

Wednesday, 11 September 2024

(10.00 am)

MR GRIFFIN: Chair, today is the last morning of opening statements from core participants. There will be no hearing this afternoon. The first opening statement this morning is on behalf of Essex Partnership University NHS Foundation Trust and will be given by Eleanor Grey King's Counsel.

THE CHAIR: Thank you.

MS GREY: Good morning, Chair. Could I just start briefly by offering apologies for the fact that I wasn't able to attend over the last couple of days? No disrespect was meant either to the Inquiry and, most importantly, to members of the families and other core participants who have been present over these last two days.

THE CHAIR: Thank you. I appreciate your apology. Thank you.

Opening statement by MS GREY

MS GREY: Chair, this is the opening statement of the Essex Partnership University NHS Foundation Trust, which I've referred to as "EPUT" or "the Trust" throughout these submissions, and if I use the term "we", it's because we are referring to EPUT, its board and its staff.

In these remarks, just to try to set them in context, we offer an apology for failing patients and

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EPUT's board and its staff are committed to doing all that they can to support you, Chair, and the Inquiry team to give patients, families and carers the answers that they have been waiting for.

In a statement provided as part of the Health and Safety Executive's prosecution of the Trust, the Trust chief executive, Paul Scott, expressed profound apologies on behalf of the Trust to the family and friends of those who tragically lost their lives and for the pain and distress they continue to experience. He went on to give a personal assurance to learning from patient deaths, the patient deaths which formed the focus of the prosecution, with a commitment to improve the environment, culture and care for all patients served by the Trust.

The Trust would like to repeat this apology and those assurances now to all the families and friends who have lost loved ones so that services locally are improved and the lessons learnt can be shared widely. We also offer condolences to anyone who has lost a loved one as a result of the failings in care within Essex mental health services. Each loss is a tragedy. We understand the importance of learning lessons from failings and from the Inquiry and to giving the fullest and most careful consideration to the Inquiry's findings

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their families when care and services have not been safe. We've acknowledged some of the main areas in which this has occurred. We've set out how the Trust and its board are responding now by referring to some of the key areas of ongoing change that we hope will be explored further in the Inquiry. The Trust board is committed to engaging candidly with the Inquiry. Finally we've set out some of the challenges faced by the Trust in their national context in the hope that the Inquiry might explore this context further and that it can be confident that learning from Essex will help to improve patient services across the whole of the UK.

But I want to start with an apology. This opening statement is delivered at an early stage of the Inquiry as part of the journey that we hope and anticipate will enable much learning and further change. That includes, I should say, further reflection by the Trust on the many important issues that have been raised by core participants' opening statements over the last two days.

But we do want to start by apologising, on behalf of both EPUT and its predecessor organisations, to everyone who has been failed: patients, family members and carers, by NHS mental health services in Essex. Patients, families and carers have a right to expect safe services and those were not always provided.

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and recommendations to reduce the risk of further losses.

EPUT is striving to improve care for those with mental health needs within Essex and the wider NHS, as the Inquiry proceeds and in the light of any recommendations and findings that it ultimately may make.

We fully appreciate that the information that will be shared and discussed during the Inquiry process will cause much distress for the bereaved and many current and former patients. The Trust, working with others within the wider NHS and alongside the voluntary sector, will do all it can to support people affected during this time and beyond.

Before the Trust addresses some of the issues and failings that the Inquiry will cover further, it may be helpful to give some context and background about the formation of the Trust. We then turn to failings, what has been done to improve care by the Trust so far and to the national picture.

Chair, I'm conscious that this repeats matters covered in our written opening statement, but we felt that it was important to put it into the public domain in full.

So if I turn to the current Essex Partnership

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1 NHS Foundation Trust, this was formed by the merger
 2 between the North Essex Partnership and South Essex
 3 Partnership University Foundation Trusts, NEPT and SEPT,
 4 on 1 April 2017. In the context of this Inquiry,
 5 looking back, as it will, over some 24 years, we, EPUT,
 6 are the corporate body which has taken over the
 7 responsibility of those preceding trusts and we refer to
 8 them all together as "the Trusts".

9 The creation of EPUT in 2017 and the appointment of
 10 Paul Scott as CEO in 2020 were all part of a process of
 11 widespread change to ensure the delivery of safe and
 12 therapeutic care to patients. This isn't the time to
 13 further outline the complexities of that past
 14 organisational history, but during the 24 years covered
 15 by the Inquiry's Terms of Reference, there have been
 16 widespread changes to the national mental health
 17 landscape of policy and resourcing, the regulatory
 18 landscape and in the commissioners to which the Trust
 19 has been held accountable. There have been changes to
 20 the physical sites from which services were provided and
 21 across the teams that delivered care. There have been
 22 significant changes to hospital configurations,
 23 services, IT systems, personnel and organisations in
 24 summary.

25 But EPUT now provides community health, mental
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1 a programme of wholesale change, with safety and
 2 engagement as the key drivers in the delivery of this
 3 vision. Prior to this and immediately following the
 4 merger of NEPT and SEPT, a programme of surveying and
 5 the removal of ligatures commenced as part of the work
 6 to bring those two organisations together.

7 Investment in the patient environment was also
 8 undertaken as well as the review and trial of new
 9 technologies, including body-worn cameras and other
 10 technical aids, such as Oxevision. While the Trust is
 11 clear about the scale of the challenges and is making
 12 significant progress, we know that there is more to do
 13 and much to learn from this Inquiry and from those who
 14 will share their experiences.

15 Addressing our engagement with this Inquiry, we are
 16 committed to working with this Inquiry and we are
 17 currently in the process of responding to its requests
 18 for statements. To date we've been asked to respond to
 19 five requests for witness statements or Rule 9 requests,
 20 to use the language of the Inquiry Rules, and we've
 21 filed five statements as a result, which we know
 22 the Inquiry will disclose to core participants and the
 23 wider public in due course. We expect to receive many
 24 further requests and we will respond as fully as we can.

25 The Inquiry has produced a detailed draft list of
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1 health and learning disability services to support more
 2 than 3.2 million people living across Essex, Luton,
 3 Bedfordshire and Suffolk. This is in fact a wider
 4 footprint than the framework set by the Inquiry's Terms
 5 of Reference, which commit it to looking at events
 6 within Essex. We work across more than 200 sites with
 7 more than 6,500 staff. There are around 100,000
 8 patients in our care at any one time. EPUT provides
 9 a variety of mental and physical health services, from
 10 acute mental health inpatient care to diabetes and
 11 end-of-life community-based care.

12 Many of the steps taken by the Trust have taken
 13 place against the backdrop of the pandemic in 2020 to
 14 2023, which created particular stresses for both
 15 patients, their families and loved ones as well as
 16 staff. EPUT was the lead provider for the COVID-19
 17 vaccination programme and had delivered about
 18 1.6 million vaccines to people in Essex, Suffolk and
 19 Norfolk. Generally, over the course of 24 years covered
 20 by this Inquiry, there has been rising demand for
 21 services, including considerable pressures on beds and
 22 large numbers of out-of-area placements.

23 In 2021, we launched a vision to be the leading
 24 health and well-being service in the provision of mental
 25 health and community care and since then we've continued
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1 issues and the Trust knows that the causes of deaths of
 2 patients in its care, as well as other serious safety
 3 incidents and possible failings in care, will be
 4 explored in detail by your Inquiry. We've heard over
 5 the last two days submissions that deaths, perhaps all
 6 deaths, were preventable. We know that the Inquiry is
 7 required, through its Terms of Reference, to investigate
 8 the circumstances surrounding the deaths of mental
 9 health inpatients within the scope of its Terms of
 10 Reference. The scope of those Terms of Reference is
 11 wide and the Inquiry will encounter a wide range of
 12 circumstances as a result. Those mental health patients
 13 who died within the 24 years under investigation will
 14 include patients who did die of natural causes unrelated
 15 to mental health issues, such as some who were on the
 16 end-of-life palliative pathways.

17 We have established a Lampard Oversight Committee,
 18 which reports directly to the board and is jointly
 19 chaired with the Trust's Audit Committee and senior
 20 independent director. In addition, we have a dedicated
 21 Inquiry project team, which includes a registered mental
 22 health nurse. These arrangements will ensure that the
 23 Trust considers any emerging learning from the Inquiry
 24 as it continues.

25 But I want to move to the subject of care failings.
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1 We are making determined efforts to improve services,
 2 but the Trust approaches this Inquiry and the evidence
 3 it will hear very conscious of the fact that, despite
 4 significant improvements over recent years and
 5 a transformative plan to improve patient care and
 6 services, EPUT still has many improvements to make. We
 7 know that the Terms of Reference and the list of issues
 8 that we've referred to set out a comprehensive list of
 9 areas for investigation. We acknowledge from the outset
 10 of this Inquiry that there have been significant
 11 failures to deliver safe and therapeutic patient
 12 treatment and care. We will seek to assist the Inquiry
 13 in investigating all those issues. At this early stage,
 14 we've highlighted a number of the areas in which there
 15 have been significant failings, but the relatively brief
 16 summary which follows below, which I'm just about to
 17 recount, is not intended to be either an exhaustive list
 18 of failures or an analysis of their causes at this
 19 stage.

20 If I address the subject of ligature points and
 21 other environmental risks to patients. Many people of
 22 course will know that the Health and Safety Executive
 23 brought a prosecution against the Trust and, in
 24 November 2020, the Trust pleaded guilty to a charge
 25 that, during the period from October 2004 to the end

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1 given by the CQC was "requires improvement".

2 On the topic of sexual and physical abuse, we
 3 acknowledge that there have been serious allegations of
 4 sexual assault of patients by staff and also of staff by
 5 other staff members. There's a history of criticism in
 6 relation to a lack of segregation on wards which leads
 7 to sexual safety risks. We also acknowledge that there
 8 have been a significant number of incidents involving
 9 violence, abuse and excessive use of restraint. The
 10 Channel 4 Dispatches documentary in October 2022
 11 highlighted issues within the scope of this Inquiry,
 12 including the abuse and mockery of patients by staff and
 13 the excessive use of restraint, and of course it was
 14 followed by CQC inspections in November 2022.

15 We know that patients sectioned under the
 16 Mental Health Act have left the grounds of Trust
 17 facilities and failed to return. Sometimes they have
 18 left without authorisation and sometimes after being
 19 granted day release or other forms of relief, but they
 20 failed to return as agreed. The seriousness of the risk
 21 is illustrated by the fact that a number of absent
 22 patients have taken their own lives.

23 Patients have also taken their lives shortly after
 24 being discharged from the Trust's care after delays in
 25 receiving prescriptions, medication or urgent mental

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1 of March 2015, we failed to manage the environmental
 2 risk from fixed ligature points within our inpatient
 3 mental health wards, exposing vulnerable patients in our
 4 care to the risk of harm. During this period, some 11
 5 inpatients hanged themselves using ligature points and,
 6 in addition, others were harmed due to the failure of
 7 the Trust to eliminate ligature points on our wards. In
 8 the prosecution, the Trust accepted that lessons learned
 9 did not always result in the required or effective
 10 remedial action. We also know that further deaths
 11 involving fixed ligature points occurred after 2015.

12 We also know there have been serious issues raised
 13 about staff conduct, including the neglect and abuse of
 14 patients, staff falling asleep on duty and inadequate
 15 patient observations. Low staffing levels, including
 16 those below those authorised by the Trust, were reported
 17 on various wards.

18 Although it registered some areas of improvement in
 19 culture and staff morale, the 2023 Care Quality
 20 Commission or CQC report also highlighted areas where
 21 the Trust needed to act to support staff. These
 22 included staff and managers' failures to report or
 23 escalate incidences of abuse of staff, including in
 24 cases of racial abuse of staff by patients, which the
 25 CQC was told was seen regularly. The overall rating

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1 health support or following assessments of their mental
 2 health needs that were later found to be inadequate due
 3 to inaccurate or out-of-date care plans, insufficient
 4 monitoring or errors and oversights in patient records
 5 or information-sharing. The co-ordination of services,
 6 including communication with partner organisations and
 7 services, has been a repeated issue.

8 Failings in care have been exacerbated by failures
 9 on the part of the Trust to listen properly or to act
 10 upon the concerns of patients, families and friends.
 11 While there's a lot of work happening now, which I will
 12 turn to, aiming to capture the feedback of
 13 service users, families and carers and to make sure that
 14 it's listened to, the Trust acknowledges that failures
 15 to listen have led to inadequacies in care planning and
 16 in the management of patients' care.

17 We also know that safety, hygiene and quality issues
 18 have been identified at a number of EPUT facilities.
 19 Last year's CQC report of July 2023 downgraded the
 20 status of the Trust adult mental health wards and
 21 psychiatric intensive care units to "inadequate". It
 22 examined the environment, noting, for example, that ward
 23 showers and bathrooms were said to be "visibly dirty"
 24 and the overall environment "worn and gloomy".

25 On the topic of staff engagement with

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1 investigations, we know that concerns were raised by the
2 Essex Mental Health Inquiry's former chair,
3 Geraldine Strathdee, about the lack of staff response
4 and engagement with her independent Inquiry and its
5 work.

6 As a result we welcome the statutory powers of the
7 Lampard Inquiry, which give legal clarity to the
8 position of witnesses and to the work of the Inquiry in
9 general. The Trust is doing all that it reasonably can
10 to ensure that staff members, past and present, engage
11 fully with the Inquiry and give full and frank evidence.
12 We have provided regular updates to all staff through
13 a variety of methods, including direct mail from our CEO
14 and executive director lead, and we've held dedicated
15 staff sessions to answer questions. We've also
16 conducted staff site visits to ensure that all staff are
17 aware of this Inquiry and the important role they have
18 to play in it.

19 Professionals in the NHS owe obligations of candour,
20 but in addition the staff have put in place arrangements
21 by which staff members can seek legal advice and support
22 in giving evidence. The Trust is very much open to
23 considering any further suggestion to protect the
24 interests of those who wish to speak up and which would
25 further the public interest in the Inquiry hearing

1 services are safe and meet patient needs. Again, this
2 isn't a complete account. Full details will be set out
3 in statements and other evidence to the Inquiry and will
4 no doubt be explored further by it.

5 On the topic of ligature points and other
6 environmental risks, there is now a ligature risk
7 reduction group that meets every month and is chaired by
8 the executive chief operating officer. After its
9 formation in 2017, we undertook a full fixed ligature
10 review across all Trust inpatient wards and spent over
11 6.3 million on the removal of fixed ligature points.
12 Further gaps have been tackled by the 20 million spent
13 since 2020 on inpatient services addressing environments
14 and safety, including further work to reduce fixed
15 ligature risks across the estate. All mental health and
16 learning disability wards had a ligature environmental
17 risk assessment carried out in the last year and
18 received a six-month follow-up review, which focused on
19 clinical risk management and staff coaching.

20 The need for training reflects the many complexities
21 of this area of risk. There has been a pattern of the
22 risk shifting from secured ligature points, such as door
23 handles, to unsecured ligature points, clothing and
24 bedding. So managing ligature risks in the physical
25 environment has to be considered in the wider context of

1 candid evidence from the widest possible group of staff
2 members.

3 My Lady, after recounting those issues, I'd like to
4 turn to the current leadership and the remedial
5 programme in hand. Even as this Inquiry progresses,
6 EPUT continues to treat patients on a daily basis. At
7 any one time, as I've mentioned, there are some 100,000
8 patients in EPUT's care. Despite the serious failings
9 that we've acknowledged and the ongoing challenges,
10 there have also been improvements and change initiated
11 by the new board after EPUT was formed in April 2017.
12 Progress has not always been smooth or uninterrupted and
13 we know there have been further tragedies as well as
14 external shocks, like the COVID-19 pandemic, but there
15 has also been significant development of services and of
16 our links with partner agencies and universities. The
17 work is led by the EPUT board, which has focused time
18 and resources on understanding the issues and in taking
19 action to address them.

20 The board appointed its first director of people and
21 culture in August 2019 and then the "Freedom to Speak
22 Up" guardian, both key posts in promoting cultural
23 change amongst staff.

24 So, Chair, I will seek to outline some of the main
25 steps that have been taken since 2017 to ensure that

1 care provision, including training, staffing, security,
2 patient risk assessment, patient engagement, observation
3 and care planning. In relation to bedroom doors, the
4 trust is mitigating risk by using assisted technology,
5 such as door top alarms, and these were in place for
6 some 96% of patient incidents during 2023 and 2024.

7 On patient safety, in 2021 we launched our patient
8 safety strategy, "Safety First, Safety Always", with the
9 ambition to provide the safest possible care. We've
10 introduced new technologies to support safer care
11 including the remote monitoring tool, Oxevision, which
12 allows staff to continuously track the vital signs of
13 patients, monitor their activity and conduct
14 observations, alongside CCTV and body-worn cameras, all
15 of which may provide data if there are safeguarding
16 concerns. We do recognise that that technology must not
17 be a substitute for inpatient observations and also that
18 staff must be properly trained, confident in its use and
19 aware that it doesn't replace their role and duties to
20 check on patients if the alarm is activated. And
21 further information about those changes will be supplied
22 in our statements to the Inquiry.

23 We were an early adopter of NHS England's Patient
24 Safety Incident Response Framework, which was rolled out
25 to all NHS trusts in 2023. That NHS England framework

1 governs how EPUT investigates and learns from patient
2 safety incidents and we've assisted other trusts in
3 introducing this new framework.

4 On the topic of staff numbers and culture, we know
5 that the mental health workforce nationwide has been
6 under significant stress, with workforce shortages
7 affecting staff workload, well-being, morale and the
8 ability of staff to provide high quality care. Against
9 that background, we have undertaken a major recruitment
10 drive. We welcomed over 1,700 new colleagues in 2023,
11 including 220 from overseas. We're now accredited with
12 the NHS Pastoral Care Quality Award for support offered
13 to nurses and those recruited internationally. Vacancy
14 rates in the inpatient units have fallen to 10% from an
15 all-time high of 40% in 2020 and we are on track to have
16 no inpatient vacancies by the end of 2024. We know we
17 will still be recruiting for Time to Care vacancies
18 although we remain on track to reduce our vacancy rate.

19 Through a major transformational programme, "Time to
20 Care", we've created new roles, including new site
21 managers, senior nurses, at Rochford Hospital and
22 Linden Centre to support staff and to address conduct,
23 such as the staff sleeping on duty reported by the CQC
24 in its July 2023 report.

25 The Trust has introduced a new behaviour framework
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1 forward.

2 Recruitment of those roles is underway. Time to
3 Care will invest 14.4 million in 2024/2025, with further
4 investment annually over the five years of the
5 programme. The investment does allow for planned
6 reductions in the numbers and use of temporary staff and
7 a reduction in out-of-area placements. This is to
8 enable greater continuity and quality of care and
9 increasing care hours per patient, lower sickness
10 levels, improved staff retention and, we hope, improved
11 length of stay on our wards, all of which to support the
12 delivery of better patient experience. Time to Care
13 also aims to ensure that supporting technology are in
14 place to enable Trust staff to spend more time in direct
15 patient care. Again we provide further details in
16 response to Inquiry witness statement requests. We've
17 also completed, as we mentioned, the recruitment of
18 international nurses, with investment of 6.7 million in
19 2023/2024.

20 But we know that families haven't been involved or
21 listened to properly in many instances where there were
22 tragic harms to patients. We are committed to
23 developing a "family first" approach to our services and
24 to working with service users, families and carers to
25 support people to manage their own care and to support
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1 to ensure that every member of the organisation
2 understands their responsibilities and their duty of
3 care, including the need to report incidents of abuse.
4 The sexual and physical safety of both patients and
5 staff continues to be an area of trust [sic] and concern
6 for EPUT, which will give the fullest co-operation to
7 any police investigation of criminal allegations. We've
8 signed up to the NHS Sexual Safety Charter, launched
9 in September 2023, which provides the framework for
10 a zero tolerance approach to unwanted, harmful or
11 inappropriate sexual behaviour for both patients and
12 staff. All this is linked to the cultural change that
13 we've already referred to, including the importance that
14 we attach to the Freedom to Speak Up initiatives and the
15 staff behaviour frameworks.

16 As we've already mentioned, the Trust has recently
17 developed Time to Care, which is a five-year programme
18 of change, co-created with service users and their
19 families. We plan to recruit more than 300 full-time
20 equivalent posts, adding new therapeutic roles to teams
21 on wards: occupational therapists, physiotherapists,
22 activity co-ordinators. We've also funded the
23 appointment of peer support workers as part of our
24 commitment to involve people with lived experiences
25 within our services and to help shape changes going
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1 their loved ones. We're determined to progressively
2 build and further strengthen patient and public
3 participation as a golden thread woven through our
4 strategic priorities and plans and there has been
5 a renewed focus on listening to patients' families and
6 carers.

7 We've introduced a reward and recognition policy for
8 people with lived experience so that people with lived
9 experience are paid or can choose to receive other
10 non-monetary recognition when working on the co-design
11 and improvement work, and this has facilitated the
12 introduction of peer support workers on our ward in
13 2023.

14 We've introduced the Patient, Carer and Family
15 Collaborative, a key decision-making body made up of
16 patients, carers and staff at every level of our
17 organisation that meets on a quarterly basis. We've
18 appointed a service user as our coproduction lead.
19 Those feedback routes are supported by the forum and the
20 iWantGreatCare, a feedback service for carers,
21 service users and families.

22 The number of lived experience ambassadors employed
23 by the Trust has tripled over the last two years, now
24 with over 200 current and former patients now working
25 alongside EPUT to shape improvement.
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1 Some of this work was recognised in the most recent
 2 CQC inspection of December 2022, published in July of
 3 2023. The Trust is not seeking to gloss over the many
 4 failings identified and the CQC ratings on "requires
 5 improvement", but it is also fair to note that the CQC
 6 did rate the caring dimension of the Trust's services as
 7 "good", recognising that patients and carers gave
 8 largely positive feedback on the way that staff treated
 9 them and the support they offered. But the Trust board
 10 recognises the need to embed change through the
 11 organisation, to ensure that strategies are effectively
 12 implemented at every level and influence every patient
 13 interaction.

14 Chair, I'll turn, if I may, to the national context,
 15 conscious, as I am, that that is part of your
 16 investigation or your Terms of Reference. We operate as
 17 a statutory body within the wider NHS, operating at
 18 a local level alongside bodies such as the integrated
 19 care boards, other provider NHS trusts, independent
 20 sector providers, primary care providers and local
 21 authorities.

22 Overall the NHS is regulated and inspected by the
 23 Department of Health and Social Care and national bodies
 24 such as the Care Quality Commission, the Health and
 25 Safety Executive and NHS England. The delivery of

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1 challenges in providing an overview of how many people
 2 die while in contact with inpatient services and the
 3 cause of their deaths. There's no published national
 4 overview for the deaths of people in inpatient mental
 5 health services nor of the total numbers of deaths of
 6 people in contact with mental health services at
 7 a provider level. She made a range of recommendations
 8 to improve data collection.

9 So, in looking at the national context, it's
 10 apparent from a number of reports that, sadly, there has
 11 and continues to be a high risk of self-inflicted death
 12 for those with mental illnesses. There are at least now
 13 a number of data sources regarding patient safety and
 14 death, but it's clear that concerns have been raised in
 15 numerous reports about the quality of data which is
 16 available to enable qualitative analysis of mental
 17 health services and their safety across England.

18 We know that the Healthcare Services Safety
 19 Investigations Body or HSSIB is carrying out an
 20 investigation into the safety of mental health services,
 21 due to conclude by the end of this year. HSSIB will
 22 develop learning from inpatient mental health deaths and
 23 near misses to improve patient safety by again examining
 24 the mechanisms that capture data on deaths and near
 25 misses across the mental health provider landscape and

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1 services to individual patients by different providers
 2 clearly overlaps and, whilst integration is a key NHS
 3 objective, including integration with social care, this
 4 is a complex system set within a statutory framework and
 5 subject to national guidance and regulation.

6 Sadly, the Lampard Inquiry, your Inquiry, Chair, is
 7 not unique in the focus of some of its work. At present
 8 there are a number of public inquiries considering
 9 issues touching upon the performance of the NHS. These
 10 include the Covid-19 Inquiry and the Thirlwall Inquiry
 11 and there has recently been the commitment to
 12 a judge-led inquiry to learn lessons from the tragic
 13 killings in Nottingham by a former patient.

14 There have also been a range of investigations into
 15 issues in mental health services across the UK,
 16 including in relation to subjects that are at the
 17 forefront of this Inquiry, including the Wessely
 18 Independent Review of the Mental Health Act as well as
 19 various CQC and other reports.

20 We know that Dr Strathdee was commissioned by the
 21 Department of Health and Social Care to carry out
 22 a Rapid review into data on mental health inpatient
 23 settings", and she found that there were significant
 24 difficulties in obtaining and interpreting mental health
 25 data at present. Her report identified significant

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1 it will also further examine topics such as the local,
 2 regional and national oversight and accountability
 3 framework for deaths.

4 Many issues raised by this Inquiry's Terms of
 5 Reference have long been concerns in relation to mental
 6 health services nationwide. We've already mentioned how
 7 the Wessely Review identified extensive problems with
 8 the mental health inpatient estate, describing the
 9 environment as being "anything but therapeutic",
 10 explaining that "facilities are substandard and worn
 11 out", which makes the delivery of good care difficult.
 12 That review called for capital investment by the
 13 Government and the NHS to "modernise the NHS estate" and
 14 to improve physical environments. The CQC report on the
 15 state of care in mental health services from 2014 to
 16 2017 identified similar themes.

17 Ligature risks were also identified by the CQC in
 18 that report as being an issue, as many wards contained
 19 fixtures and fittings that people who are at risk of
 20 suicide could use as ligature anchor points. The
 21 National Confidential Inquiry into Suicide and Safety in
 22 Mental Health Annual Reports, which investigate data on
 23 health suicides, including in its 2022 report, found
 24 that, between 2009 and 2019, 49% of deaths by hanging or
 25 strangulation on wards used a door as a ligature point.

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1 Best practice guidance, such as that contained
2 within the Department of Health's Environmental Design
3 Guide, can help to reduce risk, but it's challenging to
4 eliminate all risks with deaths by strangulation taking
5 place in circumstances tragically where there is no
6 ligature point.

7 We also know that sexual safety on mental health
8 wards is also an ongoing issue and, Chair, in our
9 written submissions we refer to the 2018 CQC review of
10 this issue and its finding that sexual incidents were
11 "commonplace" on mental health wards, that incidents
12 were unreported or were not investigated, that gender
13 separation was not achieved or well managed, that staff
14 hadn't received adequate training and that risk
15 assessments and care plans were not always in place in
16 relation to sexual safety.

17 Staffing we know is a further area of common
18 difficulty, with services struggling to ensure adequate
19 staffing and a national shortage of mental health
20 nurses. In areas of high staff turnover, this can
21 create a negative effect on morale which is difficult to
22 address.

23 There are many other systemic issues that are
24 relevant to this Inquiry which we've noted in our
25 written submissions, many of them commented on by the

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1 guidance, capital investment, staffing transformation,
2 is critical for our services and for others across the
3 country. We hope to learn from any examples of good
4 practice that may be identified. To that end, we'd be
5 keen to see evidence commissioned by the Inquiry on what
6 works and to identify durable solutions to problems that
7 are stubborn, deep-seated and widespread.

8 In relation to any national benchmarking data, it's
9 our submission that the Inquiry should aim to seek both
10 to understand what's available and what's not, both to
11 place issues and outcomes within EPUT in a national
12 context and to inform its recommendations. Although the
13 data quality and completeness issues that I've referred
14 to may make this task difficult, we do highlight the
15 importance for the Inquiry of seeking to put deaths in
16 care at EPUT into a national context, including
17 examining the extent to which EPUT and its predecessors
18 have been outliers. If the Inquiry is to make
19 recommendations that can have a national application,
20 they would be informed, we would gently suggest, by
21 information about whether what is being examined is
22 a national or a local issue or the extent of both.

23 It is important that collectively the wider NHS and
24 the health sector should understand and take action as
25 a result of the learning that you and your team will

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1 King's Fund Mental Health Review, the 360-degree review
2 of mental healthcare, only published in February 2024,
3 which said:

4 "There is a great deal of data on mental [health]
5 illness and mental health services. However, issues
6 with coverage and quality of data limit its value for
7 being able to plan services and understand what is going
8 on. This directly impacts on the quality and safety of
9 care, and efforts to improve care."

10 The Terms of Reference of this Inquiry anticipate
11 that the Inquiry may make recommendations that are
12 intended to apply nationally. Against this background,
13 we would invite you, the chair, to build on the work of
14 previous reviews and ongoing inquiries. You may wish to
15 take into account the recommendations made elsewhere by
16 other public bodies and to assess the data available to
17 enable analysis of the national context. Indeed, the
18 previous reviews and any barriers to implementation of
19 their recommendations may offer insights into the
20 challenges surrounding the provision of quality mental
21 health services across the 24-year period of your review
22 and give a flavour of the complex system within which
23 mental health service providers operate.

24 We take the view that identifying effective levers
25 to address such challenges, whether they consist of

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1 undoubtedly deliver. We see this Inquiry as a space for
2 openness and transparency as well as a willingness to be
3 accountable and to take action which exceeds the
4 reputation or culture of individual organisations. We
5 commit to approaching the Inquiry in an open,
6 collaborative and supportive way to achieve this.

7 So in closing, Chair, the Trust would like to
8 reiterate to all those who have suffered the loss of
9 a loved one that we are sorry and to acknowledge that,
10 even when there may be a firm hope and belief that the
11 Inquiry will deliver the answers they have been seeking,
12 nothing can bring back a loved one. We, the Trust, will
13 hold that truth with us as we move forward to our
14 commitment to deliver safe and therapeutic care to
15 patients.

16 **THE CHAIR:** Thank you.

17 **MS GREY:** Thank you, Chair.

18 **MR GRIFFIN:** Chair, the second and final opening statement
19 this morning will be on behalf of North East London
20 NHS Foundation Trust and will be given by
21 Valerie Charbit. It may take a short moment for
22 Ms Charbit to come down and install herself. **(Pause)**

23 **MS CHARBIT:** Good morning.

24 **THE CHAIR:** Good morning.

25 **MS CHARBIT:** I represent North East London

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1 NHS Foundation Trust. I'm going to call them "NELFT"
2 for the purposes of this opening.

3 **Opening statement by MS CHARBIT**

4 **MS CHARBIT:** Thank you, Chair, for this opportunity to
5 address you in addition to NELFT's written opening
6 statement. I will also take this opportunity to respond
7 to some of the points raised in other core participants'
8 opening statements.

9 I would like to say at the outset to families and
10 friends of all of those who have died or suffered under
11 the care of mental health services how sorry NELFT is.
12 We are grateful for the support NELFT has had over the
13 last year from local residents in developing an
14 expert-by-experience-led strategy to improve services
15 delivered by NELFT. NELFT would like to emphasise it is
16 committed to assisting the Inquiry in improving the
17 outcome for Essex residents and more widely across the
18 mental health service provision.

19 NELFT's commitment to being open and transparent
20 with the Inquiry will resonate throughout the Inquiry's
21 processes. Since 2023 and 2024, NELFT has appointed
22 a new chief executive and deputy chief executive, the
23 latter of whom has been present to listen to all of the
24 opening statements. NELFT is committed to assisting
25 this Inquiry and learning from it. NELFT is also

1 that the matters under investigation by the Inquiry have
2 had on patients and their family and friends in Essex
3 through the Essex Mental Health Independent Inquiry and
4 other legal proceedings which went before the
5 Lampard Inquiry. NELFT is fully committed to supporting
6 and cooperating with the Inquiry in order to understand
7 what happened and to learn from it for the benefit of
8 those families, their friends and future service users.
9 NELFT will consider carefully the disclosure, once
10 received from the Inquiry, with a view to making wider
11 improvements to the provision of mental health services
12 in Essex.

13 Can I give a very short brief history of NELFT?
14 North East London Mental Health NHS Trust was first
15 established in June 2000 and became operational in
16 April 2001. North East London Mental Health NHS Trust
17 then became NELFT, North East London Foundation Trust,
18 in 2008. NELFT currently provides an extensive range of
19 integrated community and mental health services for
20 people living in the London boroughs of Barking and
21 Dagenham, Havering, Redbridge and Waltham Forest. NELFT
22 also provides community health services and dementia
23 crisis support for people living in the South-West Essex
24 areas of Basildon, Brentwood and Thurrock. NELFT's
25 provision of Child and Adolescent Mental Health

1 committed to ensuring meaningful changes in NELFT's
2 processes when recommended by the Inquiry.

3 The process of change has already commenced by
4 enhancing clinical leadership at board level and expert
5 by experience leadership within operational teams. We
6 note you, Chair, also referred to the Inquiry
7 investigating both good practice and bad practice and we
8 look forward to sharing NELFT's journey of using quality
9 improvement methods to enhance clinical outcomes for
10 patients.

11 NELFT wishes to make clear that it will seek to
12 apply a rigorous, reflective and self-critical approach
13 to the analysis of its role in the events with which
14 this Inquiry is concerned. As part of NELFT's
15 commitment to helping the Inquiry with its
16 investigations, NELFT has devoted considerable resources
17 to responding to the Inquiry's Rule 9 requests for
18 statements to date as openly and comprehensively as
19 possible and with complete candour. It will continue to
20 do so.

21 A dedicated project team has been set up within
22 NELFT which is being led by NELFT's deputy
23 chief executive, demonstrating how seriously NELFT takes
24 its commitment to the Inquiry.

25 NELFT is acutely aware of the devastating impact

1 Services, CAMHS, commenced on 1 November 2015.

2 Whilst NELFT does not currently operate any
3 inpatient units in Essex, NELFT and its predecessor
4 organisation historically provided mental health
5 services at Mascalls Park, a medium-secure mental health
6 unit at the Warley Hospital site near Brentwood.
7 Typically, residents from Havering and Barking and
8 Dagenham accessed care at Mascalls Park. Mascalls Park
9 also accepted residents from Essex and out of area, if
10 necessary, and Mascalls Park closed in January 2011.

11 May I move on to say something about the compilation
12 by NELFT of the list of those that have been deceased?
13 In order to compile the list of deceased for the
14 Inquiry, NELFT has reviewed five computer systems it
15 used for electronic patient records between 2003 and
16 2023. All records prior to 2003 were paper records and
17 the computer systems are SEPIA, introduced in 2003; RiO,
18 introduced in 2006; SystemOne, introduced in 2011; and
19 Windip, linked to RiO, introduced in 2011; and CareDoc,
20 linked to RiO, introduced in 2017.

21 NELFT sought retrieval of a large number of paper
22 records available in the archives, provided by a third
23 party, Iron Mountain, which were still available, and
24 those have also been searched.

25 NELFT is also willing to disclose any protected

1 characteristics it has in respect of its list of
2 deceased, if that information is captured in its
3 records. It agrees that it is important that any
4 protected characteristics and intersectionality are also
5 identified as part of this Inquiry.

6 May I move on briefly to say something about changes
7 to mental health guidance? NELFT's services in Essex
8 were provided against a backdrop of the emerging
9 national approach to mental healthcare. The first
10 clinical mental health guidance was published by the
11 National Institute for Healthcare and Excellence, NICE,
12 in 2002 and this guidance has been updated twice since
13 it was published. Since 2002, NICE has published 80
14 pieces of mental health guidance signifying the
15 ever-evolving standards over the relevant period of this
16 Inquiry.

17 It was not until 2011, when references to "parity of
18 esteem" were made, which was the first public health
19 strategy to give equal weight to both mental and
20 physical health. It was from parity of esteem that the
21 Mental Health Investment Standard was developed, which
22 became operational in 2015/2016 and sought to increase
23 the level of investment in mental health services across
24 England.

25 In 2017 an independent review of the
33

1 opening statements this week. The Inquiry will be
2 considering what they have said together with their
3 written opening statements. The Inquiry has also
4 received written opening statements from the Department
5 of Health and Social Care, NHS England, the
6 Care Quality Commission and the Royal College of
7 Psychiatrists. We thank them too for what they have
8 provided. All written opening statements will be going
9 on to the Inquiry website, lampardinquiry.org.uk,
10 I think later today, but shortly in any event.

11 The hearings will start again on Monday at
12 10 o'clock, when we will start to hear commemorative and
13 impact evidence from those most closely affected by the
14 matters the Inquiry is investigating.

15 Thank you, Chair.

16 **THE CHAIR:** Thank you.
17 **(10.55 am)**

18 **(The hearing adjourned until**
19 **Monday, 16 September 2024 at 10.00 am)**
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1 Mental Health Act 1983 was undertaken in response to
2 concerns raised about the efficacy of the Act and the
3 review accepted that changes were needed to make it
4 easier for patients and service users to participate in
5 decisions about their care and sought to restore their
6 dignity. Since then, the Government has proposed
7 reforms which NELFT is aware of and, as you will be
8 aware, Chair, have not yet been enacted. NELFT welcomes
9 your indication that you, Chair, will seek to appoint
10 assessors or suitable experts to properly understand how
11 these changes have impacted care in mental health
12 throughout the 24-year period.

13 NELFT has not sought in this opening statement to
14 set out a formal response to your provisional list of
15 issues and it looks forward to exploring these matters
16 with the Inquiry in due course.

17 In conclusion, NELFT remains fully committed to
18 supporting the Inquiry with candour in every way it can.
19 It is committed to learning and changing to prevent any
20 future deaths of mental health patients or any future
21 suffering of mental health patients.

22 Thank you very much.

23 **Closing remarks by MR GRIFFIN**
24 **MR GRIFFIN:** Chair, that marks the end of the opening
25 statements. I would like to thank those who have given
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