the European Convention on Human Rights to the
19 Parliamentary Health Ombudsman, who, again, your Counsel
20 to the Inquiry referred us to this morning. He
21 identified in 2019 and before then that patients have
22 the right to be treated with dignity and respect in
23 accordance with their human rights and his report went
24 on to observe that his casework showed an individual's
25 human rights can be infringed as a matter of poor care.

1 The Ombudsman went on to say, "Patients who use mental
2 health services should be treated with dignity at all
3 times, particularly in times of crisis, when an
4 individual's illness may compromise their own ability to
5 understand their own actions. It is vital to the trust
6 we place in mental health services that they protect and
7 respect our human rights when we cannot do so for
8 ourselves [as read]".
9 Then we ask what the NHS itself says about the
10 legitimate expectations we have when we go to them as
11 a patient. And there's a constitution -- as you'll see
12 in our written submissions. Chair, you will know
13 this -- there is a constitution to the NHS and it begins
14 as follows:
15 "The NHS belongs to the people. It is there to
16 improve our health and well-being, supporting us to keep
17 mentally and physically well, to get better when we're
18 ill [as read]."
19 It carries on:
20 "The service is designed to improve, prevent,
21 diagnose and treat both physical and mental health
22 problems with equal regard. It has a duty to each and
23 every individual it serves and it must respect their
24 human rights [as read]."
25 Yet a further example of the legitimate expectation

1 that my families had in placing their loved ones in the
2 NHS' hands is Dr Strathdee's Rapid Review commissioned
3 earlier. Its ministerial foreword, so written by the
4 minister, says:
5 "Every patient deserves to be treated in an
6 environment where they receive high quality care and are
7 treated with dignity and respect, and their families and
8 carers deserve to be reassured that their loved ones are
9 safe."
10 Now, all of that seems blindingly obvious and none
11 of it would have needed to be articulated so explicitly
12 had things not gone so wrong.
13 We've also written that we expect -- and I won't
14 unpick this very much more verbally here and now because
15 everyone will be able to read, Chair, as you have
16 already read, our written opening. It is legitimate to
17 expect a duty of candour, not least because, in
18 October 2014, eight of the regulators of healthcare
19 professionals in the UK, including the General Medical
20 Council and the Nursing and Midwifery Council,
21 identified that all healthcare professionals have a duty
22 of candour. You'll recall it's being frank, it's being
23 honest, it's being open. It's not concealing or
24 obscuring.
25 We say there are two components to this duty and

1 this expectation that my core participants had of
2 placing their loved ones into the hands of the NHS --
3 two components: first, a duty to be open and honest with
4 patients if something goes wrong. There's advice in
5 those publications on how to apologise. The second
6 component, though, is to be open and honest within the
7 organisation itself so as to encourage a learning
8 culture by reporting adverse incidents that lead to harm
9 as well as near-misses. So our clients are entitled to
10 expect that the complaints and concerns they raised
11 would have been listened to and promptly addressed, and
12 we anticipate -- we fear that you will find that this
13 duty of candour has not been adhered to nor has the
14 learning culture been established.
15 Again, the Parliamentary Health Ombudsman -- as I'm
16 sure the Inquiry will look at in due course and your
17 leading Counsel to the Inquiry has mentioned already --
18 after a number of reports into serious issues and events
19 identified -- we identify as follows, that wherever
20 there is a -- so far as we've been able to find on
21 public web pages where there's a Trust's response to
22 concerns to prevent future deaths expressed by
23 a coroner, there is a statement which invariably reads
24 along these lines from the Trust:
25 "I'd like to begin by extending my deepest

1 condolences to the patient's family. This has been an
2 extremely difficult time for them and I hope my response
3 provides the patient's family and you [the coroner] with
4 assurance that the Trust takes their loss seriously and
5 has taken action to address the issues of concern raised
6 in your report [as read]."
7 Now, the mere fact that that is repeated and
8 repeated but at the same time the same sorts of
9 incidents recur and recur, those words ring hollow.
10 So we say that all this that's happened has betrayed
11 the trust placed in the Essex Trusts by our patients and
12 their families. Our patients are exhausted -- our
13 parents are exhausted, our families are exhausted and
14 upset from the experience, but they expected as
15 a minimum that healthcare professionals would treat
16 their relatives with compassion, decency and tenderness
17 that they would have done themselves. They did not
18 expect their loved ones to be belittled, ignored or
19 abused, and if it did happen, the least they then
20 expected was transparency, which they did not get.
21 So, Chair, that explains why, and I'm sure you
22 understand already, our clients have come to expect
23 little that is good and much that is bad due to what
24 they have experienced from figures of authority, from
25 Trusts, from those whose job it should have been to have

1 protected them, and, again, as graphically illustrated
2 earlier in my opening now and in the newspapers on
3 Saturday, from those politicians whose job ought to have
4 been to have ensured those steps were maintained.
5 So we hope and look forward to this Inquiry
6 demonstrating that your approach and your counsel's team
7 will be thorough, vigorous, trustworthy, capable of
8 meaningful change and demonstrating that to our clients.
9 But turning from the expectation to what actually
10 happened, I'm going to tread very lightly here because
11 you will in due course hear -- and over the next two
12 weeks you will hear details from families who have lost
13 loved ones. Instead of seeing their loved ones getting
14 better, as they'd hoped and expected, they had to watch
15 helplessly as they got worse. Their own efforts to
16 intervene would have been rebuffed by the Trusts and
17 they suffered the devastating loss of family members.
18 In our written opening for you, Chair, we have not
19 set out very many individual examples of the failings.
20 We have sought instead to categorise them and we've
21 identified no fewer than 20 areas in which we expect and
22 regret that you are probably going to find that there
23 has been a lack of care, there has been neglect, there
24 has been systemic failings, ranging from, on the one
25 hand, poor engagement with families, dismissive

1 language, lack of compassion, failing to involve
2 patients and families in decision-making, core
3 collaboration between agencies, discharging patients at
4 inappropriate times; and on the other side of that coin,
5 failing to admit them when in desperate need,
6 inaccessible out-of-hours services, a lack of
7 understanding of neurodiversity, which your leading
8 counsel touched on earlier this morning, lack of
9 understanding of addiction, inappropriate medication,
10 misdiagnosis, inappropriate use of restraint and force
11 and various other issues; combined then to make what is
12 bad worse by poor record-keeping, clerical errors,
13 inaccessible records, seeking to conceal and seeking to
14 change records. Those are examples of the sorts of
15 things we believe this Inquiry will hear about.
16 I'm going to give you, if I may, four further
17 slightly sharper examples. First, at a point in time
18 which I'm sure the Inquiry will itself investigate in
19 due course, the Conduct and Competence Committee of the
20 Nursing and Midwifery Council found that a nurse
21 employed by the Essex Trusts had said about a patient
22 words to the effect of, "He was just a drunk anyway", in
23 the context of his death, and she'd previously -- or
24 they had previously said words to the effect of, "If
25 I ever get like that, I want to go to Switzerland".

1 That individual's conduct was investigated after it was
2 discovered that they and others had attempted to cover
3 up by manufacturing a backdated care plan for a patient
4 after their death.
5 Quite separately, Chair, you will be aware of and no
6 doubt have in mind to investigate an inquest jury which
7 found that two groups of staff claimed to have unlocked
8 a door behind which another patient was dying and they,
9 the jury, concluded that both groups were correct, and
10 the only but horrifying implication of that is that the
11 first set of people to unlock the door simply closed it
12 and locked it again.
13 The fourth example, one I won't delve into any
14 deeper, but allegations of sexual abuse perpetrated on
15 inpatients and complaints about potential sexual abuse
16 or alleged sexual abuse not being appropriately followed
17 up. So those are the sorts of things that happened as
18 opposed to the expectation that our core participants
19 had.
20 So turning finally then to what we hope and expect
21 from this Inquiry. First of all, as I said, we look for
22 candour, we look for justice, we look for this Inquiry
23 to find the truth and we absolutely recognise that that
24 is the aspiration, the determination that you and your
25 counsel team share, and we're grateful for that. We

1 recognise, though, that if you merely report on what
2 happened and cannot effect change, then this Inquiry
3 will not have served its function. We recognise that
4 many other public inquiries have dealt with cumulative
5 failures on the part of the NHS, for instance the recent
6 report of the Infected Blood Inquiry. The chair,
7 Sir Brian Langstaff, noted:
8 "It is a sad fact that very few inquiries into
9 aspects of the health service or parts of it have ended
10 without recognition of the cultural need to change.
11 Over the past 50 to 60 years there have been several
12 inquiries of different types but nearly all have had
13 some such recommendation [as read]."
14 Sir Brian Langstaff, the chair of that Inquiry, went
15 on to say that the retiring Parliamentary Health Service
16 Ombudsman, Rob Behrens, to whom your leading counsel
17 referred earlier, reported as recently as March 2024 as
18 describing parts of his experience over the last seven
19 years as:
20 "... having to confront a cover-up culture within
21 the NHS, including the altering of care plans, the
22 disappearance of crucial documents after patients have
23 died and a robust denial in the face of documentary
24 evidence [as read]."
25 So, Chair, you know we've raised those concerns at

1 the very outset because we hope to be able -- we aspire
2 to be able to work with you and your counsel team to
3 find new and different ways to ensure that cultures can
4 change, that you make recommendations which don't simply
5 lie gathering dust.
6 We recognise that indeed in your own review of the
7 Leeds Teaching Hospital NHS Trust into the abuses
8 perpetrated by Jimmy Savile you said as follows:
9 "If there is any legacy from what we have learned
10 from the behaviour of Savile through this and other
11 investigations, it should be that both within and
12 outwith the NHS we all pay more attention to what is
13 going on around us; we become more courageous in
14 challenging behaviour that is unacceptable or that
15 concerns us in some way. Pretending not to see cannot
16 be an option. Acting with compassion requires a shared
17 commitment to protect and safeguard the most vulnerable,
18 to take responsibility, to raise concerns and to expect
19 and demand action by those in authority [as read]."
20 We're grateful for you having expressed those
21 thoughts in that way in your report into Savile. So we
22 do encourage you -- we're grateful to have heard you
23 earlier today saying you're going to keep an open mind
24 about how to proceed with this Inquiry. We encourage
25 you to use the full extent of your formal powers and

1 your influence to effect change in the recommendations
2 you make.
3 We recognise that you will be mindful, from
4 conducting previous inquiries and from the learning from
5 other inquiries, that it is hard to effect change and
6 that we need political will, we need practical
7 recommendations, and we need things that can tangibly be
8 done and then can be checked that they've been done, not
9 simply again left to gather dust.
10 So we, again, encourage you -- we've done so in
11 writing and I do so again publicly today -- to turn your
12 mind at the very outset to the question of ensuring the
13 efficacy of your recommendations, how we can be sure
14 they'll be done. Again, we offer to be involved as core
15 participants to assist in that insofar as we can.
16 We're grateful to have heard from you and from your
17 counsel that you want to foster an environment of
18 collaboration with and amongst the core participants and
19 it's only through that, we believe, that you may -- we
20 may together achieve meaningful change. We do believe
21 and hope that meaningful change is possible with the
22 right approach, with the right resources and with strong
23 recommendations.
24 My clients, my core participants, have to put their
25 faith in both the Government and in this Inquiry. We

1 hope that we have begun a path of that faith and trust
2 being earned but our final request, as I've put in
3 writing, is for this Inquiry and for the Government to
4 demonstrate their trustworthiness during the conduct of
5 this Inquiry and in implementing recommendations. I do
6 say, on behalf of all of my core participants, that we
7 look forward to working with you in this Inquiry. Thank
8 you.
9 THE CHAIR: Thank you very much, Mr Snowden.
10 MR GRIFFIN: Mr Snowden has referred to his written opening
11 statement. I can indicate that the written opening
12 statements of all core participants will be put onto
13 the Inquiry website after the close of opening
14 statements on Wednesday, so they'll be on the website
15 this week.
16 THE CHAIR: Thank you.
17 MR GRIFFIN: We reconvene tomorrow at 10.00 am, when we will
18 hear further opening statements.
19 THE CHAIR: Thank you very much. Thank you, everybody.
20 (3.34 pm)
21 (The hearing adjourned until
22 Tuesday, 10 September 2024 at 10.00 am)
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