After much campaigning and following the Public Administration and Constitutional Affairs Committee (PACAC) meeting of 15 October 2019, we were told that a Statutory Public Inquiry into Richard's death would not take place. There being two specific reasons: (1) such inquiries did not happen for single numbers; and (2) that problems needed to be more systemic in nature.

With yet further assistance from our MP, James Cartlidge, we secured an Independent Inquiry into Richard's death following his raising a Friday Adjournment Debate. The subject of that debate will most likely come up in evidential sessions of this Inquiry.

Statements already given to this Inquiry show that other families walked a parallel path and likely conjointly grew into the non-statutory Essex Mental Health Independent Inquiry (EMHII). The specifics of which growth I neither know nor seek to know.

As a family we are grateful to EMHII for the following: firstly it allowed Linda, my wife, to give evidence in an informal setting compatible with her nature; and secondly it allowed my son, given his circumstance, to give evidence at all.

We are also grateful to the staff of this Inquiry for their knowledge of the evidence we have already given, and hope that that evidence has helped inform them as they take on the challenge of further understanding the desperately sad issues that underly these proceedings.

Ironically, it would seem the Independent Inquiry's inability to meet its Terms of Reference (ToR) were later to sweep away the aforementioned PACAC reasons blocking a Statutory Public Inquiry into deaths at Essex mental health facilities.

The two key facts to emerge from EMHII were: (1) the number of deaths meeting that Inquiry's ToR approached 2,000; and (2) of some 14,000 current and past staff, just a handful had agreed to engage with EMHII.

The number of qualifying deaths clearly and terrifying overwhelmed the first PACAC constraint of 'single numbers'. But it was EMHII's second fact that dispensed with PACAC's second condition. But why was it systemic?

For a systemic failure it is necessary to first consider EPUT/ NEPT as a system. And systems need control to achieve their objectives. When driving and your car drifts to the right, you turn slightly to left to correct the error. That is negative feedback, and it is an essential element in any stable system, and without it any controlled system will fail.

Mental health is both a profession and a vocation, and each of its practitioners should have the opportunity to raise failings and then contribute to the prevention of their future reoccurrence. And yet, across what is now nearly a quarter of a century, no more than 0.1% of practitioners chose, for whatever reason, to raise their voice at EMHII to correct the failings in their chosen career path and provide the negative feedback essential to the prevention of future deaths.

That is a systemic failure.

And although the above argument is here applied to internal control, the same argument can be applied to external control bodies. As a family we are pleased to see the relevant external control bodies listed within the ToR of this Statutory Inquiry.

Chair, I respectfully submit that the apparent internal and external control failings here considered be matters for your Inquiry, for without a voice for practitioners or a willingness, or ability, to act by regulators, any satisfactory long-term solution will be difficult, if not impossible, to achieve as either will be lacking the negative feedback necessary for effective control and therefore the prevention of future deaths.

For negative feedback to work, a system requires a set-point against which to measure its errors; for an organisation the set-point is a target. I shall return to this delicate issue at the conclusion of my commemorative statement.