Monday 26 November 2024

(10.00 am)

Opening remarks from THE CHAIR

THE CHAIR: ... here today watching and participating in this virtual hearing room. I announced in September that a series of the Inquiry's further hearings will take place in person in 2025 and 2026 at a physical venue in London. However, virtual hearings have an important role to play in inquiries too and I'm very pleased to present this virtual hearing now.

Put simply, a virtual hearing is one that takes place using technology, rather than from inside a hearing venue. Participants can attend the hearings from any location via video link. Virtual hearings have become increasingly common in the UK since the Covid pandemic. They have been used by other public inquiries and by others, including the courts and coroners. They can be an effective and convenient way of proceeding. Virtual sessions are the preference of some people and the Inquiry must consider the accessibility needs of all our witnesses.

I wish to emphasise from the outset, that the statements and evidence given during a virtual hearing carry exactly the same importance and value as those that given are at in-person hearings.

I recognise that there will be parts of the hearing that may be difficult and may be traumatic to listen to. The Inquiry places the well-being of those engaging with it at the centre of its work. I'd like to remind everyone that independent emotional support services, overseen by the Inquiry's Chief Psychologist, are available. Anyone who needs assistance during the hearing should please contact my Inquiry team, who will help them to access the support.

As is now well known, the purpose of this Inquiry is to investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trusts.

We are considering the 24-year period between the start of 2000 and the end of 2023. We'll be investigating matters of the gravest public concern and significance.

In September, the Inquiry heard opening statements from a range of core participants. We also heard deeply moving accounts about those who have died, given by members of their families and by their friends. I expressed my deepest gratitude at the end of the hearing for those accounts, which will ensure that we, at all times, keep in our minds the real people and their families and friends who experienced the mental

health inpatient services with which we are concerned.

Today and for the next two days we will hear further opening statements and commemorative and impact evidence in relation to those who have died. We will not be hearing from patients and former patients at this stage.

I have considered the further written opening statements which have been provided to me. These have been extremely helpful and provide further discussion of the issues under investigation. I look forward to hearing from the counsel and solicitors of those bereaved Core Participant families shortly.

I have also received and further read further commemorative and impact accounts. As will soon be seen, these accounts are powerful, and will be given by people describing with dignity, pride and courage to those who have died.

Some commemorative and impact accounts are not being read publicly during this hearing, at the request of the families, but I have read and will listen to them privately and I am immensely grateful to all those who provided them.

Some of the contents of these accounts may have been redacted, for privacy reasons or because the statement includes matter which are more appropriately dealt with during the substantive evidence phase.

I have read and considered in full the unredacted versions of each and every statement provided to the Inquiry ahead of this hearing.

I want to thank all those who have contributed, opening statements and accounts. The commemorative and impact accounts are crucial to my understanding and the understanding of all of us at the Inquiry of the true impact of the deaths and harms which have occurred.

After this hearing, once all the impact and commemorative accounts have been given, I have asked my Inquiry team to consider how we may gather together all the accounts heard by the Inquiry and present them in a way that preserves and reflects their importance to the Inquiry's work. I want this to be done in collaboration with the families who provided these accounts.

I think it's important, at this stage, to restate a number of key points. We're the first public inquiry set up in the UK to investigate mental health care. We will investigate matters of grave importance relating to life and death. We will seek out the truth. We will be fair, thorough and balanced in examining the issues, and will act with an appreciation for many changes, institutional, legal or otherwise, taking place during the years under consideration.

We are independent. We are independent from those engaging with the Inquiry and, more widely, from Government or any health body or other organisation. We are concerned about what occurred under the care of Essex NHS mental health trusts. We will investigate what went right as well as what went wrong.

We will champion good practice in mental health inpatient care and how things can be improved.

The Inquiry is urgent. Matters that have been identified remain of current concern. We need to address them as quickly as possible to limit any further unnecessary suffering.

The Inquiry is of national significance and I will make recommendations for real change. My findings and recommendations are likely to be relevant right across the country, meaning that any necessary improvements in mental health care, as a result of this Inquiry, are made not only in Essex but also nationally.

The breadth and urgency of the Inquiry's work is demonstrated by our work in a range of areas. Family experience and the lived experience of those who have experienced inpatient mental health services are at the heart of this Inquiry. During our first public hearing since September this year, around 50 family witnesses provided impact evidence. During this virtual hearing,

we shall hear from around 30 more.

The Inquiry has sought to contact in excess of 5,000 people, who may have been affected by the matters which the Inquiry is investigating, informing them of the Inquiry and explaining to them how to get in touch. Letters have been sent by the mental health provider to every next of kin for whom they have an address, either postal or e-mail, from across of the 24-year period of the Inquiry. These letters have been sent to next of kin for all deaths potentially in the scope of the Inquiry to make them aware of the work of the Inquiry, although we recognise these will include deaths of people who did not experience issues with the care they received and deaths which had entirely natural causes.

New families have approached the Inquiry as a result of these letters, and we're grateful to be hearing from some of these families during this hearing.

I appreciate that it can be extremely daunting for some of these families to engage in Inquiry proceedings and I understand that many of these individuals are unrepresented. I'm thankful to them for approaching the Inquiry, and we will continue to support them through the Inquiry's engagement team.

I wish to offer all family members who are Core Participants the opportunity of an informal virtual

meeting with me. This is an open offer for any such families who may wish to attend. My Inquiry team will be in contact with these families shortly, either directly or through recognised legal representatives.

The Inquiry is currently working closely with its Chief Psychologist to undertake a detailed review of its approach to engaging with and obtaining evidence from current and former patients, as well as the families of living patients.

The Inquiry recognises that engaging with it may increase distress for some individuals, and it's of central importance that we do so in a responsible and effective way. Working with its Chief Psychologist the inquiry will put in place a patient framework to minimise risk, prioritise safety and avoid exacerbating any trauma which may have been suffered.

So far, the Inquiry has sent out over 130 formal Rule 9 requests for evidence. In addition to seeking commemorative evidence from families, these Rule 9 requests have included requests for evidence and witness statements from the trusts involved in this Inquiry, and from other healthcare providers, along with requests for evidence and witness statements from other organisations whom the Inquiry considers hold relevant material.

Most importantly, following these hearings, the

Inquiry will liaise against with the recognised legal representatives of the bereaved families and friends. This liaison will be prior to sending out Rule 9 requests to those families and friends, asking them to assist the Inquiry by giving evidence about what happened to their family member or friend. This will be an important first stage in their providing substantive evidence to the Inquiry.

The Inquiry has already interviewed number of members of staff who work within mental health services and who have approached the Inquiry and volunteered to share their information. This is very much the beginning of the Inquiry gathering evidence from staff. I'm grateful to all staff who have so far come forward and given their time to the Inquiry.

Since our terms of reference were set by the Government in April this year, I've granted 91 applications for Core Participant status. This is out of a total of 134 applications made, meaning that a little under 70 per cent of all applications to date have been successful.

This Inquiry is actively engaged with a number of witnesses who have not applied for Core Participant status. Their evidence remains equally crucial to the Inquiry's work.

I want to turn now to the Inquiry's planned approach to investigations. It's imperative that the Inquiry acts quickly, given the urgency of the matters it's investigating. Sadly, deaths within Essex continue. It would not be possible or practicable for the Inquiry to investigate in depth every death which falls within the scope. To allow the Inquiry to provide its final report, and to make meaningful recommendations within a reasonable period, the Inquiry will take a sampling approach. That is, the Inquiry's investigations will begin with case reviews and analysis of a sample death.

As Counsel to the Inquiry stated during his opening statement at the September hearing, deaths related to current Core Participants will be included in this initial sample, unless there is some reason why that should not be appropriate, for example if they do not wish to be included. My Inquiry team will be closely engaging with Core Participants and their legal representatives on this in due course.

The identification of additional cases, which are not related to Core Participants, will be carried out with great care, in conjunction with the Inquiry's incoming data expert. This is to ensure that the case analysis undertaken properly represents the full breadth of issues that the Inquiry is investigating. The first

step in conducting case reviews into the death selected for inclusion in the sample will be to gather key facts and information relating to each of the cases and to write to Core Participant families and friends to ask for detailed, substantive evidence of what happened in their particular case? The Inquiry will also begin the task of gathering evidence from the relevant trusts and any other relevant sources.

The process adopted by the Inquiry will remain responsive, both to developments in our investigations and to the evidence the Inquiry is gathering from those affected.

This Inquiry will remain flexible in its approach, and will adapt its processes as appropriate throughout, to ensure that we approach our investigations in the most thorough and effective manner possible. Further detail on the Inquiry's approach to case analysis will be published on our website in due course.

Public inquiries are only as effective as the implementation of their recommendation. Too often, the findings and recommendations from public inquiries have failed to deliver substantive and long lasting change.

The recommendations made by this Inquiry must be relevant in order to be fully implemented and effective.

Changes to inpatient mental health care, such as

those arising from the Mental Health Bill, introduced in Parliament on 6 November, and any policy changes that may result from the Government's 10-year health plan will alter the landscape into which the Inquiry's recommendations will be made.

I and my Inquiry team remain ever alert to the change in landscape of mental health care, which will continue to develop throughout the life of this Inquiry.

Counsel to the Inquiry, Nicholas Griffin KC, will have a little more to say about recommendations in a moment.

My key ambition for the Lampard Inquiry, is that it results in real world change, not only for those with past lived experience of inpatient service and the families of those who died but also for future patients accessing inpatient mental health care in Essex and across the country.

I wish to finish by, once again, thanking all those who have provided statements and accounts as part of this hearing. Your accounts convey the human impact behind the issues being considered by this Inquiry and I am very grateful to you for sharing them with the Inquiry.

Mr Griffin?

Opening Remarks by MR GRIFFIN

MR GRIFFIN: Thank you, Chair. You have already referred to the emotional support that is available today and for the duration of this hearing, and I can provide a little further detail now.

The Inquiry has engaged the organisation Hestia, which will provide trauma-informed support for those engaging with the Inquiry, including witnesses and Core Participants. A dedicated counselling service is available during this hearing. Hestia will be watching live and will be available to facilitate support calls.

For anyone wishing to access this support, please contact the Inquiry team's mailbox on contact@lampardinquiry.org.uk. Further information is available on the Lampard Inquiry website at lampardinquiry.org.uk, under the "Support" tab at the top right-hand corner.

As we have been saying, Chair, we want all those engaging with the Inquiry to feel safe and supported.

Today we will hear three opening statements as well as the start of our commemorative and impact evidence. An opening statement will be provided by Maya Sikand KC, who is instructed by Leigh Day Solicitors, on behalf of the family of Terrence Pimm and the family of Joshua Leader and Catherine Peck, who is the sister of Richard Harland Elliott. An opening statement will also be

provided by Brenda Campbell, King's Counsel, who is instructed by Bindmans LLP on behalf of Tammy Smith, the mother of Sophie Alderman, and the family of Edwige Nsilu.

A further opening statement will be given by Aimee Brackfield of Irwin Mitchell solicitors on behalf of Michelle Booroff, who the mother of Jayden Booroff.

There are now some updates I would like to provide.

The Inquiry produced its provisional list of issues earlier this year. This is intended to provide further detail on the issues under consideration and to help guide the Inquiry's investigative work. We will review the provisional list of issues to take into account the many points that were helpfully raised by those engaging with the Inquiry following its publication, and at the September hearing. It is now clear that further matters of relevance will be raised at this hearing, and they will also be factored in. We are very grateful for this assistance.

I note that Ms Campbell KC's written opening statement suggests that the Inquiry should require the trusts and others to provide position statements. In broad terms, position statements may provide an inquiry with a better early understanding of the role played by particular organisations. This may help it to

crystallise issues, focus on key areas and understand those areas in which it is accepted that standards fell below what was acceptable or, conversely, which provide examples of good practice.

Chair, I know you wish to consider the need for position statements in this Inquiry.

Several opening statements prepared both for this hearing and the one in September have also referred to the duty of candour and to the Government's legislative intention to bring in what is sometimes referred to as Hillsborough law. These are important points which the Inquiry is considering very carefully. However, it is right to make clear that the Inquiry considers that, when it comes to incidents in healthcare settings, there has long been a duty of candour both for organisations, senior members of those organisations and for individual healthcare professionals. The Inquiry intents to take all steps available to it to ensure the open and frank disclosure of information from those with whom it engages.

Furthermore, in line with its terms of reference, the Inquiry will, where appropriate, investigate alleged failures by organisations and individuals to act with candour.

Chair, you said in the September hearing that the

Inquiry is committed to publishing a figure of the number of deaths in the scope of this Inquiry as soon as we have finished analysing and interrogating the information provided to us by the relevant healthcare providers.

You added that, shockingly, this number is likely only ever to be approximate, also that it is clear that the number of deaths in scope will be significantly in excess of the 2,000 that were being considered by the Inquiry during its non-statutory phase. The Inquiry is deliberately referring globally to deaths that are in scope, rather than, for example, to preventable deaths, although it's a sad fact that the Inquiry has already heard of deaths where there are concerns and, indeed, strong beliefs and findings that there were serious failings in the care provided. Further analysis will be conducted by a data analyst and health statistician.

I can report now that, despite considerable work done in this area, regrettably, we are not yet at the stage where we are able to release a figure. We are not yet able to release even an approximate figure, in which we can have confidence that it is the most accurate representation of the number of deaths in scope that can be achieved. The Inquiry will continue to provide updates on this important matter. The Inquiry has

procured Relativity as its document review platform. It will be used for document management and for internal purposes during our disclosure processes.

Disclosure to participants will be managed by a secure document transfer outside the platform itself. Recognised legal representatives will not need access to the Inquiry's platform in order to engage with our disclosure processes.

As mentioned in September, the Inquiry is also in the process of planning seminars to cover important background information, including, for example, the legislative and policy landscape over the 24-year period with which the Inquiry is concerned. The Inquiry will be addressing what mental health care should look like, the relevant standards for providers and professionals in mental health services, and how those standards should be applied. The intention is to provide this information in advance of the April hearing.

Following a rigorous selection process, which has included liaison with Core Participants, the Inquiry will shortly confirm the appointment of number of independent assessors. The Inquiry is very pleased to have secured the assistance of these extremely experienced individuals who are all experts in their respective areas of mental health provision, and who

will inform the Inquiry on important clinical aspects of its work.

The appointed assessors occupy a range of clinical posts and come with considerable experience of providing frontline mental health care. They will be in post shortly, at which time full details will be published on the Inquiry's website.

Chair, I know you intend to consider the need for further assessments providing assistance in other areas as the Inquiry progresses.

As the Inquiry announced in September, the next hearing will be held in April and into May 2025. It will be an in-person hearing and take place at Arundel House in London. The Inquiry is currently working towards this hearing and beyond.

The focus of the hearing in April will be on important contextual evidence relating to the provision of mental health care in Essex. The Inquiry is actively seeking material in relation to the processes and procedures around inpatient admission and the way in which inpatient care is delivered, which includes issues relating towards safety. Furthermore, the Inquiry is collating material arising from past investigations, reviews and previous proceedings, both internal and external, and examining the response of providers and

others to those matters over time.

The Inquiry intends also to focus on evidence relating to some discrete issues. We will specify which in the new year, having considered the points helpfully raised in September and being raised in this hearing.

As you have already stated, Chair, throughout this time, the Inquiry team will be concerned with undertaking the very important task of obtaining evidence from the families and friends of those who died and investigating the circumstances of its chosen case reviews, the approach to which you have already outlined. The Inquiry is drawing up plans addressing how to hear from people with lived experience of mental health and patient services in Essex.

Many of the Core Participant opening statements, both in September and in this hearing, have referred to the importance of the recommendations you will be making. They have referred specifically to the requirement that these recommendations must be implemented by the relevant Government, health or other body if meaningful change is to be made.

Chair, I know you agree with this. Whilst it is currently too early to be considering the content of any recommendations you may make, now is the right time to start considering their implementation. In other words,

what can be done to ensure that your recommendations, when made, are clear, focused, in an implementable format and that they are then implemented by the responsible body? Indeed, we will expect those within these responsible bodies to be preparing for their speedy implementation from the earliest stages.

You have accordingly directed that a Lampard Inquiry recommendations forum should be set up. The Counsel to the Inquiry team will start this by producing a note expanding on these points to a discussion.

Thank you, Chair. That is all I wish to say now by way of update. We are grateful for the continuing collaboration and engagement of those involved in this Inquiry.

Chair, we now take a ten-minute break while things are put in order for the first of the opening statements that we will hear. So we will be back in ten minutes. Thank you.

(10.30 am)

(A short break)

(10.40 am)

MR GRIFFIN: Chair, the first opening statement that you will hear is made on behalf of the family of Joshua Leader, the family of Terrence Pimm and the family of Richard Elliott. They are represented by Leigh Day

Solicitors and the opening is to be given by Maya Sikand, King's Counsel.

Maya, please start your opening when you're ready.

Opening statement by MS SIKAND

MS SIKAND: Thank you, Nick. Good morning, chair. It is my privilege to make this opening statement on behalf of the three Core Participant families currently represented by Leigh Day in this Inquiry, and as Nick just said it's the Leader family, the Pimm family, and the Elliott family.

Each family has suffered the immeasurable loss of a served one: Joshua Leader, known as Josh, who died in 2020; Terrence Joseph Pimm, known as TJ, who died in 2016; and Richard Elliott who died in 2002.

Each family entrusted the care of their loved one to the mental health services in Essex with the basic expectation that, at the very least, they would be kept safe. The knowledge that this did not happen, that their loved one's deaths were or may have been preventable, make their loss particularly painful.

These three families, whilst still grieving the deeply personal loss of their loved ones, are bound by a common sense of helplessness, anger and disbelief as to how this could have happened to them.

Chair, to learn that there may be thousands of

families in a similar position brings little comfort to them. They recognise that the path to reach this Statutory Inquiry has been long and hard fought and they pay tribute to the families who have campaigned for years for the failings of NHS Trusts in Essex to be scrutinised, and thank them.

Our clients' shared expectations from this Inquiry is that they are afforded answers and the assurance that no other family will suffer like they have in the future. Chair, these are twin expectations, not hopes, otherwise this process will be for nothing.

As others have already said, the provision of mental health care in Essex has been the subject of longstanding and robust criticism for the past several decades, from a range of independent bodies, including the Care Quality Commission, the Nursing and Midwifery Council and other professional regulators: the coroners courts; the criminal courts; and the Parliamentary and Health Service Ombudsman. Despite these investigations identifying significant and similar features in respect of patient safety, the relevant NHS Trusts in Essex have persistently failed to take or even acknowledge the need for the urgent action required.

This entrenched failure to learn lessons has led to many more suffering serious harm and death. Chair, that

this Inquiry still does not have, and may never have, a definitive figure for the number of deaths within scope is both stark and troubling.

It is also illustrative of the challenge this Inquiry is faced with in trying to unlock/unpick the true scale of the systemic failures which prevailed between the years of 2000 and 2023, and continue to prevail within the Trusts, as well as making recommendations which will make a tangible difference.

It is precisely because such failures may remain unaddressed, and so the consequent risks to patient safety remain a live issue, that there is a dispiriting urgency to this Inquiry.

The Inquiry will need to move at pace with the flexibility to respond to new lines of relevant investigations when they arise. Our clients welcome your indication, Chair, that, if the evidence reveals issues of urgent concern, you will move quickly to ensure the relevant healthcare bodies are notified and action taken. We also invite you, Chair, to reconsider the value of issuing an interim report of your actual findings and recommendations in view of the dynamic context within which the terms of reference will been interrogated.

Your indication that you will use the full extent of

your statutory powers to compel the production of all necessary evidence from corporate CPs is, of course, welcome, Chair. This is especially important in view of the cavalier and combative approach too often adopted by the Trusts in previous investigations, which was, as we all now know, a key reason to this Inquiry being placed on a statutory footing.

Our clients bring very different, albeit equally valuable, perspectives to this Inquiry. For the Leader and Pimm families, their participation in this Inquiry has only been made possible by your more expansive interpretation of an inpatient death to that adopted in the non-statutory phase of this Inquiry. Both their loved ones, Josh and TJ, died in the community following wholly inadequate mental health assessments conducted by the Trusts which led to neither being admitted onto an inpatient ward when their families were convinced that they needed to be to keep them safe.

By contrast, Mrs Peck's brother, Richard, was detained on an acute adult ward but died less than 12 hours into his admission, in circumstances which raise serious questions over the use of restraint, as well as the level of observations in what was then described as "seclusion".

Despite these patients being on either side of the

hospital threshold and the time frame of their deaths spanning nearly two decades, that is from 2002 to 2020, their communality of experience, in respect of the lack of basic safeguards and clinical decision making, is significant.

I move on now, Chair, to talk about the background to our Core Participants. Given the early stage of this Inquiry, we do not propose to rehearse the detail of the evidential background, insofar as it is known to us in relation to each of our three Core Participant families.

The extent of the information that each family has about what happened to their loved ones is notably varied, affected by the paucity of the Trusts' own post-death investigations, clinical record-keeping and the limitations of the coronial proceedings. The question as to why their loved ones were failed by these protective institutions remains unanswered. It will only be through the process of this Inquiry, Chair, that they will be able to place their own loss within the broader picture of systemic failures that are likely to emerge.

It is, however, important to say something at this stage as to what our clients do know and how their experiences inform their involvement in this Inquiry, and to tell their stories: to illustrate how hard each

family worked to try to make mental health professionals listen to them.

I start, Chair, with Joshua: Josh Leader. He was 35 when he died. He leaves a young son and a loving, grieving family. His family, who will deliver a commemorative statement after I have finished, have said about him that his enthusiasms were infectious and they hoped they might have carried him on to more stable ground. His laughter, goofy, seismic, seemed to rise upped from the ground he stood on.

Josh had a long history of mental ill health, had been an inpatient in various psychiatric hospitals and had been receiving care and treatment in the community. In November 2019, Josh moved into the catchment area for Essex Partnership University Trust, EPUT, having moved to his parents house in Colchester after a breakdown in his own living arrangements. In November 2019, Josh was referred to EPUT's specialist psychosis team, where a care plan was completed for him and, in December 2019, Josh was allocated a care coordinator.

Josh's family report that he was fairly stable around this time and moved out of his patients' house to accommodation nearby, which he shared with a flatmate. Unfortunately, however, in or around early March 2020 Josh's mental health deteriorated after he stopped

taking his medication. A pattern that was all too family to his family. At a review in March 2020, as the pandemic hit, Josh was noted to be presenting with suicidal ideation with plan and intent. Josh was referred to EPUT's home treatment team who assessed him and decided to offer no further service.

On 10 April 2020 Josh said he was going to end his life and said goodbye to his family, who then contacted emergency services and Josh's care coordinator. An appointment was arranged with a core trainee, CT, level doctor in EPUT's specialist psychosis team. Josh's anti-psychotic medication was discontinued, which caused significant concern to his family, who made urgent interventions and, in the following weeks, there were discussions between Josh, his family, his care coordinator and the CT-level doctor during which various changes were made to his medication.

In May 2020, Josh's mother contacted his care coordinator on multiple occasions expressing concerns about Josh's behaviour and symptoms, including that he was not taking his medication. Josh's brother also raised the absence of a Section 117 Mental Health Act assessment, care plan and funding, as a mechanism to secure Josh the support to which he was entitled and never received.

From around July 2020 onwards, Josh's family repeated concerns about Josh's medication, in particular his non-compliance, and the negative impact of not being on anti-psychotic medication, and made clear they felt Josh needed inpatient care in order to prevent further deterioration and harm. In or around August 2020, Josh was in contact with a family friend, a professor in neuropsychology based in South Africa, seeking an opinion. By around mid-September 2020 Josh was again expressing feelings of desperation to his family and was still not taking his medication.

His mother reported these concerns to EPUT's crisis service and his brother also contacted Josh's care coordinator. Josh also wrote around this time to the professor in neuropsychology. He wrote:

"The NHS and councils here in the UK have shown that they're not at all interested in helping me."

On 18 September 2020 a consultant psychiatrist from EPUT's Specialist Psychosis Team made a plan to meet Josh and his family some six weeks later, on 29 October 2020, because she had no immediate concerns about him. By contrast, his family was extremely worried. They report that by mid-September Josh was "really spinning out of control", and "in perpetual crisis", speaking obsessively about needing to flee and how he was

"unsafe" in Essex and obsessing over imaginary illnesses that he had self-diagnosed.

His family was desperate for Josh to have a proper care plan, to be supported to consistently take his anti-psychotic medication. They felt that Josh needed to try anti-psychotic depot injections, due to his repeated problems of non-compliance. They told his care coordinator that they could not wait until the end of October and that Josh needed more support urgently, but they were not listened to.

In the event, the psychiatrist reduced Josh's dosage of medication. Josh was, at this time, still waiting for a psychotherapy referral. In early October, Josh's family became worried he was planning to go to America in a state of very poor mental health and with no support or plans for his care. Josh expressed suicidal intent to his family, who again contacted his care coordinator to ask for help. Josh's family felt his situation was becoming desperate.

On 17 October 2020, Josh's mother again reported to EPUT's crisis team that her son had suicidal thoughts and intent and that he had messaged his family saying goodbye. Josh expressed plans to end his life by hanging the following day to healthcare professionals.

On 18 October, the police were called and removed

a rope from Josh. In the event, Josh was then referred to EPUT's Home First Team, HFT. He had a video consultation with a consultant from the HFT on 20 October 2020 of which Josh's family were not aware and to which they were not invited. Josh still continued to express suicidal intent to his family and, on 24 October 2020, his mother contacted EPUT's HFT after Josh had said he was going to a railway station to end his life. He was described as presenting as erratic and intense during a visit from the team that day.

The one hope that the family had was that the appointment with a consultant psychiatrist from the Specialist Psychosis Team on 29 October 2020 would resolve the proper approach to treatment for Josh. That appointment, Chair, was cancelled on the evening before the meeting, on the basis that Josh was now under the care of the HFT. This last-minute cancellation, on the basis of compartmentalised care provision, was a crushing blow to the family, who had been pushing and waiting for this specialist help for months.

Josh was instead reviewed by a consultant psychiatrist from EPUT's HFT with his brother attending by phone on 30 October 2020 in a rushed meeting lasting only half an hour. The HFT psychiatrist found that Josh was not displaying any symptoms of psychosis and

prescribed him an anxiolytic, rather than an anti-psychotic medication.

Josh continued to be seen daily by EPUT's HFT in early November and self-reported an improvement in mood on the new medication. His family, however, reported that this was part of a well-known cycle for Josh after a change in medication and that he was continuing to speak to his family about suicidal thoughts. Josh's mother again reported these concerns to the HFT. Josh's care coordinator visits were then reduced to every other day with a joint review plan for 12 November 2020.

On 11 November 2020, Josh's brother contacted EPUT's HFT to express concerns about his brother, after he repeated suicidal thoughts to his family, and to request a meeting. This meeting resulted in Josh being discharged from EPUT's HFT, back to the Specialist Psychosis Team, who then assessed Josh's level of risk as the lowest level, according to its RAG rating, despite the family's view to the contrary.

Following further intervention from Josh's family, and the family friend in South Africa, Josh was assessed by the EPUT consultant psychiatrist on 19 November 2020. However, Josh's family were not involved and were unaware of this appointment.

On Saturday, 21 November 2020, Josh again told his

parents that he wanted to end his life. He talked about being able to buy medication online and asked his family to help him. His family reported this to EPUT's crisis team. The next day, out of desperation and fear, his mother took him to The Lakes Mental Health unit in Colchester, as you know, Chair, run by EPUT at the time. Josh was assessed by a Crisis Response Team nurse in the presence of his family, with a view to admission. His family considered at the time that the nurse's assessment was thorough and comprehensive. That nurse took time to build trust with Josh, spoke with him privately and explored his protective factors, which meant that Josh felt able to disclose that he felt actively suicidal.

Josh's family understood during the assessment that it was agreed by the Crisis Response Team that Josh, with his consent, would be offered inpatient treatment. However, a Band 6 psychiatric nurse, working for the HFT in a gatekeeping role, providing assessment for acute intervention, which was either admission to hospital or support from the HFT, subsequently refused inpatient treatment.

At Josh's inquest the Band 6 nurse gave a markedly different account from that which he had given in his written statement to the coroner. He said he was unsure

whether he had read any of Josh's medical notes before conducting the assessment as to whether to admit him, and also said that during the assessment he "broke [his] own processes, I don't know why", in failing to provide an alternative care plan upon refusing hospital admission. The coroner also found at the inquest that the gatekeeping nurse had told Josh and his family during the assessment that:

"There is no psychiatrist in the world who would prescribe Josh anti-psychotic medication."

Yet only days before, plan had been agreed to explore depot anti-psychotic medication with a consultant psychiatrist. Although Josh was not offered inpatient admission or any further support from the HFT following this gatekeeping assessment, he was told he would be visited the following day, 23 November, 2020. No visit took place.

Josh said to his mother that day, "You see, Mum, they did not come", and his mother told Josh's inquest that, having not been admitted to hospital the previous day:

"Josh was already feeling he was not going to receive the help he needed, and this just confirmed it."

Josh's brother sent a text message to the care coordinator explaining that the weekend had been "very

difficult with Josh, who was again threatening suicide". He repeated his requests for anti-psychotic medication to be described for Josh and for a family meeting, signing his text off with the words "in desperation".

On 24 November 2020, Josh sent a text to his care coordinator saying, "Can we speak today? I need a prescription from the doctor for an anti-psychotic".

The same day Josh's mother sent a text to the care coordinator saying that she felt her son was on "the very edge of taking his life. We are utterly stuck and Josh will die".

That morning, the care coordinator called Josh, who said he was walking around the woods near his house. Josh is recorded as saying he "does feel suicidal", and that "He has a plan to hang himself", but that "He is not going to do it because of his mother".

The care coordinator visited Josh at just after 11.00 am that day and noted that Josh denied suicidal thoughts and "felt safe".

Josh was found having ended his life using a ligature later that day, some five hours after the care coordinator's visit.

The EPUT Patient Safety Incident Investigation, PSII, report into Josh's death drew no conclusions as to the cause of Josh's death and made recommendations which

did not address the systemic issues raised by his death. In stark contrast, His Majesty's Area Coroner for Essex -- or then Her Majesty's Area Coroner for Essex -- concluded Josh's inquest on 11 July 2024, recording an extremely critical narrative conclusion, and finding that Josh died by suicide, contributed to by neglect.

Chair, as you know, neglect in this context is a high level test to satisfy and signals a gross failure to provide basic care, which is causative of death.

Chair, I now move on to TJ Pimm.

TJ was 30 years old when he died. His mother, Karon Pimm, gave a moving commemorative statement about her son in the October hearings, as you may recall, in which she spoke of her bright son, who, despite his struggles, was trying his best to forge a positive future. He was due to start a well-paid corporate job the month he died.

TJ had a long history of anxiety and depression, complicated by alcohol dependence. Whilst he struggled with intermittent symptoms in his early adult years, these started to intensify in late 2015, following the breakdown of his relationship, which involved an altercation in respect of which he was charged with assault.

He moved back in with his parents and was sentenced

in February 2016 to a community order, as well as being made subject to a restraining order, which brought him under the arm of the probation services. His parents witnessed a rapid decline in his mental health over the next few months, increasingly characterised by suicidal ideation.

TJ turned to alcohol to blunt his feelings, and was signed off work for stress-related illness. Whilst he saw his GP in this period for his low mood and was prescribed anti-depressants, he had no engagement with secondary mental health services.

On 8 August 2016, the British Transport Police were called after TJ was found at a train station threatening to jump. He was taken to his sister's house nearby, where police officers found him in a desperate state, crying and intoxicated. TJ himself admitted that he needed mental health help. His sister reiterated this to police officers and warned them that he tended to minimise the extent of his distress. An ambulance was called with his mother arriving soon after. Police made the subsequent decision to detain TJ pursuant to Section 136 of the Mental Health Act 1983. As you know, Chair, this Section grants the police emergency powers to detain an individual who they suspect to be suffering from a mental disorder in a public place and who is in

immediate need of care or control.

This is not a power of arrest but one of basic safeguarding, the purpose of which is to remove the individual to a place of safety, most often a mental health hospital unit, with police custody only as a last resort to facilitate a mental health assessment.

TJ was therefore conveyed to Goodmayes Hospital run by North East London Foundation Trust, NELFT, for assessment. However, for reasons which remain unexplained, he was not assessed there nor did the hospital have any records of his admission.

Late in the evening of 8 August 2016, TJ was subsequently transferred to the Harbour suite, the health-based place of safety at The Lakes Mental Health Unit, located next door to Colchester Hospital.

His mother, Karon, who was herself a registered general nurse in the urology department at Colchester Hospital, repeatedly called the unit asking what was happening and when her son would be assessed. She expressly requested to speak to the consultant psychiatrist who would be assessing TJ to share her concerns, reiterating that her son would likely disassemble and downplay the extent of his symptoms.

The mental health assessment conducted by an Approved Mental Health Practitioner, an AMPH, and

consultant psychiatrist, proceeded on 9 August 2016, without seeking Mrs Pimm's involvement or even notifying her that it was taking place. Chair, she was just minutes away and would have wanted to provide vital information about his historical and current presentation.

Without Mrs Pimm's input, the assessment was critically limited. Despite this being TJ's first ever point of contact with psychiatric services, presenting in the context of a clear crisis, little attempt was made to elicit a clinical history from him or to explore the current triggers for his suicidal impulses. TJ's assurances that he was fine were taken at face value, with his problems attributed solely to alcohol misuse, rather than mental illness.

He was not admitted as an inpatient under section or informally, nor was there any evidence to indicate that informal admission was actively considered. Rather, he was discharged the same day with no follow-up support or signposting. His mother, who thought TJ might finally get the help he needed, was in disbelief when she received a call from The Lakes asking her to pick him up.

Over the next several weeks, TJ further spiralled. On 24 August 2016, a warrant was issued for his arrest

after he failed to appear at court. In a call to the police the following day, TJ's father advised that he did not know where his son was and that he was concerned for his welfare, after threatening suicide again just the day before. He pressed that his son needed to be arrested and taken to hospital. TJ attended an appointment with his probation officer that afternoon, where he presented in marked distress, disclosing that he had taken himself to two separate sites, contemplating suicide, before coming there.

His probation officer, understandably concerned for TJ's welfare, brought him straight to A&E at Colchester Hospital for an urgent assessment, notifying Mrs Pimm, who met them there. TJ was seen by a Mental Health Liaison Team nurse, MHLT nurse, I'm going to say, a part of the access and assessment team, which was run at the time by the North Essex Partnership University NHS Foundation Trust, NEPT, and latterly EPUT. The nurse was briefed on TJ's section 136 MHA detention on 9 August 2016 and of his disclosure of suicidal intent earlier that afternoon.

Whilst she considered TJ was unfit for assessment, as he was intoxicated, the nurse initially offered him a bed on the unit to stay overnight with a view to him being assessed the following morning. However, on

discovering that there was an outstanding warrant against TJ, the nurse insisted on what his family perceived as a concerning volte face, that he had to attend the police station instead to be arrested. This was despite repeated requests from his mother that TJ remain at the hospital.

In her evidence to the inquest, the MHLT nurse stated that she felt "compromised" by the fact that there was an arrest warrant in play and maintained that, despite being aware of TJ's suicidal disclosure, police custody was the "safest option" for him.

Once again, therefore, TJ was sent away with his mother without having received a proper mental health assessment and with no care plan or provision in place to support him and his family, or mitigate the risk of self-harm.

On 26 August 2016, Mrs Pimm drove her son into Colchester with the understanding that he was going to attend the police station. TJ went to see his probation officer, also indicating to her that he was going to hand himself in. When his probation officer subsequently called the police station to check if he had done so, they confirmed he had not turned up. Shortly thereafter, police received a call that TJ had jumped from a high building and died.

The subsequent Serious Investigation Report, SIR, completed into TJ's death did not identify any relevant failures on the part of the Trust. The report summarily concluded that both crisis assessments were adequately conducted, instead seeking to attribute TJ's alcohol abuse as a significant contributory factor to his death, despite the fact that he was not under the influence at the time of his death. By marked contrast, in the subsequent inquest into TJ's death, heard in April 2017, clear criticism was made of TJ's clinical care.

The jury found that TJ's risk of suicide had not been properly assessed and inadequate measures were taken to manage his risk of suicide. The coroner issued a wide-ranging Prevention of Future Death Report against EPUT, Essex Police, and Essex Community Rehabilitation Company, responsible for local probation services, addressing the key concerns raised in the inquest, including inter-agency coordination, family involvement in mental health assessments and training for mental practitioners on patients subject to a warrant.

The Pimm family, like the Leaders, tried desperately and repeatedly to get their son the help he needed. Each time, they were rebuffed and ignored, turned away by the gatekeepers, and left to shoulder the immense burden of caring for their very unwell son alone.

What is particularly cruel about that experience, chair, is how close they feel they came to getting their son the protection he needed. TJ's sole point of contact with mental health services on 9 and 25 August 2016 represented two critical junctures for meaningful clinical intervention, when his acutely suicidal state could and should have been readily identified and safeguarded. On both occasions his family felt the momentary sense of relief of believing that TJ was somewhere safe, that he would receive the treatment he required, only for this to be undercut by the anguish of his discharge back to the community.

The abdication of clinical responsibility in TJ's case meant that he was never properly assessed by the trust, much less afforded the help he patently needed by way of an inpatient admission.

Similar failures and frustrations characterised the experience of the Leaders. We know, of course, that inpatient admission would not necessarily have guaranteed TJ's or Josh's safety and that, shockingly, patients faced serious and avoidable harm whilst on the Essex Trust wards.

This disturbing irony that they may have been no safer on the other side of the hospital door speaks to the central concern of this Inquiry, Chair. However,

the Pimm and Leader families were not even afforded that hope, that stay of desperation, in knowing that their loved ones were finally under the direct care and responsibility of mental health professionals.

Chair, I move on now to Richard Elliott. Richard was 48 when he died. He was an inpatient at the time. The exact circumstances of his death remain unclear to his family. A brief two-day inquest into his death heard by a coroner sitting without a jury concluded that he had died by natural causes whilst an inpatient on Peter Bruff Ward in Clacton Hospital run at the time by NEPT. This bare conclusion, recorded on 15 November 2002, belies the events surrounding his admission, which, as far as his family can tell from the witness evidence provided to the inquest, point to concerning clinical practices and possible lapses in care.

Mrs Peck, Richard's sister, has very recently been recognised as a CP, having only become aware of this Inquiry within the past few months. A 36-page bundle of witness statements is all that she received from the coroner's court. She is yet to receive the underlying medical records and witness evidence from the key clinicians involved in the events preceding his death. She hopes this Inquiry will, among many other important functions, facilitate the provision of such evidence in

order to afford her long-awaited answers. She and her family still do not have the comfort of closure that a properly conducted inquest can sometimes bring.

Chair, Richard had a longstanding history of severe mental illness, suffering from bipolar disorder with acute psychotic episodes, which led to numerous inpatient admissions, including previously to the Peter Bruff Ward. He had been known to EPUT since 1985 and appeared stuck, like many who suffer from acute mental illness, in a relentless cycle of relapsing and remitting ill health over the years that followed. His family had repeatedly sought, over many years, to raise concerns with Richard's different medical teams over his treatment, including periods when they believed he was being over-medicated or wrongly medicated -- these concerns repeatedly rebuffed -- which the family feel significantly impacted on Richard's willingness to engage with these services and on his subsequent deterioration.

In May 2002, Richard suffered a serious relapse in his psychosis. On 23 May 2002, his community consultant psychiatrist was notified of his deterioration, in particular that he was presenting as increasingly disturbed. A rapid response team was assembled, comprising numerous police officers, the psychiatrist,

a GP and a social worker to attend his home. Richard was encountered as highly paranoid, making threats and accusing the GP of having burgled him.

The decision was made to detain Richard under Section 3 of the Mental Health Act. Given concerns over possible escalation in risk, police decided to assemble a level 2 entry, which appears to have meant convening numerous officers, possibly up to eight and possibly in riot gear -- the facts remain unclear at this stage -- to effect his transfer to hospital. Richard, however, complied and went voluntarily with the officers.

On arrival at Clacton Hospital, Richard was unwilling to come onto the ward, staff having to coax him and redirect him away from other wards. It appears that very soon into his admission -- the evidence available would suggest around 15 minutes -- the decision was made to administer Richard two different anti-psychotic medications, together with a benzodiazepine, via intramuscular injection. The arrangements for prescribing and monitoring the administration of such rapid tranquilisation so early on into his admission remain unclear at present. This uncertainty is amplified in the family's mind by the fact that the toxicological bloods analysis appeared to only have detected the presence of the benzodiazepine,

lorazepam, which was found to fall above the therapeutic concentration, just, into the toxic range.

It also remains unclear and to what extent manual restraint was used against Richard, the limited evidence from the inquest appearing inconsistent on this.

Richard was initially placed in overnight seclusion and was commenced on continuous observations, seemingly to monitor for adverse sedative effects from the medication.

However, seclusion appears to have been terminated around four to five hours in, despite the fact that he was observed to be highly sedated, non-conversant and not in control of his bodily functions. After this point, it is unclear what level of observations Richard was subject to, despite his unstable presentation. Throughout the early hours of the morning of 24 May 2002, Richard presented again several times as not in control of his bodily functions and restless, requiring several members to change him.

During further checks, he was observed to present with stertorous breathing and signs of sleep apnoea, which Richard suffered from. It is not easy, Chair, for his family to put these details into the public domain, as respecting Richard's dignity is of paramount importance to them. However, they want to highlight

that there were the clearest signs of his physical vulnerability and it remains unclear what steps, if any, were taken to monitor his vital signs in this period or to maintain his dignity accordingly.

It was around 0520 that staff noticed his breathing that quietened and entered to find his pulse faint and his lips blue. We note that there is no witness statement from the staff nurse who discovered Richard unresponsive and who raised the alarm, and who appears to have been the one responsible for observing him in the proximate period.

Emergency resuscitation efforts were initiated, however Richard very sadly passed away shortly after. His medical cause of death was attributed to by cardiac complications, ie natural causes. That was the record.

The limited information that Mrs Peck and the Elliott family hold about Richard's death leaves them understandably with many painful questions. The evidence provided to the inquest raises serious and seemingly un-probed concerns as to the use and appropriateness of restrictive measures against Richard, including seclusion, possible restraint to administer medication, possible over-medication and inadequate clinical monitoring.

From the piecemeal investigation into Richard's

death to date, the family has been left only with the agonising image of him dying alone, heavily sedated in a seclusion room. It is firmly hoped that the work of this Inquiry will help bring his family some clarity as to what happened to Richard whilst in the care of the Essex trusts.

Chair, I now move on to some of the thematic concerns for our Core Participants.

Drawing from these experiences of our clients and their loved ones, as outlined so far, we seek to emphasise at this stage some of the core thematic concerns that they hold, which reflect and inform your terms of reference, Chair, and your provisional list of key issues.

Given the incipient stage of this Inquiry, Chair, we provide only a general outline of such concerns, recognising that these may well evolve or change as the evidential picture develops and, of course, Chair, we welcome the earlier indication from Counsel to the Inquiry that the provisional list of key issues is likely to expand, taking on board some of the matters that we raise.

Our first thematic concern falls under the subheading "Admission assessments". An important and distinctive feature of the circumstances surrounding

Joshua and TJ's deaths is that, unlike what we believe will be the majority of cases before this Inquiry, they were not inpatients on mental health units. Rather, both patients died very shortly after inadequate assessments, which resulted in decisions not to admit them as an inpatient nor to provide them with the necessary support in the community.

The nature and appropriateness of these admission assessments will require careful and nuanced consideration by this Inquiry. Chair, we also believe this Inquiry should look at what weight is given to the views of other state agencies seeking an assessment on behalf of a vulnerable patient, such as the probation services and the police, given that TJ was brought to hospital by each of these agencies on separate occasions.

In a similar vein, Chair, we believe this Inquiry will also need to consider the applicable policies and guidelines in place at the time for mental health staff working in acute settings, concerning the management of patients who are open to the criminal justice system, including whether such processes were and remain fit for purpose, and the extent to which staff were apprised of and applied such guidance in their mental health assessments.

Such assessments are the key route to determining whether an individual may require inpatient admission, or more intensive community care, commensurate with their clinical needs and risk. For many vulnerable individuals in crisis, such assessments may well be their only point of contact with secondary mental health services.

Chair, it's vital that these assessments are comprehensive, robust and inclusive, and carried out by staff with the correct expertise and training. They should not be conducted in a way in which pre-judges the individual's problems based on, for example, concomitant substance misuse issues or their socioeconomic circumstances. Families, who so often know their loved ones and their challenges better than any clinician, must be proactively involved, Chair, rather than be treated with hostility or suspicion, as unwelcome meddlers or an adjunct or an afterthought. Even when, for whatever reason, consent is not provided by a patient for clinical information to be shared with third parties, including their families, this should not obviate the need to listen to families' expert knowledge of their loved ones.

Moreover, proper and advanced consideration must be applied to the type of assessment required for

a particular patient. As a provisional list of issues recognises, there is a significant difference between assessments for detention under the Mental Health Act 1983, and other mental health assessments which may be conducted in acute care settings, or health-based places of safety.

An assessment under the MHA 1983 must be conducted as you know, Chair, in accordance with specific legislative criteria and processes are set out in the Mental Health Act Code of Practice, including being carried out by two psychiatrists, one of whom must be an approved practitioner under Section 12 of the Act, as well as reviewed by an AMPH. The assessment should follow a specific and structured format directed at assessing whether detention is required in the context of their mental state and risk to self, and/or to others. As part of this process, the patient's nearest relative must be consulted.

These safeguards do not apply with the same rigour to alternative mental health assessments which may be conducted in relation to potential admission. That, Chair, increases, rather than reduces, the need for such assessments to be scrutinised in the context of your Inquiry.

Neither of the assessments that Josh and TJ

underwent in the days before their deaths were conducted under the Mental Health Act 1983. Despite undergoing a gatekeeping assessment on 22 November 2020, consequent to an express recommendation from EPUT's crisis resolution team that he required inpatient admission, and Josh himself agreeing to this with the support of his family, the decision was taken not to admit him as a voluntary patient, nor was any consideration given to whether he may, in fact, be detainable under the Mental Health Act.

Similarly, the MHL team nurse who reviewed TJ on 25 August 2016 failed wholesale to consider whether he required admission, either under the Mental Health Act 1983 or, informally, instead erroneously determining that he could not be assessed at all, given the outstanding warrant for his arrest.

Chair, neither Joshua nor TJ received the systematic evaluation of their acute mental state and risk profile which they and their families expected, and to which they were entitled, nor was any input sought from a psychiatrist. Both mental health assessments, insofar as they can even be described as such, marked critical missed opportunities to keep safe two individuals who were in a state of conspicuous crisis.

The shortcomings in the assessment that Josh and TJ

received underscore how important they are as a gateway or barrier to receiving necessary treatment. Such limited assessments not only precluded informed consideration of whether an inpatient assessment was required but, in the alternative, the critical question of what safeguards were needed to manage their risk on discharge. Both TJ and Josh were sent home with no specific safety or care plan in place, nor any form of safety netting guidance provided to their overwhelmed parents.

Josh left the hospital where he was assessed not having been admitted and with no support plan at all, with nothing more than a phone number. He was discharged back to the Specialist Psychosis Team he was already open to, with no additional intervention or safeguards implemented to mitigate his significantly increased risk. It was these inadequate discharge arrangements which the coroner found in Josh's inquest amounted to neglect, namely a very serious failure to provide basic medical care, which directly contributed to his death.

TJ, despite being actively suicidal and intoxicated, was discharged home with no care plan whatsoever, nor a referral or even signposting to community mental health services.

The importance of ensuring that robust safety plans are in place for at-risk individuals is a matter of core clinical practice, Chair, as recognised by the Royal College of Psychiatrists. Not only can it provide critical psychological assurance to the patient but to families and carers who step into this void to care for them. The desperation, bewilderment and disbelief which the Leader and Pimm families experienced in having their acutely unwell relatives discharged back home once again with no crisis plan or safety-netting cannot be understated, Chair.

We note, Chair, that you are minded to identify a sample of cases, as you have confirmed again today, which you consider representative of the various issues which will be investigated in greater detail in order to draw wider conclusions. We invite you to consider selecting one or both of these cases as representative in respect of the treatment of inpatients who died following a decision not to admit them.

The challenges that the Pimm and Leader families experienced as committed and engaged relatives are illustrative of the systemic failings which inform and obstruct the pathway to an inpatient admission for many patients in Essex.

The next thematic concern, Chair, is the involvement

of family members in patients' care. The extent to which family members, close friends and carers were engaged with, and involved in, decisions concerning a patient's care will be a key theme that threads through this Inquiry. The failure to involve families in clinical decision making concerning their relatives has been a longstanding feature raised repeatedly in the Trust's internal post-death investigations and in coroner's inquests, including by way of Prevention of Future Death Reports. Despite this, Chair, families continue to face a system indifferent, suspicious and hostile to their views and concerns.

The involvement of family members in a patient's clinical decision making is not simply a courtesy: it underpins the clinical triangle of care model which seeks to encourage equal partnership between carers, patients and mental health professionals in order to promote a patient's safety and recovery.

Family involvement is similarly part of NICE best practice guidelines and reflected in varying terms across local trust policies. Such guidance recognises that families are an invaluable source of collateral information about a patient's needs and risks, including key indicators of relapse that clinical staff may well otherwise miss. It recognises that family members and

those close to a patient will inevitably know more about that patient than the healthcare professionals. Their collaborative involvement in care planning is a crucial component of accurate risk formulation and management.

The engagement of family members must be frontloaded, not reactive, their input being sought at an early stage in a patient's care, as opposed to leaving them fighting hard to be heard.

The provisional list of issues, Chair, places particular emphasis on the engagement of family members and carers, "from the point of admission through to discharge". The exclusion of family members from a patient's care, however, significantly pre-dates the point of inpatient admission, Chair.

For the Leader and Pimm families, for instance, despite tireless attempts to advocate for Josh and TJ, their concerns were repeatedly deprecated and dismissed by the various healthcare professionals involved in their care.

For the Leader family, their countless attempts to inform the relevant clinical teams throughout 2020 of Josh's well-known cycle of rapid deterioration, including as to his intensifying suicidal ideation and the urgent need for him to be restarted on anti-psychotic medication, which were known to stabilise

him, were simply not registered, or worse, were actively discounted by the Trusts.

Despite the family's decade-long insight into Josh's cyclical pattern of illness, they were never invited to undertake a carers' assessment nor to crucial meetings concerning his care planning. This followed through to the gatekeeping assessment on 22 November 2020, where the failure to heed the family's warning that Josh was seriously psychotic had severe consequences, Chair, directly informing the decision not to admit him for inpatient care.

In TJ's case, a failure to involve his mother in his Section 136 assessment at The Lakes Unit, despite her repeated requests to be involved, is rendered all the more stark given her physical proximity, working on shift in the next-door hospital.

In their evidence at the inquest, the clinical staff who undertook this assessment stated that they did not consider that they needed to contact family members, as they did not consider that TJ was mentally unwell or at risk. The perversity of this rationale lies, of course, in the fact that the input of Mrs Pimm was the key missing factor in understanding just how unwell TJ was and how urgent his need for acute intervention. It is important for this Inquiry to understand how this

misconception of family input as a bolt-on, optional consideration, rather than a core component of clinical care, operates as a barrier to effective care for patients in crisis in the community. As for TJ and Josh, it can result in them being wrongly denied the prospect of inpatient admission and of a clearer pathway to recovery.

The investigation as to why family inclusive care was and is not being effectively implemented for Essex mental health patients will cut across a number of the issues that this Inquiry will look at, this will likely include, for instance, the composition and training of staff and the wider culture at each provider.

Experience from previous inquests and investigations points to lack of understanding from clinical staff as to the therapeutic rationale for family involvement, possibly informed by negative views of family members as intrusive or undermining of clinical efforts. Chair, the Inquiry will also need to appreciate that, whilst magnified within the Essex Trusts, issues concerning family engagement apply on an NHS-wide scale. Inevitably, the Inquiry will need to interrogate this issue on a national level in order to ascertain how and whether a step change in this area can be achieved.

The next thematic concern, Chair, is patients who

have contact with the criminal justice system. The intersection between the criminal justice system and mental health services is well established, Chair. Extensive research and studies have confirmed that people with various forms of mental illness are highly over-represented in the criminal justice system, that people who are subject to criminal proceedings have the same rights to psychiatric assessments and treatment as anyone else ought to be uncontroversial, Chair. However, this is all too frequently not reflected, in practice, with healthcare agencies failing to work effectively with the police, prison and probation services to ensure that vulnerable individuals involved in the criminal justice system have their mental health needs promptly assessed and met.

Chair, TJ's case exemplifies a disjunction between the mental health services and the criminal justice services. His A&E assessment on 25 August 2016 was cut short due to the nurse's erroneous belief, as I've already said, that she could not assess or admit TJ as he was subject to an arrest warrant.

This betrays a fundamental misunderstanding of the primacy of professional clinical duties, with TJ's suspect status being prioritised over his mental assessment needs. That he was subject to an arrest

warrant did not diminish and in fact only reinforced the necessity for conducting a comprehensive assessment of his acute mental state in the context of his current stressors, including his outstanding criminal proceedings.

The suggestion from the MHLT nurse assessing TJ, in her evidence at the inquest, that police custody was the "safest" place for TJ, where he could be assessed by a force medical examiner, is deeply concerning. It is axiomatic that custody should always be a matter of last resort for mentally vulnerable people involved with the criminal justice system.

I pause there, Chair, to note, in fact, that there are plans afoot to remove police station and prisons from the list of places of safety in the new Mental Health Bill, which, as it happens, is being debated today, as I speak.

Chair, it is especially important, where the patient is in active crisis, to avoid police custody, particularly when the patient, like TJ, is already within the protective hospital setting. Moreover, despite TJ seemingly being discharged on the misconceived premise that he would present to police custody and be assessed there, no liaison was made with the police to ensure he was safely delivered to custody

by either service, which of course he was not.

This failure to ensure continuity of clinical protection between the mental health and criminal justice services will be of particular relevance to your consideration, Chair, of the interaction between the Essex Trusts and other public bodies, including but not limited to the police and HMPPS.

In your explanatory note on scope, Chair, you indicate that you will consider, as appropriate, the particular circumstances which may inform an individual patient's experiences within the trusts, listing various examples including physical health issues, drug and alcohol addiction, and "other social and economic factors".

We invite you, Chair, to expand such consideration, impliedly or otherwise, to include any contact or involvement a patient may have with the criminal justice system. In view of the complex and intersecting vulnerabilities that many such patients have, we suggest this is an important lens through which the Inquiry should approach and interpret such evidence.

Our next thematic concern, Chair, is the use of restrictive practices in the inpatient mental health setting.

The use of restrictive practices, including

restraint and seclusion, using the terminology of the time of Richard's death, against those suffering from mental illness, is closely associated with adverse therapeutic outcomes for patients, in particular, the use of force as a tool to manage and respond to acute episodes of serious mental crisis is inimical to the clinical good management and treatment of vulnerable patients. The impact of inappropriate restraint can not only lead too worsening of a patient's underlying illness but can cause irreparable damage to the therapeutic relationship between clinical staff and patients. These principles are well embedded in clinically structure, Chair, and more widely, including in the recent Brook House Inquiry report, which scrutinised the harmful effects of the use and misuse of force against mentally vulnerable immigration detainees.

It is accordingly vital that, in a clinical setting, recourse to restrictive practices must be a matter of last resort and used for the shortest period possible. Within this context, the use, extent and appropriateness of restrictive practices will play a predominant theme within this Inquiry. Previous investigations, ranging from CQC inspection reports to the 2022 Dispatches documentary, have exposed concerning patterns of the overuse of restraint and segregation, as you know,

Chair. The high reliance on agency and non-regular staff, known as bank staff, who were less adept at de-escalation and less familiar with the patients, may appear to be a relevant factor informing this, though this, of course, will be a matter for you, Chair.

This Inquiry will need to closely scrutinise the specific systemic and cultural conditions which give rise to the misuse of such practices, and the harmful consequences this poses for patients and staff alike. This firmly endorsed by our clients, in particular Mrs Peck, who has serious and unallayed concerns as to whether inappropriate restraint, manual, chemical, and by way of segregation, may have been used against her brother in the immediate period preceding his death.

Chair, our last thematic issue of concern is the lack of availability of psychological treatment. In the months before he died, Josh was referred for psychological treatment, which is a recognised part of the interventions for schizophrenia and something which, in view of his poor compliance with medication, may have been helpful for him. This treatment, or indeed any psychological input, was never provided to him. Whilst it is likely that there are waiting lists in many part of the country for psychological treatment, including in Essex, Josh was not even assessed during the last year

of his care under EPUT.

Josh's family consider that this lack of contact was inexplicable, particularly as he was under a Specialist Psychosis Team, and psychological treatments are a key intervention. This issue, Chair, should be considered carefully by the Inquiry.

Chair, drawing to a close and looking ahead. Given the early stage of this Inquiry, we don't propose to set out a detailed or definitive position on proposed recommendations, and we note what was said today in opening about a forum. Recommendations must necessarily await the conclusion of the evidence, Chair. We offer here only a general indication as to what our clients expect to gain from this Inquiry and how that might be achieved. First and foremost, as I have already said, all three of our families want to know more about what happened to their loved ones, how and why they were failed by the healthcare bodies entrusted with their care.

Chair, even for those who have gleaned some answers from previous investigations, the full picture still remains incomplete. It is hoped that this Inquiry will fill such gaps through own wider evidence-gathering processes, similarly, that in bringing their own individual experience forward to this Inquiry, our

clients can assist you, Chair, in your role in understanding the true extent of any systemic failures and of the preventative action required.

We fully support the indication given by you, Chair, in your first opening statement that you will make robust recommendations for change where needed, underpinned by time limits for their implementation.

For Inquiry recommendations to have teeth, they must be specific, realistic and time bound, along with some mechanism for monitoring their implementation. The recent report from the Statutory Inquiries Committee, entitled "Public Inquiries Enhancing Public Trust", reflects the vexed difficulties public inquiries face in ensuring that their recommendations, despite being accepted by Government, are actually implemented. The inexcusable torpor of public institutions in the wake of such investigation risks both undermining the central purpose of the inquiry concerned, as well as the recurrence of further avoidable tragedies.

Drawing from such cautionary learning, this Inquiry, Chair, is invited to consider convening a further hearing following and within 12 months from the publication of your report, Chair, in order to hear evidence as to the implementation of and compliance with any such recommendations.

We note the robust approach by Sir Brian Langstaff in the Infected Blood Inquiry and invite you, Chair, to keep the Inquiry open until you are satisfied that the Government and relevant NHS bodies have responded adequately, or provided sufficient reasons as to why any recommendation will not be implemented.

Chair, this is vital, not only to ensure that meaningful change is enacted but for the sake of the patients and bereaved families involved in this Inquiry, that they know that the relevant state bodies are being held to account, that all the hard work of this Inquiry was not in vain. The scope for making national recommendations where appropriate is also strongly recommended -- sorry, is also strongly encouraged, Chair. The standard and adequacy of mental inpatient care and treatment in Essex cannot be considered in silo. As you recognise in your provisional list of issues, Chair, an important function to this Inquiry will be in ascertaining whether and to what extent Essex was an outlier or to what extent such systemic failings recur across other mental health trusts.

Whilst not seeking to prejudge the evidence, it is anticipated that certain thematic concerns that arise from this Inquiry will likely apply on a national level. Your willingness, Chair, to make such recommendations on

a national level, where necessary, is supported, Chair. In the context of potential national recommendations, we firmly endorse the longstanding call from INQUEST for the introduction of a national oversight mechanism, responsible for analysing and monitoring the implementation of recommendations from inquests, inquiries and other independent post-death investigations.

This is a fundamental lever for holding public authorities to account and ensuring that effective, evidenced change is implemented, which will prevent further harm.

As INQUEST makes clear, the current disjointed system is not fit for purpose with no independent, single body responsible for monitoring the implementation of Prevention of Future Death Reports and ensuring that recommended changes from inquiries are not forgotten, or stalled. The identification of the same thematic concerns, again and again, within the coroners' and inquiry reports is a stark indication as to the need for such an independent mechanism to ensure that lessons are learned and preventable harm avoided. The nature of this Inquiry, Chair, makes it the most apposite vehicle for recommending this change.

Indeed, if not made by this Inquiry, it begs the

question of which inquiry would be better placed and equipped to bring forward this much needed reform.

Another critical route to holding healthcare bodies to account is by way of criminal proceedings. Just last month, it was announced that North East London NHS Foundation Trusts, or NELFT, as it's come to be known, a CP to this Inquiry, as you know, Chair, will stand trial for corporate manslaughter over the death of a mental health inpatient at Goodmayes Hospital in East London, together with a former ward manager charged with gross negligence manslaughter.

As we know from the passage to this Inquiry, there have been several prosecutions brought by the CQC and the Health and Safety Executive in this area. However, Chair, as far as we are aware, this is the very first time that an NHS Trust has been charged with corporate manslaughter concerning a death in a mental health unit. It should be a clear and compulsory part of the process of accountability that, where a mental health inpatient has died in circumstances which suggest very serious breaches of clinical care, this is reflected in a full and thorough criminal investigation with a view to bringing possible homicide charges.

We know that this course is rarely taken in subsequent police investigation and, where it is, it is

rare for a resultant charge to be bought by the Crown Prosecution Service. This leaves a lacuna in accountability for bereaved loved ones, who are often left to feel that, no matter how robust the findings of any inquest, such state authorities have been effectively let off the hook.

We invite you, Chair, to consider how criminal proceedings can be more effectively deployed in this area. For instance, by way of the introduction of specific guidance on when a case of self-inflicted death in the context of state psychiatric detention should be referred to the police for investigation of possible manslaughter charges, individually and/or against the particular organisation.

Chair, we note the overtures from various corporate Core Participants within their opening statements as to their commitment to engage with this Inquiry openly and collaboratively. Whilst welcome, it must be recognised that, given the longstanding experiences of our clients and of any other CPS in this Inquiry, and those who are not CPs, of the Trusts' institutional defensiveness and lack of candour, such assurances cannot, Chair, be taken at face value. Our clients' trust in these public bodies have been fundamentally undermined. These State Core Participants, in particular the Trusts, will need

to make good their words through their actions in this Inquiry and in effecting the necessary change beyond.

In conclusion, Chair, our clients look forward to the opportunity to engage with the Inquiry or the Core Participants and other interested parties and to assist you, Chair, to conduct a full and robust investigation into matters falling within your terms of reference.

As you noted, Chair, in your initial opening, this is the first statutory public inquiry in respect of mental health provision. This Inquiry, therefore, has a unique opportunity to insist upon and drive meaningful change for mental health patients within the Essex Trusts and nationally. We fervently hope, Chair, that it will carry through the work done here to bring an end to the repeated cycle of institutional failures and avoidable tragedy.

Thank you, Chair.

THE CHAIR: Thank you.

MR GRIFFIN: Chair, we will now have a short break for ten minutes, meaning that we will restart at just around 12.22, just after 12.20. Thank you very much.

(12.13 pm)

(A short break)

(12.22 pm)

MR GRIFFIN: We will now hear the two commemorative and impact accounts made on behalf of the Leader and Elliott families. The first account is provided by Samuel Leader, Joshua's brother, by way of a pre-recorded video. Before it is played, I'm going to ask our evidence handler, Amanda, to please put up the photo of Joshua.

(Photograph displayed)

Thank you. Would you now play the video, please.

Pre-recorded statement by SAMUEL LEADER

MR LEADER: He was the last of four children, a surprise. He never stopped surprising us. A few times as a toddler he escaped, and would be found in the local sweetshop, or in a neighbour's home, or having clambered onto a stranger's parked motorbike, clutching the accelerators with his tiny hands. He loved crispy duck, hip-hop music, the films of Stanley Kubrick. He loved his family and we loved him. He is a chasm in us, our individual hearts.

Grown, he was 6 foot 1 or so, with thick dark brown hair, handsome with his long face and body, thin legs that curved out slightly. He loved Liquorice Allsorts, New York City, practical jokes, his son. Almost four years have passed and we are forgetting who he was and it feels like losing him again. He tried so many

things, so many ways to live: intense exercise regimes, religions, courses of study, weird gadgets, professional paths. He was quickly bored or frustrated, and often crippled by his extreme sensitivity and empathy for others. He lived or tried to live in many places, towns and cities across England and France, in America, Kenya, Israel, Amsterdam, Peru.

He had a degree in graphic design, was always drawing things, produced startling and strange images. He was musically inclined and taught himself the piano. He loved Bach as performed by Glenn Gould. Every subject interested him: Orthodox Judaism, Tai Chi, experimental music. He was sceptical at times, yet trusting, credulous. He could discuss Brutalist architecture, Bitcoin, black holes, Buddhist theology.

These were more than enjoyable pass-times: they contained the possibility of lasting solutions to his troubles. They reflected -- briefly -- his deepest hopes and designs. He met weekly with an Orthodox rabbi to analyse and discuss Talmudic texts, meanwhile Attending Buddhist ceremonies, investigating obscure herbal remedies and esoteric techniques to reprogram his brain.

Times spent with Josh were rarely dull. Smalltalk was rarer still. He would push you to say what you

thought about something or someone, react with a critical or approving glint in his eye, then a chuckle and a comment you could never predict. His enthusiasms were infectious, and we hoped they might have carried him onto more stable ground. His laughter -- goofy, seismic -- seemed to rise up from the ground he stood on. He once diffused the tension of a family Christmas by jumping into the stagnant freezing water of a broken Jacuzzi, howling and giggling at the agony. In Peru Sam watched him relish a soup with a whole cow hoof in it, then a pie made from a rainforest guinea pig.

He was variable: at times joyful, other times afflicted with loathing for the world and above all for himself. He hated false, shallow people, half-measures, conventions followed for their own sake. He hated all blandness -- in people, music, food. He loved smoothies, pancakes, spaghetti with bolognese sauce.

Here is Josh in the kitchen cooking bolognese: he moves with precision, long arms reaching here and there. The room swells with his presence and the delicious aromas of his cooking. He loves to feed his friends and his family. His heart is full. Laughter bursts from him. He is on the good side of life. He takes you into his bosom, and you ride carelessly on the embrace of his happiness. His charisma is like a boat on a great river

Wide enough to hold us all. Then, fears overcome him. He wants to protect his family.

He says, "Let us all go and live in Israel. In a kibbutz. We will travel there by boat. We can heal together. We must make a decision. Things are wrong".

He wanted to be a billionaire, an M.C., a good dad. The baby was born at home. Joshua acted as mid-wife. His girlfriend's mother was in the kitchen, vigilant and responsible nervously keeping watch behind the door as the contractions increased. She saw Joshua suffused with a sense of purpose as they waited for the midwife, perfectly calm and in control. She heard her daughter say, "I cannot do this!" To which Joshua gently replied, "But you are doing it!" His voice carried her through as the baby was born.

Lack of sleep and the awareness he would have to relinquish his childhood dreams to make space to a new life soon turned his thoughts dark. A few days later he went away into the woods by himself. For three days he stayed there on his own, in a psychedelic delirium, desperate to fix his broken brain.

He could not be the man he needed to be. The couple disintegrated as his confusion increased. They could not hold together the mysterious threads of love, which little by little frayed and disappeared. She could not

embrace Joshua's mental pirouettes, nor could he grasp the intensity of her disappointment.

"I need to heal", he often said, but couldn't tell you from what precise injury to his soul. He could not accept his suffering was a matter of mere chemicals in the meat of his brain. He was glorious in his isolation -- a loneliness we will never comprehend. He wanted answers, cures, solutions. He was relentless in his striving to overcome himself. He wanted desperately to find a way to live.

Now that he is gone we still so often reach for him from within ourselves:

Josh, we want to say, I saw something today that would have made you laugh.

Josh, we want to say when the world seems broken: I think I might know how you felt.

Josh, we want to say, when we are lonely and it seems no one could possibly understand: I am sorry I wasn't there for you. I tried, I tried, but not enough.

Josh, we want to say, I wish you could be here, to see this thing I'm proud of, to see your beautiful son, to laugh at this video, to taste this peach.

Joshua's absence echoes through our days. There is always someone not there, someone missing at the dinner

table, the Christmas present roster, the WhatsApp thread. We are always waiting for his laughter, his strange perspectives. Moments of joy and pride are tinged with a feeling of loss, regret. That he might have found a way to live, that we might have -- should have -- helped him better.

We, his family, feel his loss in ways we cannot say, but we are also determined for something good to come of this. For the world to be a safer, more accepting place for people like him. For us, the Lampard Inquiry is part of that ambition.

Josh too had such large ambitions to the very end - not just for himself but for his family, his son. He was often confused and often confusing, incomprehensible confounding. He embodied many contradictions. Sometimes he lied, but there was a rare and disarming sincerity to him. He made friends more easily than he lost them. He continually faced institutional disbelief, indifference, even scorn. In the last month of his Life he tried to go to America to volunteer at the Camphill Association of North America, a community for people with developmental disabilities. He felt that in helping others, he might help himself. He had secured a place, a plane ticket, had bought a good rucksack and clothes for all seasons. When the plan

fell through he was crushed. To the very end he was looking for a way to live, even when it seemed to him impossible. He wanted to help others live. He wanted help to live.

MR GRIFFIN: Thank you. Please can we now see the further photos.

(Photographs displayed)

Yes, thank you.

Chair, that is the last photograph and indeed that is the end of this account.

THE CHAIR: I'm very grateful. That was a very moving account of Joshua.

MR GRIFFIN: The next account is about Richard Elliott, and it is by his sister, Catherine Peck, and it will be read by Maya Sikand. Can we first, please, put up the photograph?

(Photograph displayed)

Maya, please read the account when you're ready.

Statement of CATHERINE PECK read by MS SIKAND

MS SIKAND: Thank you. I'm reading a commemorative account for Richard Harland Elliott from his sister, Catherine Peck and, after that, I shall read her impact statement.

"I started to write this commemorative statement about my brother Richard's life, but I kept remembering things I had missed or forgotten about. How to include

everything about someone who was a larger than life character? Once you met Richard, he was never forgotten. There was much more to Richard than the label of bipolar, or manic depressive, as it was more commonly known then. He was a fiancé, a son, a brother, an uncle, nephew, cousin, friend, advocate and supporter to many.

"Richard Harland Elliott was born in Southend on the 1 December 1953. He was just 48 years old when he died in Peter Bruff Ward, Clacton Hospital. Our parents, Colin and Barbara, who were Anglo-Indians, who had chosen England as their home. When Richard was six months old and I was 18 months old we both contracted whooping cough. Richard was quite ill and was left with bronchial asthma and breathing problems which plagued him for the rest of his life. When Richard was about three years old we moved to Colchester, this was where he made some lifelong friends.

"There were eight siblings: I was the eldest and Richard was the eldest of the six boys. Richard had a good childhood, part of the baby boom years. There were always friends to play with, enough for an impromptu football match, cricket, rounders or just playing games in the woods, making dens and go-karts. The children always looked out for one another, going to

play early and returning when dinner was ready. He learned to play the trumpet and joined the Boy Scouts, attended church on Sundays and joined the St John Ambulance Brigade, taking many of their exams, and I still have his certificates.

"Richard was a sensitive child and I remember when he was about eight coming to me with tears in his eyes on Christmas Day. He had heard a news report that a family of children had been killed in a house fire on Christmas Eve. Richard could only imagine how excited they would have been on going to bed. He was deeply affected.

"Richard was an intelligent boy, passed O level examinations and was Head Boy at Alderman Blaxill School in his final year, and was highly thought of by the teaching staff and pupils too. He attended college to train as a television, radio and telecommunications engineer, passing the exams and eventually being employed by British Telecom as a telecom engineer.

"He married his teenage sweetheart when he was 21, bought a house in Colchester and got two springer spaniels, Boots and Snoopy. Realising it was going to be difficult to raise a family in England with only one wage coming in, they made the decision to emigrate to Canada where they had recently been on holiday and had

a friend they could lodge with.

"Unfortunately Richard's marriage broke up. He had to leave the house with his two dogs. He was badly affected by the divorce. There was probably nothing that Richard wanted more than to be a father, something that would affect him throughout his life. He soon spent his savings on finding accommodation for himself and dogs, eventually having to give his beloved dogs up too.

"He sofa-surfed, had a job as a doorman in a nightclub, then as a manager. He ended up living on the street, it seems, and that's where he had his first episode of mental illness and was hospitalised. In hospital in Canada, thousands of miles away from family and friends, he was treated with electroshock therapy, ECT. We believe he had several treatments.

"Eventually, a doctor made contact with my parents, who sent them money for his plane ticket home. When he alighted from the plane, he was just an empty shell, and had to relearn how to hold a conversation, feed himself, dress himself, use a remote, use the phone, everything.

"However, his inner strength fought through and eventually, after several years, he returned to work. He said later it was as if he was a toddler and had to grow up all over again.

"The first time he had a relapse all his siblings attended an appointment with his hospital doctor and requested some kind of counselling or talking therapy but we were told they didn't treat mental illness in that way: only with medication.

"Richard came home from hospital over-medicated and barely functioning. He went to work, ate, slept, that's all. He couldn't hold a conversation, could just listen and respond if he had time to gather his thoughts, couldn't crack a joke, couldn't participate.

"This resulted in him ceasing his medication, which he called a 'chemical straitjacket'. Over the years, he continued to have episodes of illness for which he was hospitalised but was soon balanced out with appropriate medication and was home again. For years, he came to my house every week to play with my children, have a meal with us and play scrabble. He always bounced back until the hospital changed his treatment to his detriment.

"Richard was over 6' tall with black hair and often sported a beard or moustache, well dressed when going out, he was an imposing figure. He was sociable with a good sense of humour and a ready smile. He loved music, anything from Pink Floyd, to soul, to trance and anything in between. Music was always playing in the background. He loved to dress up and go dancing, which

he was very good at, and to meet people.

"He was an extrovert, really, a good conversationalist. Where he was interested in the person he was conversing with, he had empathy. He was very interested in mental health care and the hospitals and the community, having been a key member of CHUMS, Colchester Health Users of Mental Services, part of Colchester Mind. He loved cars, driving, nature, the countryside, camping, loved his dogs and people. He once camped near a river in Canada for days watching beavers build a dam. He had cameras and took many slides and photos of his travel.

"And poetry. He loved to write poetry: poems to women in his life, for his family on special occasions, poems about people, places, mental illness, needs, emotions, hopes and dreams."

I'd like to read you one now. It's called "Past Friend":

"Hello, dear friend. What has happened to thee?

"You're a shadow of your former self, half the one you used to be.

"I've often wondered what has become of you,

"We don't see you around town like we used to do.

"I've heard many tales, I've heard you're on drugs.

"So I've not kept contact, as it's a game for mugs.

"You say you're on medication, well that's a different story.

"I see from your face you've lost the power and glory.

"You used to set the town alight with your panache,

"Nowadays it appears to me you're very short of cash.

"I'm glad I met you today but I see you struggle with living,

"Your eyes lack their lustre, but your soul is ever giving.

"Mental breakdowns take their toll but recovery from drugs is the worst.

"Take your time to get better but, please, put yourself first."

RH Elliott.

"On 23 May 2002, my parents, Colin and Barbara, along with Richard's fiancé, went to Richard's flat in Dovercourt. They hadn't heard from Richard for a few days and were concerned.

"They found a police presence outside the flat and were told that he was to be sectioned and transported to hospital. Richard was reluctant to go with doctors or police, so Mum spoke with Richard and calmed him down. She could see that he needed medication but was told he

was being sectioned and police had been called to force him to go to hospital. About eight police officers in riot gear turned up at the flat, along with another police dog handler. Fearing Richard would be forcibly restrained, Mum reasoned with him that, if he went with them voluntarily, he wouldn't get hurt.

"He finished his second cup of coffee, got dressed, firstly in his Elliott tartan kilt, his best outfit, then changing his mind and changing to a pair of trousers, he smoked another cigarette and voluntarily walked to the police car and then moved to the transport vehicle when it arrived and walked into the hospital.

"Richard had previously attended the day hospital and wandered over to see the staff. However, he was coaxed into the correct area and lay down voluntarily, apparently in the seclusion room, to receive the three intramuscular injections the nurses administered. Within it seems, 15 minutes of being admitted, he was sedated and was left apparently face down on a mattress on the floor. Within 12 hours, Richard was dead, the facts of which will be investigated by this Inquiry.

"When he died, Richard owned his flat in Dovercourt. He was engaged to a young lady and was planning to get married. She still goes to sleep cuddling Richard's T-shirt.

"Richard loved people. He helped others in the mental health system and contributed to the local service users' magazine, Wits' End. Richard had for many years advocated on behalf of mental health service users, writing many letters and articles. He wanted to change the way patients were treated and lobbied for reform.

"Richard died too soon, in the care of the people who were meant to look after and protect him. A larger than life character."

I'll read out the impact statement from his sister, Catherine Peck.

"My parents had struggled to successfully bring up eight children but, through their hard work and care, Richard survived whooping cough, tonsillitis, bouts of asthma where he could barely breathe, chickenpox, measles, mumps, an operation to remove his adenoids and almost drowning in the sea at Bolton at the age of eight, and being rescued by a lifeguard.

"When Richard emigrated to Covid-19 in his 20s my parents never stop worrying about him. When Richard had a breakdown in Canada, my parents found the money to pay for him to come home, nursed him whilst he relearnt to talk, to eat, to dress himself. They did everything for him and with him until he felt confident enough to be

independent.

"They supported him through several breakdowns and visited him every week. Richard had confided to me and Mum that he was fearful that he would die when being forcefully restrained in the hospital, and this made him very reluctant to seek help.

"The evening before he died, my mother persuaded Richard to voluntarily go with the hospital staff and police to Clacton Hospital, so he wouldn't have to endure this, only to be told that he had died within 12 hours of being admitted.

"I not only lost my brother and my children their uncle, who we were very close to, but we also lost our mother and grandmother, as we had known her. Instead of Mum being our support, we became hers, watching her grieving and wracked with guilt for the things she had said and done to persuade him to go to hospital and, ultimately, his death. If it hadn't been for her faith in God and belief that she would see him again, I'm not sure how she would have coped.

"Dealing with the funeral, sorting out his finances, emptying his home of belongings, selling his property, took their toll. The day after Richard died, my parents were visited by hospital staff, who apologised for Richard's death in their care but at the coroner's

hearing six months later, instead of an official apology, they were blindsided by false accusations, hearsay and speculation, which further traumatised them. My mother's life was never the same again. Losing a child is bad enough but feeling that you had failed them, hadn't protected them, was something she never got over.

"His fiancé was devastated by his sudden death and still talks about her love for Richard, her only true love, and how her life might have been had he lived. She still goes to sleep cuddling his T-shirt.

"Richard thought the change in the mental health services, and this is our wish now, so no one ever has to endure what our family, especially our mother and Richard's partner, had to go through. Mental health hospitals should be a safe place for people, a sanctuary where they have your best interests at the core of their service. It should be a refuge, where you are at your most vulnerable, to offer advice, support and strategies to cope with life, not a place which you fear having to enter.

"I have once again started to read Richard's poems, letters, write-ups, papers, articles and correspondence. It is heartbreaking to read now, even after all these years. He so wanted to make a difference to the care

which patients received but his life was cut short. He died far too early and in a very distressing way.

"The Lampard Inquiry cannot bring Richard back but I am hoping it will bring about changes, like involving the families in and the treatment of their loved ones. And answers. I need answers."

MR GRIFFIN: Thank you, Maya.

Amanda, would you put up the further photographs, please.

(Photographs were displayed)

That is the last photograph and, Chair, that is the end of this account.

THE CHAIR: Can you please pass on my thanks to Mrs Peck for her account and impact statement.

MR GRIFFIN: Chair, we now move to the second opening statement and it's made on behalf of Michelle Booroff, the mother of Jayden Booroff, and it's given by Aimee Brackfield of Irwin Mitchell Solicitors.

I'm going to ask that the pre-recorded video is played now, please.

Pre-recorded opening statement by MS BRACKFIELD.

MS BRACKFIELD: This opening statement is made on behalf of the Core Participant (CP), Michelle Booroff, represented by Irwin Mitchell solicitors.

Ms Booroff is a CP by virtue of her son, Jayden

Andrew Booroff, having tragically died on 23 October 2020 further to absconding from the Linden Centre in Chelmsford, run by Essex Partnership University NHS Foundation Trust (EPUT). Jayden was detained under section 2 of The Mental Health Act 1983 at the time of his death. Ms Booroff has not yet provided a commemorative and impact statement to help the Chair understand who Jayden was, though she very much hopes to be able to do so in due course. This is largely due to how difficult, and traumatic, writing such a statement is.

We very much hope the Chair will hear directly from Ms Booroff about her son, whose life was tragically cut short. We use this opportunity now to give the Chair a very brief introduction to Jayden.

Jayden was 23 years old, when he tragically died. He was a much-loved son, brother, nephew and friend. He adored music, singing, and musical theatre. Hearing Ms Booroff speak about Jayden, it is obvious that he was an empathetic, kind, happy, fun, and talented young man. He had hoped to travel more in his future, and could be a very spiritual and philosophical person. He loved wildlife, helping the people around him, singing with his mother, performing, and thinking deeply about the world. Those who knew him still tell Ms Booroff now

what a beautiful soul he is.

The Inquiry is at an early stage. The Chair will, hopefully, come to hear detailed evidence about Jayden's treatment and care, or lack thereof, during his time as an inpatient under EPUT. That evidence will not be rehearsed here, save as to provide the Chair with an understanding of why Ms Booroff has chosen to participate in this Inquiry, and the truths she hopes to uncover in doing so.

Jayden's experiences, sadly, raise a multitude of concerns falling within several of the Terms of Reference and Provisional List of Issues. In relation to the Chair's proposed approach to potentially pick a sample of cases in order to investigate these issues, we request that the Chair considers using Jayden's experiences within this sample.

Jayden's mental health began to deteriorate towards the end of 2019 and beginning of 2020. Ms Booroff, like so many families, battled, alone, for months, trying to support Jayden with his mental ill health. Ms Booroff sought help as Jayden's mental health became increasingly poorer. She experienced countless examples of being ignored, discredited, dismissed, and made to feel like she was an overbearing, interfering mother when seeking this support. Even when Jayden was brought

to A&E due to his concerning and alarming mental health presentation, her concerns for Jayden were dismissed and Jayden was sent home for treatment despite her pleas for him to be placed in a safe environment due to his acute psychosis.

Ms Booroff describes this period of time as a period of significant delayed intervention. Ms Booroff will forever question how things might have turned out for Jayden had he received the early intervention he needed and deserved, and that she had sought for him.

In September 2020, Ms Booroff was finally able to convince mental health professionals within the Trust that Jayden required urgent help. This led to his admission to The Lakes, in Colchester.

Ms Booroff fought hard and tirelessly for Jayden to be placed in The Lakes. She placed her trust in EPUT to care for her son. This trust now appears to Ms Booroff to have been misplaced misguided. She should have been able to trust EPUT, and initially, she did. She believed Jayden would be safe once under the care of professionals, whose duty it was to provide compassionate, caring, and responsible treatment and care to her mentally ill son. She now cannot understand how she could have believed that would be the case. She now experiences feelings of guilt that she pushed so

hard for Jayden to be admitted to hospital.

Whilst detained in The Lakes, Jayden would call Ms Booroff, telling her how scared and disturbed he was by the behaviour of staff towards, and in front of, patients. He described staff playing cruel mind games with patients, tormenting and teasing them. He described how staff would sit back and watch fights break out between patients, instead of intervening. When Ms Booroff would visit Jayden, waiting in the reception area she overheard members of staff complaining about patients. When his mental health deteriorated further, and he was later detained in the Linden Centre, Jayden told his mum about staff taunting him. Ms Booroff was torn and did not know what to believe; she had thought her son had gone to a place of safety to be cared for. She knew he was unwell. She hoped that what he was reporting to her was a symptom of his psychosis, rather than his reality.

The Chair will hopefully come to hear evidence about Jayden's premature and rushed discharge from The Lakes. The issues of discharge planning, care planning, communication between services and communication with family members and patients are important and key themes falling within the Inquiry's Terms of Reference. Sadly, these are all issues that directly and routinely

reflected Jayden's experiences with EPUT.

Ms Booroff had significant concerns regarding physicians' medication and prescription decisions for Jayden during his detention at the Linden Centre. Ms Booroff is keen to ensure that the Inquiry investigates such decisions made by the Trust. During Jayden's short period of involvement with EPUT, he was prescribed medication against his wishes and in spite of concerns raised by Ms Booroff regarding their necessity and efficacy, and potential side effects.

After a short period of living back in the community, with little to no effective support from the relevant mental health services, Jayden came to be detained in the Linden Centre. Sadly, he absconded only a few days following his admission, and died the same evening he absconded.

Whilst detained in the Linden Centre, Jayden was incredibly mentally unwell. He was suffering with psychosis and disclosed on numerous occasions his thoughts of ending his life. He was often nonsensical in his speech and spoke to Ms Booroff at length about moving to the next realm. He had become paranoid, scared, and confused. He was presenting a very high risk to himself and staff knew he was not safe to leave the ward. However, on 23 October 2020, Jayden followed

a member of staff through three secure, locked doors, and out of the Linden Centre. Within 2 hours of escaping, he had been struck by a train and tragically killed. Essex Police failed to classify Jayden's AWOL as being high risk, due to poor and incomprehensible communication between EPUT and the police.

Ms Booroff had, and continues to have, considerable concerns about the circumstances of Jayden's detention in The Lakes and the Linden Centre, and his treatment overall under EPUT. We seek to provide here a brief overview of those concerns, as they relate to and inform the Chair's Terms of References and Provisional List of Issues. Given the early stage of the Inquiry, this is an overview only which inevitably will require further detail, evidence, and consideration as the Inquiry Progresses.

Ms Booroff is encouraged that the majority of her concerns have been identified in the Chair's Terms of Reference and Provisional List of Issues. She echoes the sentiments put forward in the opening statements of other family core participants and the charity INQUEST in outlining the importance of thorough investigation of those concerns and issues. The breadth of the issues arising in relation to Essex mental health services' care and treatment of patients is alarming. In order to

avoid repetition of already well-aired concerns and issues, Ms Booroff's concerns are listed concisely below, and are identified as they relate to Jayden's history.

Those concerns include:

A) Staff's failure to understand Jayden's complex mental health presentations. Ms Booroff witnessed, throughout the period of Jayden's involvement with EPUT, a lack of professional curiosity to understand Jayden's complex mental health presentation. Assumptions and presumptions were made as to his concerning presentation, leading to worrying clinical decisions including failures to admit Jayden to hospital, prescription of medications Ms Booroff and Jayden did not agree to, and incomplete risk assessments.

B) Staff attitudes and stigmatisation regarding addiction. Jayden suffered with various addictions, alongside his other mental health conditions. The Provisional List of Issues outlines that this Inquiry will investigate how factors including drug and alcohol addiction were considered and subsequently managed. Ms Booroff's experience was that Jayden's addiction was not managed, but rather used to explain his behaviours and justify a lack of treatment. Ms Booroff was left with the distinct impression that Jayden was being

blamed for his presentation due to his addiction and this was something he would need to overcome before he would be deserving of treatment. Ms Booroff has considerable concerns as to systemic and deep-routed attitudes by Essex mental health services' staff regarding addiction and its management in the nexus of care treatment.

C) Poor record keeping and general care management, and failures of handover and communication between staff. The management of Jayden's care records was inconsistent at best, with outdated care plans and risk assessments. Risk information often was not communicated or updated between teams, and from Ms Booroff to staff on the ward. This included information about Jayden's risk of absconding, which was not shared to staff on the ward where he absconded from. Concerns about record keeping in relation to Essex mental health services have sadly been regularly documented and raised in Inquests, CQC inspection reports, and other investigations. Pertinent and important information regarding Jayden's suicidal thoughts and intentions to abscond were not handed over between staff and team members when Jayden was detained at the Linden Centre. Moreover, the information shared by Ms Booroff often was not adequately recorded.

Ultimately, staff had an incomplete and misinformed picture of Jayden's risk and care needs.

D) Discharge planning and decision making for inpatients. Jayden was discharged with no updated care plan, in a very rushed manner, and amid confusion and uncertainty regarding the community team and after-care support he was being discharged into. This exacerbated his, and Ms Booroff's, feelings of being alone to support Jayden in a time of high and complex need. In particular, the Chair's questions in her Provisional List of Issues relating to whether discharge procedures were followed, the appropriateness of discharge, and whether all available and necessary information known at the time of discharge was available are of concern to Ms Booroff.

E) Lack of consistent staff members on the ward, and the impact this had on Jayden's care and treatment. Ms Booroff, like many other family members and patient CPs, was and remains concerned by the number of bank/agency staff employed by Essex mental health services, their level of training, interviewing processes, and the high level of turnover of staff, all resulting in a distinct lack of consistency in care. Linked to this is also the recurring issue of staff being on leave, but having no cover in place, and

patients and/or family members having to make do in their absence. When coupled with poor record keeping, communication, and information handover by staff, these concerns become starker and more troubling as the margins for mistakes and incompetency grow.

F) Failure to engage and involve Ms Booroff in decision making for Jayden's care and treatment. This is an issue repeatedly raised by family member CPs, and Ms Booroff echoes the sentiments raised in the opening statement of the charity INQUEST regarding this concern. Family members are valuable sources of information regarding their loved one's background and risk management. Ms Booroff's input into her son's care, and attempts to communicate further information pertinent to his care, treatment and risk assessment was routinely seen as interfering, irrelevant and even unhelpful. Staff missed significant opportunities to learn more about Jayden by communicating effectively with, and listening to, Ms Booroff.

G) A general yet frightening lack of compassion shown by staff towards Jayden and other patients. As detailed above, Jayden conveyed worrying stories and concerns about his time as an inpatient. The Channel 4 documentary, "Hospital Undercover Are They Safe?"

Dispatches brought to light the troubling and

disturbing attitudes and actions of staff towards inpatients.

H) Insecurity and inadequacy of the ward security and integrity. The entrance to the Linden Centre, a secure unit, had automatic doors opening to the community, through which Jayden was able to run when absconding from the ward. Jayden was able to follow a Healthcare Assistant through three locked doors, that could only be accessed by way of fob key. The ability for a detained patient to escape from a secure unit such as the Linden Centre particularly when no S.17 leave has been granted, was of deep distress and concern to Ms Booroff.

I) Poor communication of the urgency and severity of Jayden's AWOL to emergency services. The Coroner's Inquest heard confused evidence between witnesses for EPUT and for Essex Police regarding sharing of communication, and professionals' ability to convey and understand the urgency and severity of the implications of a detained patient absconding from the ward. Jayden was not classified as being a high risk missing person after absconding by Essex Police.

J) Poor after-care by the Trust, and other services including Essex Police and British Transport Police, following Jayden's death. Ms Booroff remains under the

care of EPUT, herself. She is experiencing long lasting and significant trauma, grief, and poor mental health as a result of the loss of her son, and the subsequent failings by EPUT to take accountability for that loss. Ms Booroff is expected to reach out to, trust, and rely upon the very service that she believes failed to keep her son safe. Moreover, she is expected to reach out to, trust, and rely upon the very service that delayed in its disclosure to the Coroner's Inquest, failed to implement the recommendations of the Patient Safety Incident Investigation report, and failed to learn from lessons before and after Jayden's death. Ms Booroff is not currently receiving care or treatment capable of meeting her needs. NHS care is the only option available to Ms Booroff. There has been no acknowledgement from the Trust of the impossible situation she has been placed in. There is no physician-patient relationship, and Ms Booroff has no faith at all in this Trust to be able to support her mental health.

Paragraph 42 of the Provisional List of Issues asks:

"How, and to what extent, were families, carers and / or other members of an inpatient's support network: a. informed of an inpatient's death; and / or b. communicated with during and after any internal

investigations. What, if any, support was offered? Was this sufficient and appropriate in the circumstances?"

Ms Booroff has had insufficient and inappropriate support from EPUT since Jayden's death. Her inability to trust these mental health services is a huge and potentially insurmountable barrier to accessing support. Ms Booroff is eager for the Chair to consider this as part of the Inquiry investigation.

The above, and more, systemic issues were deeply ingrained in Trust culture by the time Jayden came to be cared for by EPUT, and contributed to his poor treatment. The lack of care and communication from doctors and ward staff demonstrated a troubling level of carelessness and complacency regarding Jayden's safety, during the most vulnerable moments of his short life.

Ms Booroff shares the concerns raised by other family members and patient CPs as outlined in their opening statements. It is clear that the very many issues concerning Essex mental health services are often complex, interconnected, and interdependent. This will require creative, thorough and fearless investigation by the Inquiry in order to bring to light these very real and ongoing concerns so that the system can be fixed.

Ms Booroff notes Section K of the Provisional List of Issues relates to the quality of investigations

undertaken or commissioned by providers, and that the Chair will investigate how and what investigations were undertaken or commissioned by providers. Ms Booroff welcomes this approach. Ms Booroff also, however, has concerns about the Care Quality Commission's decision not to investigate Jayden's death due, according to the CQC, to there being no causal link between EPUT's failures and Jayden's death. Ms Booroff did not, and does not, agree with this decision and was disappointed at the CQC's refusal to investigate, particularly so soon after its damning unannounced inspection at Finchingfield ward in October 2020 resulting in the CQC serving a warning notice on EPUT2. Ms Booroff invites the Chair to consider such issues and decisions in this Inquiry.

It would be impossible to count the number of times the phrase "lessons learned" has been used by Essex mental health services. It has been said many times by witnesses in Coroner's Inquests, authors of Prevention of Future Death report responses, authors of Serious Incident Reports and Patient Safety Investigation Reports, and senior management at Essex mental health services to have come to have no meaning whatsoever. It is hard to see how any individual or family member let down by Essex mental health services could hear that

phrase and believe it. Ms Booroff certainly has no faith or hope when she hears Essex mental health services talk about lessons learned. In fact hearing them talk yet again about lessons they intend to learn, about failings they already knew about, causes her to feel triggered and gaslit.

Ms Booroff was legally represented in the Coroner's Inquest for Jayden. EPUT made no admissions of failings before, during, or after the Inquest evidence was heard. EPUT was poorly organised and poorly prepared for this Inquest. EPUT's delays in disclosure and decision-making plagued the inquest process, culminating in the Trust's CEO being invited to a pre inquest review hearing to explain the Trust's poor decision-making that had threatened a last-minute adjournment of the Inquest.

During that Inquest significant, disturbing and serious failings were identified in the jury's narrative conclusion. A Prevention of Future Death Report was issued by the Coroner. Both have been referred to in Appendix 1 of the Opening Statement submitted on behalf of the patients and families represented by Hodge Jones & Allen solicitors. A Patient Safety Incident Investigation was commissioned by EPUT, the findings of which included numerous criticisms of the lack of care provided to Jayden. Despite this, EPUT failed to make

admissions of failing and maintained a defensive approach at the Inquest. This process did little to assure Ms Booroff that lessons would indeed be learned.

Ms Booroff considers that the failings and ingrained systemic issues within Essex mental health services are apparent. The same issues, concerns, and failings arise time and time again in Coroner's Inquests, Prevention of Future Death reports, patient complaints, and internal incident investigations. This endless repetition of tragic and traumatic outcomes due to systemic failings within Essex mental health services is alarming, distressing, and unacceptable.

An unwillingness to learn lessons from significant failings, a toxic culture of care, and a lack of accountability from senior management has led to Essex mental health services failing and continuing to fail their community. Had the Trusts learnt from numerous recommendations investigations, serious incident reports, near misses, Coroner's Inquests and Prevention of Future Death Reports, Jayden may still be here today.

Ms Booroff currently has little to no faith that Essex mental health services will commit to recommendations made by the report. That will need to be earned and proven by the Trust CPs through the course of the Inquiry. The Chair and Inquiry will also have to

grapple with the difficult question of ensuring compliance and cooperation, and what steps can be taken if that is not forthcoming.

We have had the benefit of reviewing the opening statement of family CPS and the charity INQUEST. Ms Booroff endorses those calls for action made by other CPs including:

A) An approach by the Inquiry to obtain all potentially relevant material to determine what is and is not relevant to the Inquiry.

B) For the Chair to keep an open mind regarding the need to publish interim recommendations.

C) For the Chair to ensure that all recommendations are monitored and reviewed to ensure that those organisations tasked with implementing the recommendations do so and do so effectively.

Ms Booroff endorses the suggestion that the Chair reviews this within a set period of time following publication of the Inquiry's report.

D) INQUEST's call for the introduction of a National Oversight Mechanism.

E) For the Chair to consider when and how criminal investigations may be required following an inpatient death in a mental health setting.

We close this statement with a plea to the Chair,

and to all those participating in this Inquiry. That is a plea for transparency, honesty, and fearlessness in investigation. Ms Booroff's sincere hope is for her community to be served by an NHS Trust that holds their staff to account, and puts patients first. She hopes for an NHS Trust that has eradicated its toxic culture, including dangerous and outdated attitudes towards mental health conditions such as addiction. She hopes for an NHS Trust that she can trust. All too well this community, and Ms Booroff, have seen that nothing changes, if nothing changes. A lot now needs to change to avoid any more preventable and avoidable deaths in mental health settings within Essex. Ms Booroff is putting her faith in this Inquiry to achieve that meaningful change. Ms Booroff trusts that the Chair will prioritise maintaining Jayden's dignity and that of other patients, throughout the Inquiry.

We are grateful to the Chair for the detailed and wide reaching Terms of Reference and Provisional List of Issues determined for this Inquiry. Ms Booroff sincerely hopes that a result of this Inquiry is that no other family or individual will have to go through or endure what she, and so many others within Essex, have endured following engagement with Essex mental health services.

We look forward to working with the Inquiry on Ms Booroff's behalf.

THE CHAIR: Thank you very much indeed for that statement.

MR GRIFFIN: Chair, we will now break for lunch. We will start again in an hour, which means that we will be back at 2.15. I can indicate now, Chair, that it's likely that the hearing today will end at around 5.00 pm. That's all. Thank you very much.

(1.16 pm)

(The Short Adjournment)

(2.15 pm)

MR GRIFFIN: The final opening statement today will be given on behalf of Tammy Smith, the mother of Sophie Alderman, and the family of Edwige Nsilu. They are represented by Bindmans Solicitors and it will be given by Brenda Campbell, King's Counsel.

Brenda, please start when you're ready.

Opening statement by MS CAMPBELL

MS CAMPBELL: Thank you and thank you, Chair.

As Mr Griffin has just indicated, together with Mr Stoate and instructed by with Rachel Harger at Bindmans LLP, we represent Tammy Smith, who is the mother of Sophie Alderman, who died aged just 27 on 19 August 2022 while detained in the care of Essex Partnership University Foundation Trust or EPUT, as we

have come to know it; and the family of Edwige Nsilu, who died aged only 20 on 5 February 2020, whilst detained in the care of St Andrew's Healthcare in Essex.

Both families lost their daughters, their sisters, after entrusting them to the care of Essex Mental Health Services at a time when Edwige and Sophie were at their most vulnerable. They did so in the expectation that they would receive care, compassion, support, and treatment but, most of all, that they would be kept safe, both families had been devastated by the magnitude of their loss. Their grief endures and you will hear some detail of it in the commemorative statements to be read shortly.

Given the particular hurt arising from the preventable loss of Sophie and Edwige, it is a life sentence of grief. But, Chair, on top of that grief is trauma, and it is a deep-seated trauma that has been compounded by their experiences since the death of their daughters.

Both families have learned of a culture of failure within Essex Mental Health Services that pre-dated their daughters' deaths. They have come to learn of the many reports, recommendations, inquest verdicts that pre-dated their loss and that, had they been acted upon, might in fact have prevented their loss and yet,

instead, it seems they were largely ignored.

Both families have witnessed that, where there should be corporate reflection, responsibility and a willingness to learn, there is instead institutional defensiveness or, worse still, institutional aggression, where even the deceased and their grieving families are thought to be legitimate targets.

Both families have hoped in vain that lessons would be learned from the deaths of their daughters, that their individual inquest verdicts and reports would represent the turning point in mental health care for others and, instead, they have borne witness to the struggles of the previous Chair, Dr Strathdee, to get any meaningful engagement from the Essex Mental Health Services, much less any answers to her questions.

So both families have found themselves with membership of this Core Participant club that they had no desire ever to join, a membership for which they have paid a heavy price, one in which the enrolment criteria is bereavement and its mission is now to fight for justice and accountability for the death of their children.

It's against that background, Chair, and you will be aware, we know, of just how much courage it takes Sophie and Edwige's families to look to you and your Inquiry

for answers, to have any confidence in its outcome. You will appreciate how hollow the belated apologies from EPUT land, how difficult it is for those who have heard or read it all before to accept the assurances that you heard from EPUT and others of their commitment to assisting you and to meaningful improvement. You will also know the urgency with which change and improvement is needed, to put a stop to the rising figure of death which is already, as we know, significantly above 2,000.

Without that change, the failures that devastated Edwige and Sophie's families are doomed to repetition to be inflicted on yet more families.

Already, Chair, we know where some of those changes need to come because time and time again common failures that are apparent in the care received by Sophie and Edwige have been identified by numerous coroners and juries inquests, and in criminal proceedings, and by the Care Quality Commission, and by the Nursing and Midwifery Council, by the Parliamentary and Health Service Ombudsman.

I dare say, by the end of the three openings this afternoon, you will identify common themes amongst all those you have heard about: failures in care management and planning; failures in recordkeeping; serious staffing and training issues; failures to ensure

physical and sexual safety of vulnerable patients; failures in family engagement; failures in responding to serious inns accountants and death; and repeated failings in learning lessons to prevent future deaths.

These issues and some additional issues have been dealt with comprehensively in our written opening statement, which we know you have read with care and which we know will be published.

So, over the course of this oral address, I may touch on some of them briefly but, before returning to those issues and suggesting in due course, if I may, how necessary change might be approached by this Inquiry, it is appropriate that I tell you a little more of the two young women who, like so many others, must be at the heart of these proceedings.

Sophie Alderman was the eldest of her three siblings. She had a wonderful sense of humour, positivity and a massive heart. Her mother, Tammy Smith, recalls she was such a funny person and, as a young person, developed cheeky sarcasms which always kept her mother on her toes. Sophie had a strong and special bond with her younger sister and was an unfailingly loyal sister to her younger brother.

She died, as I've said, aged just 27 on 19 August 2022 on Willow Ward at Rochford Community Hospital.

Only weeks before Sophie's admission to that ward, an undercover documentary reporter for Channel 4 filmed shocking footage of the poor care of patients on the ward, which was later broadcast in the programme Hospital Undercover Are They Safe? A short time later, in October 2022, the Care Quality Commission inspected Willow Ward and identified risks including staff failures to follow policies and procedures for patient observations and engagement, issues with the accessibility of ligature cutters, poor staffing levels, failures to complete risk assessments.

Like so many families, learning of those failings, the lack of care and compassion and the missed opportunities, has been highly traumatic for Sophie's family.

It started with the confusion that arose from a phone call received out of the blue to Sophie's father, informing him of her death. It continued with a report containing graphic images of Sophie's death, which was sent to her mother without any warning. It was exacerbated during the inquest proceedings when evidence of the month that Sophie spent on Willow Ward, the repeated restraints, staff shortages and distress and continuing paranoia that sadly characterised her time there, was exposed.

At the inquest into Sophie's death, the jury concluded that she died by misadventure. Her family knows that she did not want to die.

Edwige Nsilu was the third of seven siblings to her parents Joyce and Flavien Nsilu. She is remembered by her family as a loving, warm and nurturing young woman with a strong affinity to her Congolese background and her African culture. Her family called her "the mother of all children" because she had a deep love for every single person. She died aged only 20 on 5 February 2020 while detained in the care of St Andrew's Healthcare Essex, a private provider that had reported received a figure in excess of 175 million in the year 2020 to 2021 from NHS Commissioners or NHS England. Meanwhile, in that same year, Welsh health boards suspended placements to St Andrew's Healthcare due to apparent concerns about the standards and safety of care provided.

In the week after Edwige's death, an inspection of the ward in which she was detained by the CQC identified numerous risks, again, staff shortages, failure to assess, manage and record patient risks adequately. We know, Chair, from Mr Griffin, King's Counsel's opening remarks to you in September, that you are alive to the need to consider the use of private placements and

concerns about the lack of proper oversight of placements funded by NHS England and others. We trust that providers, including St Andrew's Healthcare will be invited to proactively assist you in that regard.

Two years after Edwige's death, a Safeguarding Adults Review outlined evidence that she had been sexually assaulted and raped in 2018 by a member of staff at the placement where she was detained before St Andrew's. She was 18 years old at the time.

For her family to learn that Edwige had been the victim of such a violent sexual offence while detained as a vulnerable mental health patient was beyond distressing. It is something that they continue to struggle to come to terms with today.

The inquest into Edwige's death took place in June 2023. The family endured evidence, again, about staff failures to enter episodes of self-harm in Edwige's records, failures to update her care plan, and the significant delay in the emergency response when Edwige was found unconscious.

That delay, apparently borne out of a suggested mistaken belief that Edwige was some how faking it and, although dying, represented a threat, gives rise to concerns on the part of her family that structural and institutional racism impacted her care and her death,

something to which I shall return.

Again, Chair, the family's involvement in the inquest process and the manner in which sensitive and painful information was delivered to her family was acutely retraumatising. The inquest jury concluded that Edwige's death was contributed to by neglect. That Edwige was neglected at her time of greatest need is unquestionably true and unbearably painful.

Chair, moving on to some of the concerns that we wish to bring to your attention. I have already noted that you have carefully considered our written opening and, for that reason, I won't repeat all of the concerns in their entirety here. Many of the issues we highlight within it find support in the submissions that you heard in September, and indeed earlier today on behalf of other bereaved, and many of those have already courageously shared their impact statements with you.

Of course, Sophie and Edwige did not know each other but as is apparent from our written opening and from the little I have told you today, their experiences in Essex Mental Health Services shared too many worrying commonalities.

With your leave, Chair, in these oral submissions, I will focus on the following four issues of concern: firstly, over reliance on medication and an absence of

therapeutic intervention and support; secondly, a failure to safeguard the physical and sexual safety of patients; thirdly, the use of vision-based monitoring systems onwards; and, finally, structural, intersectional discrimination and racism.

As to the issue of medication versus therapeutics, you will hear shortly, Chair, the impact statement of Tammy Smith, in which she details her family's concerns about an over-reliance on medicating Sophie to the detriment of meaningful therapeutic intervention. Over the year before her death and, indeed, significantly before that, Sophie was prescribed an often changed cocktail of drugs and dosages. We expect you will find she was not unique in that regard and, indeed, to understand the heavy and possible over-reliance on medication, Chair, we urge you to consider obtaining the expert assistance of a psychopharmacologist.

For reasons that will be immediately apparent from her statement, Mrs Smith is keen for the Inquiry to explore the nexus between what appears to have been an over-reliance on medication to stabilise Sophie's mental health within a hospital setting and the failure to plan for a how compliance of medication and risk would be managed when Sophie returned to her community setting.

Her concerns chime with the experiences of the Nsilu family, who will tell you about their worries about the lack of risk management and support for Edwige and indeed for her family, particularly in relation to periods of patient leave. We expect that those concerns will chime with the experiences of many others, and they are not limited to periods of leave or returning to the community.

Chair, as the Channel 4 Dispatches programme vividly captures, there are reasons for you to be concerned as to the availability of therapeutic interventions on wards. Right up to the day of their respective deaths, when there were clear indicators of distress and increased risk for both Edwige and Sophie, there is a marked absence of compassion-based therapeutic intervention and support. Distress, headbanging, a request for urgent one-to-one support went unmet and untreated.

A significant proportion of those who deaths come within the scope of your Inquiry, Chair, will be children and young adults, no doubt each of whom wanted to get better and each of whom still had much to learn about themselves as they physically and emotionally matured into young adulthood and adulthood. But whatever the age of the person who died, the expectation

of all those who needed inpatient mental health care and of their families is that the care that they received on wards would be targeted to enable them to lead full, content and stable lives in the community. Whilst medication will properly play an important part in that, there is no magic pill. Medication must be prescribed in conjunction with meaningful, person-centred, non-pharmaceutical interventions and therapeutic support.

We ask you, Chair, as you listen to and consider the evidence, to identify and expose poor practice around over-medication, to commend good practice as to therapeutic interventions, such as you can find, and to make recommendations that will lead to meaningful change.

I turn to safeguarding the physical and sexual safety of patients. You know, Chair, that there is evidence that both Sophie and Edwige were the victims of rape or serious sexual assault: in Sophie's case as a child, in Edwige's case as a teenage mental health inpatient. Their experiences are unacceptably far too common for those in need of mental health support.

Research published by the mental health charity, Mind, noted, as far back as 2004, that 18 per cent of respondents had experienced sexual harassment and

5 per cent had experienced sexual assault whilst receiving inpatient mental health care.

Between January and August 2023, almost 4,000 sexual safety incidents were reported by mental health inpatients settings nationally. This national concern is reflected within Essex Mental Health Services too.

I have already told you of the distress of the Nsilu family on learning after Edwige's death that a staff member at her placement at St Andrew's was under criminal investigation for engaging in sexual activity with "a person with a mental disorder".

In July 2022, the Safeguarding Adults Review outlined evidence that she had indeed been sexually assaulted and raped. Edwige's family are deeply troubled by that, not only by the news but by the egregious failure to safeguard Edwige from sexual assault and rape, and by the inadequacy of the subsequent investigation, something that we submit should be interrogated by this Inquiry within your provisional list of issues in relation to safety.

In 2023, EPUT was rated as requiring improvement in respect of service safety by the CQC, which required the Trust to:

"... assess risks to the health and safety of patients receiving care and treatment, including

patients' sexual safety."

In response to a Freedom of Information Request in January of this year, EPUT disclosed that the annual numbers of reported sexual safety incidences are on the rise: 171 in 2021; 176 in 2022; and 221 in 2023. As ever with figures of sexual assault, the real figure, we suggest, is likely to be significantly greater.

In Sophie's case, Mrs Smith has an overarching concern about the reliance on restraint for any inpatient but particularly young women who have survived sexual violence. Sophie was subjected to a number of physical restraints in the lead-up to her death, particularly to administer very strong anti-psychotic medication. That can only have been highly traumatic for her.

Chair, these families look to you to explore the issues of physical and sexual safety on wards and in particular the sexual safety of women on inpatient wards. They ask you to interrogate whether the treatment of sexual abuse survivors takes into consideration their experiences of abuse, including whether physical restraint on wards is likely to be frightening, invasive and retraumatising.

Moreover, as I will return to in a moment, they ask you to be alert as to whether any failings to ensure the

physical and sexual safety of female inpatients amounts to discrimination against them.

My third topic for the purposes of this oral opening is the use of Vision-Based Monitoring Systems or VBMS, as they are known. We will again not be alone in suggesting, Chair, that it is impossible to understand the care of inpatients on mental health wards in Essex without a full examination of the use of their preferred VBMS, namely Oxehealth's Oxevision system.

The fact that you must, we suggest, closely examine the impact of Oxevision on ward environments, which would be consistent with the current questions 15 and 49 of your provisional list of issues is particularly so in light of the significant reliance on EPUT's use of Oxevision as a platform to ensure patient safety, as was reinforced in EPUT's opening statement to this Inquiry on 11 September 2024.

Chair, we are aware of at least two inquests which have concluded within the last year, including Sophie's inquest just six months ago, in which families have expressed serious concerns about EPUT's use of and reliance on the Oxevision system. We know of other trusts that have suspended the use of similar VBMS due to specific concerns about the retraumatising effect it has on patients, particularly survivors of sexual

violence, and yet at this very moment on its website and on social media, EPUT is boasting of the recent receipt of a self-nominated award commending itself in partnership with Oxevision for its use of this controversial technology in all its inpatient wards.

That EPUT should nominate itself for a patient safety award, while contemporaneously in time this Inquiry was finalising its provisional terms of reference, investigating serious failings related to the delivery of safe and therapeutic inpatient treatment, is considered by the families we represent to be breathtakingly ill judged and insensitive. Self-praise, we suggest, really is no praise at all.

In our written opening note, we have addressed in some detail the use of and the impact of the use of Oxevision, which is, so that all can understand, a system which enables infrared sensitive cameras to record activity in wards, including in inpatient bedrooms. We also set out in our written opening some of the emerging academic literature and various accounts collected by the Stop Oxevision campaign, on the risks inherent in the use of systems like Oxevision.

Given the widespread use of this VBMS in NHS Trusts in Essex, it is incumbent on this Inquiry, we would respectfully suggest, to consider that evidence and

indeed to obtain more.

The families we represent wish to take this opportunity to draw your attention to a number of strongly held preliminary concerns in respect of the use of this system: firstly data protection and patient consent; then the impact of sustained surveillance upon vulnerable patients; and, finally, the safety and efficacy of Oxevision.

Looking briefly at data protection and consent studies exploring the use of CCTV on mental health wards have shown that, contrary to the Information Commissioner's Office's Code of Practice on surveillance cameras, patients are often not told about the use of CCTV cameras on wards and patients and staff, when questioned, did not believe they were able to do anything about the cameras, including complaining about them, despite feeling uncomfortable with such a prevalence of cameras on the wards.

The 2023 CQC report on EPUT, which refers to the use of Oxevision as a "contact-free patient monitoring system", found that the trust:

"... did not ensure that all aspects of care and treatment of patients was provided with the consent of the relevant person in respect of the contact bringing patient monitoring and management system."

Chair, this is an issue of national concern. On 7 September 2023, NHS England sent a letter to all mental health trusts on the use of VBMS systems in mental health inpatient settings, raising concerns about their blanket utilisation and the issue of informed consent. It also understood that NHS England are in the process of exploring the evidence base for the use of VBMS, informed by the work of the restraint reduction network and the British institute for human rights. It may be that as a Core Participant, NHS England can assist you further in this regard. But the Inquiry is invited to explore how EPUT's own policy is being implemented in practice across its estate, including whether, in fact, Oxevision is being employed on a blanket basis without fully informed consent on EPUT wards.

That exploration is particularly important when the impact of vision-based surveillance is considered. Sophie, you will hear, had a longstanding and deep seated discomfort around cameras. They triggered acute paranoia for her. She consistently believed and expressed that she was under surveillance, including by the Government. As you will hear from Mrs Smith in Sophie's early admissions into mental health units, she would want to know the exact placements of cameras on

wards. It's for that reason that Mrs Smith was deeply concerned that the continual presence of an Oxevision camera in Sophie's room would have caused her real and significant distress. She was very upset to learn from Sophie's records in the months before she died that Sophie was complaining about the camera in her room, raising concerns that she believed the Government had hacked into it and were watching her, clearly contributing to her paranoia. Yet, Chair, the camera remained. Why? Was there a prioritisation of convenience and policy over patient wellbeing and, if so, was that justified or could it ever be justifiable?

The use of the Oxevision system is a restrictive practice. The justification for the imposition of the restriction and the efficacy of the system in achieving its stated aims must therefore be closely scrutinised.

A joint report by the Restraint Reduction Network and the British Institute for Human Rights makes clear that:

"Services must not use surveillance as an unjustified blanket restriction. For example, surveillance should not be used to overcome, alleviate or mitigate a poor organisational culture or other setting specific problem such as staff behaviour/ training. Surveillance should also not be used if it is

unlikely to succeed in addressing the issue it has been installed to overcome."

Oxehealth promote Oxevision as a tool that helps staff care for patients more safely. Chair, tools to complement the work of staff in caring for patients and keeping them safe are, of course, to be cautiously welcomed but the families we represent query the extent to which Oxevision is being used as a digital replacement for human interaction.

Put bluntly, if Oxevision can keep a digital eye on inpatients, can monitor their vital signs and can sound an alarm if vital signs cannot be verified, does that replace the need for staff to carry out their own observations?

In Sophie's inquest, EPUT was unable to provide evidence of staff having been trained in the use of the Oxevision system. No member of staff took responsibility for having been in possession of what was at the time the sole Oxevision tablet on the ward on the day of Sophie's death. If staff were not appropriately trained and were not even aware of where the tablet that monitored the Oxevision system was, it was clear that they were in likely to respond to emergency alerts as necessary.

Moreover, the likelihood of effective response to

an emergency alert from a digital system compromised by the impact of potential alarm fatigue. Having a digital alarm system on wards leads to many alarms sounding. As outlined in our written submissions, research suggests that some 72 to 99 per cent of clinical alarms are false. Alarm fatigue occurs, according to one study:

"... when clinicians are experiencing high exposure to medical device alarms, causing alarm desensitisation and leading to missed alarms or delayed response. As the frequency of alarms used in heal rises, alarm fatigue has been increasingly recognised as an important patient safety issue."

You will hear in Tammy Smith's commemorative statement in a moment more on alarm fatigue. Tragically, in Sophie's case, the cameras that caused her such anxiety in life failed to offer her any meaningful protection from death.

While an alarm sounded to alert staff that Sophie was in a risk area, this was not responded to for some six minutes. By that time, Sophie was found lifeless and unresponsive. Mrs Smith understandably found it difficult to comprehend how such an intrusive video monitoring system, which might have worsened Sophie's paranoia and mistrust, can be justified and so heavily relied upon in circumstances where its efficacy is

significantly in doubt.

Chair, structural discrimination and racism.

The families we represent endorse INQUEST's submissions on structural discrimination, as outlined in their written opening statements and powerfully reinforced by Ms Lewis in her oral opening to you in September this year. We have outlined some worrying statistics in our submissions. In their 2020-2021 Mental Health Bulletin annual report, NHS England Digital published data that suggests that women are restrained significantly more often than men.

In 2022, the Black Equity Organisation reported that almost two thirds of black people who responded to its survey had experienced prejudice from doctors and other staff in healthcare settings. This rose to three quarters amongst black people aged 18 to 34, and concerningly, given those findings, according to recent figures on detention in 2023, black people are 3.5 times more likely than white people to be detained under the Mental Health Act.

More recently, in its June 2004 report, entitled "Public harms: Racism and Misogyny in Policing, Education and Mental Health Services", a report which scrutinised the institutional harm caused to women and girls and, in particular, to black women and black girls

across our public services the Black Equity Organisation found common themes in black women's experiences of public services, including excessive force and detention, adultification and the "strong black woman" trope, the erasure and invisibility of black women's experiences and a one-size-fits-all approach to public services.

The report found that ethnic minority patients were more likely to be restrained or secluded in punitive, rather than therapeutic ways, that women were being secluded at unexpectedly high rates, and that there were often poor conditions in seclusion rooms. These findings, Chair, are of acute concern to the Nsilu family in particular, who are only too aware of racist attitudes and stereotyping of black people by healthcare professionals and by others responsible for their care, particularly when in detention.

The evidence heard at Edwige's inquest raised well founded concerns that racism and discrimination had impacted her death and, in particular, that she was a victim of the so-called "strong black woman" trope.

We say that because, having discovered Edwige unconscious, nursing staff sought to justify not engaging in immediate CPR by an alleged belief that she was feigning unconsciousness, as an apparent trick to

lull them so that she would attack them. Chair, there was simply no basis or justification for that assumption.

By contrast, there is clear evidence that it caused a delay in providing to Edwige prompt emergency medical care.

So scrutiny of the role of structural discrimination and racism, and the treatment of black or other minority ethnic service users and their families is a matter of particular importance to the families we represent, as is to the treatment of women in detention.

It should also, we say, be a matter of concern to your Inquiry and it is for that reason, and to assist you in understanding how structural and institutional racism and discrimination, including that intersectional discrimination, might have impacted the care and treatment provided by EPUT and others, that we say you should obtain expert evidence in this regard and we stand ready to assist you.

So, Chair, what can be done? Mrs Smith and the Nsilu family wish to re-emphasise that they do not consider any one of their concerns described above nor any of the other concerns we have addressed in writing can be siloed one from the other. Instead, they must be viewed through the prism of the culture and enduring

failures in leadership, which not only allowed these failings to occur but persisted and continued to persist long after failings were exposed in inquest after inquest, and inspection after inspection.

That culture and those failures in leadership sought to deflect and to minimise criticism, and to obfuscate rather than clarify and cooperate, when errors and omissions that occurred behind closed doors or on locked wards were placed under public scrutiny.

So it is not without significant trepidation that these families look to this Inquiry to break that cycle, to state clearly and unequivocally that enough is enough and that real and meaningful change must be implemented without further delay.

We know, Chair, that you and your team, even at this early stage, are already working on the identification of practical recommendations that can be and will be meaningfully implemented. We know that in order to do so, you will expect that the State Core Participants will be true to their word, will throw open the fires and provide access to the fullest disclosure, will ensure that witnesses are available, and will facilitate an environment in which so-called whistleblower witnesses feel they can give their evidence freely and without negative consequence.

But to date, the Core Participant families have seen no evidence of Essex Mental Health Services' stated commitment nor the spirit of that commitment, and their individual and collective experience has given no reason to be confident.

Moreover, Chair, the failings are so widespread and multifaceted that, to some extent, the question is: where do we start? One answer, we suggest, lies in the provision of position statements by Core Participants. In our written submissions, we set out the legal basis for directing the provision of the position statements, which is straightforward and is clearly within your power. But, Chair, it is both the history of your Inquiry and its future direction that reinforced the need for position statements in this Inquiry.

That history has already been outlined, and includes multiple widespread failings, enduring and well founded concerns about lack of candour, and an apparent corporate unwillingness to implement much needed reform, together with blurred lines of responsibility and accountability.

The future direction of this Inquiry must include confidence that you have a clear understanding of what went wrong, assisted by the fullest disclosure, confidence that you have identified lines of

responsibility and accountability, and the ability to make recommendations that are necessary, that are realisable and that will be implemented.

Corporate position statements which address all of those issues will assist you. They will assist you in identifying what failings are accepted and by whom, what remains in dispute, and therefore requires fact-finding and resolution, what changes have been or are being implemented, as well as who is accountable and who will be responsible.

There are advantages of this approach, which include, at least in your Inquiry terms, the early provision of a comprehensive account to which witnesses can later refer or be referred.

It also avoids any corporate inertia where organisations might be tempted to offer you apologies and assure their commitment to you, all the while remaining silent on particular matters, unless and until they are specifically asked, thereby causing distress, delay, and the appearance of evasiveness to bereaved families in particular.

Corporate position statements enable State Core Participants to prove themselves true to their promise from the outset.

We say that position statements which could be

requested contiguously, one following another, or to address particular themes, or to address particular periods of time, could and should address, with respect to each relevant issue as identified by the Inquiry, that organisation's narrative version of events. It could include roles, responsibilities, processes, policies. It could address resources.

It could address relevant and applicable legal or regulatory frameworks. The relationship between public and private providers; what did, did not, should or should not have happened within the knowledge of an organisation; it could address staffing practices, levels, training, future direction for staff; it could address reliance on technology such as Oxevision; it could address lessons learned and the identification of good and bad practice; it might address measures to address racism and structural discrimination in inpatient services; and of course changes that have been made are under way.

Position statements should be signed off by the chief executive or a person with that level of authority within an organisation.

Chair, we have set out in our written submissions details of other inquests and inquiries that have successfully adopted this approach. They include the

Hillsborough Inquest, the Litvinenko Inquiry, the Grenfell Inquiry, the Manchester Arena Inquiry and, recently in Scotland, the Sheku Bayoh Inquiry. Given the relatively limited number of Core Participants in your Inquiry, the volume of potentially relevant material and your terms of reference, and given also the need to progress this Inquiry as you have already identified as quickly and as comprehensively as possible, position statements will, we suggest, be a useful tool within your armoury.

Moreover, Chair, we know -- because you have said so -- that you are keeping an open mind as to the need for interim recommendations. Full and clear corporate position statements would be of significant assistance to you in assessing whether there is a need for interim recommendations and, indeed, for final recommendations, offering, we would hope, a reasonable starting position on which to build.

So, Chair, to conclude, on behalf of the families of Sophie and Edwige, we are ready to assist you and your team, to ensure this Inquiry fulfils its terms of reference and, finally, achieves a lasting change that you are committed to deliver, so that those who need mental health care in Essex and beyond receive it in therapeutic, compassionate and safe environments.

Chair, in a speech by the former Chief Coroner just over a year ago to this day, he spoke of a profound truth about the focus of death investigations, a truth that is sometimes in danger of being overlooked.

Those charged with investigating deaths often speak of putting the bereaved at the heart of the process. But a duty to put the bereaved at the heart of the process cannot exist in a vacuum. It presupposes the existence of a prior duty to the deceased, to Sophie, to Edwige and to so many others who died, to clarify the circumstances of their deaths and to enable them to contribute to the health and safety of the public as a whole by exposing and fixing preventable risks to life, and it is for that reason that we invite you to keep Edwige and Sophie and their experiences at the heart of your process, so that this Inquiry might finally discharge the posthumous duty they are owed. Thank you.

THE CHAIR: Thank you very much indeed Ms Campbell.

MR GRIFFIN: Chair, we will shortly hear some further commemorative and impact evidence. Before that, may we take a very short break for five minutes to come back at 3.10.

(3.04 pm)

(A short break)

(3.10 pm)

MR GRIFFIN: Chair, we will now hear the commemorative and impact account of Tammy Smith, Sophie Alderman's mother. It had will be read by Ms Campbell.

First, though, can I ask Amanda to put up the photograph.

Could that be taken down.

Brenda, please start when you are ready.

Statement of TAMMY SMITH read by MS CAMPBELL

MS CAMPBELL: Thank you. Tammy Smith says:

"I am the mother of Sophie Alderman. Sophie was the eldest of my three children. She was born on 26 June 1995. Sophie arrived in this world with a burst of energy nearly two weeks after her due date, weighing an impressive 9lb 8.5 ounces. Despite arriving fashionably late, a trait that became a lifelong habit, it felt like Sophie was eager to enter the world, with my labour lasting, from start to finish, just an hour. Upon laying eyes upon her for the first I was struck by a mix of shock and awe, marvelling at the little human I had nurtured for the last nine months.

"I could not stop staring at her in the fish tank like bassinet, gently prodding her every now and again to remind myself that she was real and she was mine.

"As a toddler, Sophie exuded a mixture of calmness

and curiosity. She was a most inquisitive little girl and it was truly amazing to watch her explore and engage with the world around her. Very particular about her interests, she found contentment in the simple joys of childhood, with a particular love for Winnie the Pooh. I remember having to continuously rewind the movie as we did back then because she loved to watch it over and over again.

"Even at that young age, Sophie displayed a discerning eye for character, preferring to take a second observe before fully engaging with others. Beneath that laidback exterior, Sophie was prone to over thinking. It was often very evident on her face that she was taken within the situation and wanted to observe before involving herself.

"She was never wholly committed to being in the thick of it and at birthday parties she would usually be the last person to join in the games.

"The transition to primary school brought its share of challenges, particularly when we relocated to Winchester. It was right after the summer holidays and Sophie was unable to say a proper goodbye to the friends she had, which was difficult for her. Luckily, she found solace in her new found friendship with Becky, who she met at her new school, and the friendship endured

all through primary and secondary.

"Sophie's personality began to develop more when she was in the junior stage of primary school. She was such a funny person with developed cheeky sarcasms which always kept me on my toes. However, it was around this time that she began to experience blackouts sporadically where she would just drop to the floor unconscious.

"Her battle with mental health intensified as she moved into adolescence. Blackouts, anxiety and self-harm became increasingly familiar to Sophie, though she never spoke directly to me about her struggles at this stage and it was through her school that I learned of her self-harming.

"I understand that Sophie later in life reported to treating professionals that she was raped when she was 12. I know there are also references in her records to her being 15 when this happened. I did not know anything about this at the time and only learned the information from Sophie and others much later in life.

"I know at one point it was reported to the police, but I do not know what came of this. It was not something that I spoke to her about.

"Sophie came under the care of Childhood and Adolescent Mental Health Services at about the age of 14 and she was with them until she was 18. Sophie's mental

health would improve and decline in four to six-week increments. When she was feeling good, it was very evident visually. Her make-up and hair would be done and she would make an effort to look her best. So when her mental health deteriorated, that would all go out the window. Her hair and nails would not be done and her clothes would be messy, and it was like experiencing a whole different person.

"Sometimes those peaks and drops coincided with her medication. Sophie would be put on anti-depressants for anxiety and medication that worked really well for her and would be absolutely full of life and ambition. She would tell you, 'Right, I'm doing this, I'm going to this place', just be really social and kind of what you expect from a teenager, but it was also exhaustingly manic.

"She would then come often the medication, telling me that she was fine and did not need it, and then have an episode and spiral back down, at which point she would either be put on a higher dose of the same medication or a new medication altogether. While she was adjusting to that change, things would be really rotten again.

"There was no predictability on the medication front though. Certain medication made life more manageable

for her, while others could have had the completely opposite effect.

"Sophie would always put on a brave face for her little sister and their bond was truly a special one. I remember when her little sister was born. Sophie had gone to stay the night with my best friend, Sarah, and was so excited, asking her every five minutes whether her sister had arrived. She was 17 at the time but the age gap never stopped them from having a close relationship. Sophie absolutely adored her little sister and the feeling was definitely reciprocated. They loved being silly together and pulling funny faces at each other and just being daft.

"That was Sophie to a tee, though. She had a wonderful sense of humour. I remember on one occasion I was in the kitchen and I happened to slip on a grape and fell in the most traditionally comical way. Sophie could not contain her joy that I had done such perfect slip and never let me live the moment down, always bringing it up and bursting into cries of laughter at the memory. These are moments that I will cherish and will always miss.

"With her brother Alfie, Sophie had more of a love-hate relationship, as is typical of sisters and their brothers. They would often fight and then the

next second be best of friends asking if the other wanted some sweets from the shops. They loved to get into mischief together and were quite good at not saying anything when it came to giving up information. Loyal to a fault, the pair of them.

"Sophie was the one who taught Alfie how to ride a bike without stabilisers, completely random and unprompted. She must have been about seven at the time while he was just three or four. But she had taken it upon herself to teach him, and she did it well.

"I think the major turning point in Sophie's mental health was June 2015, when she was 19 years old and about to turn 20. I had been out for the night and Sophie had stayed with Sarah. I was later told they had been discussing life and not listening to the voices. She later turned up at Sarah's house with a knife at her throat and said something like 'They said I'm going to hurt my sister. They want me to hurt my sister'. My youngest daughter was no more than a year old at this point. Sarah was pretty confused and asked who 'they' were, to which Sophie responded 'The voices'. It must have been really distressing for Sophie because she loved her sister so much, and we knew she would never do anything to hurt her.

"We took her to A&E and she was admitted to

hospital. I believe Sophie had been hearing these voices for a long time before we knew about them. I think it was around this time that I learnt that the voice was named Shona, and that this was a real person for Sophie.

"After Sophie's admission in June 2015, she seem completely detached from the situation and so she could not understand why she was not allowed home. She was just really cross with me and she thought things would be fine because, as far as she was concerned, it was not really her who had turned up with the knife.

"That incident was when I made the really difficult decision with Sophie's treating medical team that Sophie could no longer stay at home. Sophie's treating team agreed that Sophie required 24-hour care and so when she was not in hospital she was discharged to Natalie House for a year between 2015 and 2016. Natalie House was a small residential care home where Sophie could receive 24-hour care.

"There are lots of incidents of impulsive and risky behaviour between 2015 and 2017. In June 2016, Sophie was diagnosed with emotionally unstable personality disorder, which explains some of her impulsivity. There was a period in which she was particularly focused on a particular bridge, where she was detained or removed

from it on a number of occasions.

"Despite the struggles she had with her mental health, Sophie never wanted to die. She expressed to me on multiple occasions that she didn't want to die; she just wanted the voices to stop. She would often express regret after incidents of self-harm. It's so upsetting for me to think about the pain that she carried with her all through her life.

"Sophie felt deeply uncomfortable by cameras from a very young age. She hated her photograph being taken and would always shy away from cameras. At first, I understood this to be a response to being body conscious, like many young girls, but as Sophie got older it became apparent that this was something that triggered acute paranoia. She consistently believed and expressed that she was under surveillance by the government. Even when her little sister would try to take photos, Sophie would seem anxious and hide.

"In late 2016 Sophie developed neuroleptic malignant syndrome and she had to be placed in an induced coma. We were told this had been caused by the anti-psychotic medication she was taking. It was a really frightening experience. After all this, she was discharged into a bedsit but the hospital admissions and incidents of self-harm continued. There was a period between 2018

and 2019 where she did not require any admissions into hospital but received community support from Southern Health NHS, where she was then admitted and detained in hospital again until June 2019 and the typical cycle of being in and out of hospital resumed throughout 2020 and 21.

"During Sophie's early admissions into mental health units in Southampton, one of the first things Sophie would ask is, 'Where are the cameras?' Back then, it was just some CCTV cameras in corridors, there were no cameras in rooms but Sophie would want to know exactly where they were.

"Sophie moved to Ipswich on 30 October 2021 and then on to Essex on 28 March 2022, so I understand her last contact by phone with Southern Health was in early November 2021. She later came under the care of Essex University Partnership Trust from April 2022, when she was admitted to hospital there.

"Even though I was not in contact with Sophie in the period before her death, she was in touch with my husband Jason, Simon her father and her sister, regularly. Sophie would try her best to mask her mental health problems to her sister. However, Jason and Simon and I were all worried over the years that Sophie's mental health did not seem to be improving and we all

felt there was an over-reliance on medication.

"This was particularly worrying because Sophie's compliance with the medication had always been erratic. Whilst Sophie could behave impulsively, I felt there was a predictability to her behaviour. There were the four to six-week cycles in which Sophie's mental health would take a dive and Sophie would always struggle around big occasions, like birthdays, including her own. She told us, and treating medical professionals, that self-harm helped her cope with the voices that she heard. Sophie's physical appearance would also dramatically change when things were particularly bad for her. She would neglect self-care, strop brushing her hair or showering, she would also become much more irritable and paranoid.

"I believe Sophie had a disordered and complicated relationship with food. I perceived it as a very visible form of self-harm that she was doing to herself. In my experience, she always ate more when she was in hospital.

"On the 19 August 2022, Simon was informed that Sophie had died that day over the phone by a member of staff from Willow Ward. It was someone who introduced themselves as a nurse and told him', We have lost Sophie'. Simon was confused and asked whether they had

meant she had escaped. When the nurse responded that Sophie had died, he was shocked and told her he had to hang up to process what she had told him.

"He was then unable to call back and find out where Sophie was because he had not taken her name, which added to the distress and confusion. This was a particularly upsetting way to learn of our daughter's death. Simon and I are devastated by the loss of our daughter. Simon had suffered the bereavement of his wife the year before and so he was particularly struck by the grief of losing Sophie.

"Sophie is hugely missed by so many of her loved wonders. Becky still messages me to say that she's thinking of Sophie and misses her. Her sister, now 12, tells me daily that she misses Sophie and that she wishes she could come back. I know how much she must miss speaking with her. Sophie made her feel like she was the best little sister in the world and that the world was just the best place with Sophie, and this went both ways. With her sister, it felt like Sophie could momentarily shut off everything in her mind and just be daft and make silly faces, talking about everything under the sun together.

"My husband Jason, who spoke to Sophie several times a week, has been hit particularly hard. Although not

biologically related, he treated her as if he was her dad and he loved her from the minute they were introduced. Even now, the fact that he does not get to talk to her any more weighs heavily on him. He misses her so much. I am just so thankful they had each other.

"Sophie was a good person with a massive heart. I feel lucky that she was mine, that she was in my life and, even now, in the impact of losing her, she has brought massive positivity. She has changed not only my perspective but that of so many others, teaching us that there is nothing you cannot work through because nothing is ever going to be as bad as losing your sister or your daughter.

"Sophie was a wonderful person and, if she loved you, it was like winning the lottery. If she loved you, you were loved, and that was that. That is something we all miss.

"After Sophie died, I needed to understand how and why she died when she was in a hospital where I thought she would be protected. I needed this understanding to be able to properly grief the loss of Sophie and process her death.

"In October 2022, I became aware of a new Channel 4 investigative programme, Dispatches, Hospital Undercover Are They Safe? I found out that an undercover reporter

had been deployed into Willow Ward at Rochford Community Hospital where Sophie was a patient. I learnt that the conditions on this ward were heavily criticised by experts interviewed on the programme, particularly in relation to the use of restraint. It was gut wrenching to learn about this and I was left feeling really anxious about what experience Sophie had had on the ward and, though I could not bring myself to watch the documentary, I knew I needed to find out the truth about Sophie's care and death.

"Sophie's inquest opened shortly after her death and there was a first preliminary inquest review hearing on 4 November 2020. In that hearing, EPUT's lawyers told us had a report from their patient safety and incident investigation would be provided by 9 January 2023. This was the first time I remember hearing about EPUT conducting an internal investigation. I wanted to learn more about this investigation and provide the investigators with any information that I could, because I understood it was supposed to be a process of establishing the truth about Sophie's death, and a learning process for the Trust.

"A draft report was delayed and then delayed again. Eventually, I received an electronic draft in late April 2023. Before this report was sent, I had asked EPUT,

via my lawyer, to provide a copy of the terms of reference and to tell the investigator that I wanted to speak to them. These requests were ignored and I was emailed a draft report, having never spoken to the investigator. I did not feel I had been given any opportunity to provide any input on the terms of reference or that the Trust valued the contribution I might make to any learning process. The draft report was only sent to me for 'factual accuracy checking'. I felt like a tick box in their investigation.

"Worst of all, and combined compounding my experience of feeling nothing more than a tick box to EPUT, I was completely unprepared for the information the report contained. As I read the report, I came to a section which set out in graphic detail the CCTV chronology of Sophie taking her own life and her last moments when she lay dying. It was really upsetting to read this information and, because I had not been warned by EPUT in advance about the content, it was a total shock to read.

"I felt angry that EPUT had given no consideration to who they were sending this information to, to send such graphic detail with no prior warning to a bereaved family felt illustrative of how forgotten we are in the process. More generally, I felt the report was

inadequate and that there had not been a thorough investigation which was quite devastating. I was really upset by the lack of any meaningful areas identified for improvement when, even at that early stage, there seemed to be some really obvious and urgent issues which needed to be addressed.

"I met with the investigator after reading the report and I provided a lot of feedback. Ultimately, nothing really changed between the draft and final report, leaving me feeling that I had been ignored and underscoring even more the feeling of being part of a tick-box exercise for EPUT.

"I now know that Sophie had an Oxevision system monitoring her in her room on Willow Ward. She would have experienced it as a camera watching her at all times in her room and she would have hated this. It is really upsetting to know that her medical notes record her complaining of a camera in the room that she believed the government had hacked into, watching her. I hate to think of her in such distress. It's not difficult to imagine this distress, having had to sit through partially captured footage of Sophie from the hospital corridor taking her own life.

"During the investigation into Sophie's death, I learned about the purpose of the Oxehealth system,

an alarm alerts staff when patients are in a high risk area of their room, like a bathroom, for more than three minutes. They are supposed to then physically check the patient. Sophie was partially in her bathroom when she took her own life. An alarm alerted staff but they didn't respond to it.

"It's difficult for me to comprehend how such an intrusive system, which might have worsened Sophie's paranoia and mistrust, can be justified when it did not protect her. After Sophie died, EPUT also failed to ensure the retention of footage from that Oxevision camera, though it hasn't even been of use during investigations into Sophie's death.

"The inquest jury concluded that Sophie died by misadventure. We know she did not intend to take her own life. It was documented in her records throughout her care that she used self-harm as a means to escape auditory and visual hallucinations. We didn't have the opportunity to explore in Sophie's inquest why these hallucinations and paranoia seemed to have got worse over time but I really urge the Inquiry to consider the impact of surveillance technologies on patients in their rooms, particularly those who suffer with psychosis and paranoia.

"I also hope the Inquiry will consider the reliance

on technology like Oxevision to keep patients safe. I met with the author of EPUT's internal investigation report after he sent me the draft report for 'factual accuracy checking'. When I raised my concern that Sophie had not responded to Sophie's Oxevision alert he was very quick to sympathise with the staff referring to 'Alarm fatigue', from his own professional experience in health care, essentially several alarms going off regularly on wards means staff become desensitised to them. This was of no reassurance. There was no scrutiny or consideration of how alarm fatigue makes patients unsafe and how this can be prevented.

"It was a flippant comment, presented as a fact of life, a reality of any mental health ward. Nothing in the EPUT's internal investigation grappled with this.

"In truth, the entire internal investigation felt like a giant shrug of the shoulders by EPUT in response to Sophie's death. I needed the reassurance of not just feeling my concerns and questions were heard, but that EPUT were genuinely open to learning lessons from Sophie's death. Sadly, in my experience, they seemed to have no capacity for or interest in either of these things.

"My experience of EPUT was characterised by defensiveness, which worsened to obstructiveness during

the inquest into Sophie's death, with witnesses being overly defensive when providing their evidence, and providing inaccurate information about evidence that was unavailable or had been lost.

"It made an already unimaginably hard process so much more difficult to get through, practically and emotionally.

"I say this as a parent that trusted EPUT to look after my child. I understand that there may be occasions where there are mistakes while caring for our loved ones but I do not see any indication of an NHS Trust that is willing to learn from its mistakes. There have been the most serious errors or actions which has led to the deaths of our loved ones. It is beyond my comprehension that there is no sense of emergency or immediate proactivity to learn lessons to prevent future deaths. Instead, it feels like EPUT are preoccupied with being secretive and self-interested. Throughout the internal investigation and the inquest, it felt like EPUT were minimising the events which led to Sophie's death for self-gain.

"As it stands, I believe Sophie's death was entirely avoidable, a fact that beaks my heart and makes grieving even harder. But there is an opportunity to ensure that Sophie's death is not in vain, and that no family shares

this pain. In order for that to happen, lessons must be learnt so that future deaths are prevented."

Thank you.

MR GRIFFIN: Chair, that is the end of Tammy's account.

THE CHAIR: Please convey my thanks to Mrs Smith for this account of her obviously much loved daughter.

MS CAMPBELL: Thank you.

MR GRIFFIN: Ms Campbell will now read the account of Joyce Nsilu, Edwige's mother. May I ask first that the photo is put up.

Thank you very much.

Brenda, please start when you're ready.

Statement of JOYCE NSILU read by MS CAMPBELL

MS CAMPBELL: Thank you. This is the commemorative and impact evidence of Mrs Joyce Nsilu. She said:

"I am the mother of Edwige Nsilu. She was 20 years old when she died on 5 February 2020. It is important to me and my family to share with you what Edwige was like as a person, and not just what happened to her before she died.

"Edwige was born on 29 October 1999. My husband and I have seven children and Edwige was our third child. Edwige has two older brothers and four younger brothers and sisters. My husband, Flavien Nsilu, and I are from the Democratic Republic of Congo. Edwige was born and

raised in London. She was raised speaking our native language of Congolese Lingala at home. Sadly she lost the ability to speak Lingala after she was removed from the family home by Social Services at the age of 14. Flavien does not speak English, and so this really impacted her ability to communicate with him. This was very hard for Edwige as she was always particularly close with her dad growing up.

"Edwige was very close to her family. She was the older sister to her younger sisters and brother. Whenever she called home, she would always ask about the family, including the extended family. She became very anxious for the welfare of her younger sister, Docas in 2019 and 2020 who was undergoing treatment for her sickle cell disease at the time. When we were shown her bedroom in St Andrew's after she died, we saw she had photos printed out of all her family on the wall, including all her siblings and cousins.

"Edwige had a strong affinity to her Congolese background and African culture. She had never visited Congo but she had always talked about visiting when she was read from hospital. When we used to visit her in hospital she'd frequently ask us to bring her African food. She also requested that I make her an African style dress. She wore this dress in photographs that we

saw in her room in St Andrew's and she wore it to visit her family in Christmas in 2019. Edwige regularly expressed a wish to visit Congo one day.

"Edwige was a devoted Christian, as we all are in our family. When we used to speak to Edwige on the phone, she would often tell us how much she missed the church, and she was always asking us to pray for her. Edwige was loving, warm, nurturing, gorgeous and strong. We called her the mother of all children because she had a deep love for every single person. Edwige was such a blessing to our family and I know that one day, with God's grace, we will see her again.

"Edwige will always be our daughter, big sister and aunt. She never got to meet her nieces and nephews but we will always proudly tell them, and future generations, of who she was. We miss her dearly and we are tormented knowing things could have been different and Edwige's death could have been prevented. We are still recovering from the inquest into her death, which only finished last year. The jury believed Edwige's death had been contributed to by neglect and several failures by the hospital and staff, who were supposed to keep her safe.

"I strongly believe that my daughter experienced mistreatment because she was black and because of

racism. It is so hard to go over what happened, how and why Edwige died, reliving the investigations and the uncertainty after she died, but we have committed ourselves to the Inquiry because we still have questions unanswered, concerns that don't feel resolved, and we still hope for changes for all those under the care of Essex Mental Health Services and their families.

"We want health services and providers to be open and transparent, not to keep secrets and to communicate with parents and families of patients."

That is signed by Joyce Nsilu.

MR GRIFFIN: That's the end of the account.

THE CHAIR: Again, I'm very grateful to Mrs Nsilu for this account of her daughter, Edwige, and will you please thank her for me?

MS CAMPBELL: I will, thank you.

MR GRIFFIN: Chair, we now take a break for around 15 minutes, just a little bit more, until 4.00 pm, please.

(3.43 pm)

(A short break)

(4.00 pm)

MR GRIFFIN: Chair, we now hear the account of Savannah Ridpath, who is talking about her mother, Georgina Sefton. Could the video be played now, please.

Pre-recorded statement by SAVANNAH RIDPATH

MS RIDPATH: I am reading this statement in remembrance of my mother, Georgina Sefton, whose life was tragically cut short while she was seeking help for her mental health issues. Though I never had the opportunity to know her, her absence has left a profound impact on my life. She is more than just a number in a statistic, she was a person with goals, dreams, struggles, and a desire for healing.

You asked me to provide a commemorative account about my mum but I can't do that. I wish I could give you stories of happy times where she took me to the park and pushed me on the swings; or where we had fun Christmas traditions like opening gifts on Christmas Eve or having hot cocoa by the fire; or her proudly standing by my side at graduation, walking me down the aisle, holding her grandchildren but sadly that is not my reality.

Instead, I am left with the weight of unfulfilled dreams and memories that will never be. The moments we never shared are a constant reminder of what was lost. I yearn for the connection that should have been, the comfort of her presence in my life. Instead, I navigate a world where her absence is a daily reminder of the love I crave but can never fully experience.

My mother faced many challenges, including substance abuse, but it is crucial to understand that she was in the hospital seeking assistance, hoping for a chance at recovery. The fact that she sought help demonstrates her strength and desire to change. Unfortunately, that chance was taken away from her and I am left with countless questions about what was transpired during her time in the hospital.

My mother knew she was unable to care for me as a baby, so I was put into care. She wrote letters to me, one of them stating:

"I hope to see you again someday. If you do not wish to see me for whatever, it's not a problem, but I would very much like to see you when you're ready".

That was written on 31 January '06. She died five months later. I will see her again, but it just won't be in this lifetime. I wish I could feel her touch and hear her voice and for her to hold me But I can't; that opportunity was taken away from me.

As I navigate the grief of not knowing her, I reach out to those in positions of authority to reflect on the systems in place. There is a pressing need for change-change that prioritises the well-being of individuals struggling with mental health issues, ensuring that they are treated with dignity and care,

rather than being left to become just another statistic.

It pains me to think of her as merely another number among many. Each number represents a life filled with potential, love and complexity. My mother was not perfect; she battled her demons but she was also a daughter, a friend, a sister, and someone who deserved compassion and support.

I want to clarify that my intention is not to place blame or suggest that any individual is solely responsible for my mother's tragic passing. However, when I reflect on the broader context, it becomes painfully clear that significant changes are urgently needed within our mental health system. My mother's name is just one among many, a stark reminder of the countless lives affected by a system that is frankly, in disarray. I have experienced this firsthand as a previous patient myself and, later on, as a support worker in a psychiatric hospital.

By sharing my mother's story, I hope to shine a light on the pressing need for reform and increased support within mental health care. Each life lost represents a profound tragedy that's impact echoes far beyond the individual; it echoes through families, communities and society at large. They are not just statistics or abstract concepts; they are cherished

individuals whose potential has been extinguished far too soon.

It is imperative that we honour the memory of my mother and others like her by advocating for a system that prioritises mental health, offers adequate support, and fosters an environment where individuals can seek help without fear or stigma. Together, we can amplify these voices and work towards a future where no one else has to endure the heartbreak of losing a loved one to a broken system. Where people get to experience hot cocoas by the fire and be pushed on a swing in a playground. Let us remember that every life lost should not just be another sombre statistic but a call to action that demands our attention and commitment to change.

MR GRIFFIN: That is the end of Savannah's account.

THE CHAIR: It can't have been easy for her deliver that account and I hope she is aware that we are very, very grateful.

MR GRIFFIN: The next account that we hear is given by Linda Lindsay and it's about her son, Christopher Nichols. These are pre-recorded videos and, in them, we'll see Linda and, sitting next to her, her husband Iain. May I ask first of all that the photograph is put up, please.

(Photograph was displayed)

Thank you very much. Would you now play the videos.

Pre-recorded statement by LINDA LINDSAY

MS LINDSAY: What can I tell you about Christopher?

How can I get all that effervescent, enthusiastic, bubbly spirit into a short statement?

Or describe the whirlwind of energy that he was? It is going to be very difficult -- but here goes.

I can tell you he was kind, he was thoughtful, considerate and he would do anything for anyone. He loved his family and friends alike. He loved animals, dogs in particular being his pet of choice.

I can tell you he was a pleasure to be around. He certainly was -- most of the time.

He loved unusual words and sayings.

Discombobulated was one of his favourites; it described him very well too.

Follow me -- I'll be right behind you, was one of his favoured phrases.

He was one of the funniest people you could ever meet, he just loved to make people laugh, he could mimic any accent, and didn't have a bad bone in his body. When he walked into a room, everyone hoped he'd sit with them.

Most importantly, he was my son, a brother,

a nephew, friend to many -- he was just a wonderful, amazing, kind young man.

If you blend all of these traits together, add a pair of beautiful blue eyes, and a dazzling smile that could melt any heart, then you might get some idea of the Christopher we knew and loved with all our hearts.

Christopher Thomas Nichols was born on 11 January 1978 at Royal Air Force hospital in Swindon. His dad Steve, older brother Terry and I lived at RAF Abingdon, which was about forty miles away.

When he was six months old, we moved to RAF Lossimouth in Scotland.

From there, we went to RAF Laarbruch in Germany for three years.

He started kindergarten while we were there and bagged the part of King Herod in the Christmas Nativity concert -- he was so excited!

However, a few days before the performance, he fell head-first from his bike, and scraped his nose and face. He looked a right mess.

This caused his brother to call him "King Horrid" which didn't go down too well. Terry was always teasing him.

From there he went to Maas First School on the bus with his brother.

It was whilst living in Germany, that his lifelong "bromance" with Kermit the Frog began.

Bought as a Christmas present, he loved that frog, it was never very far from his side. I believe his Aunty Beverley bought it for him.

On a visit to England to catch up with the families, we caught a ferry from Ostend.

We joked that Kermit might have to walk the plank, because he didn't have a ticket, but Chris was getting upset, so we left it.

As the ferry docked, we made our way down to the car deck, but before we reached it, there was an almighty scream from Chris: he'd lost Kermit!

His dad ran as quickly as he could back up to where we'd been sitting, but Kermit was nowhere to be seen. We spoke to some of the crew, but they couldn't help. Kermit had gone.

He was inconsolable.

He was very reluctant to get into the car without his beloved frog, but we didn't have a choice: we had to go. He was so miserable the whole visit. All the family scoured the shops for a replacement, but couldn't find one.

When we arrived back home, I wrote a scrawly note to Chris from Kermit, which magically appeared in our flat.

It said, that as the ship was docking in Dover, Kermit had seen a lady frog in distress, so hopped off to offer his assistance. When he arrived back to the ship, we had left. Sad as he was, he knew that he didn't know his way to Nanna's house, and couldn't swim all the way back to Germany, so he'd gone off to stay with his new amphibian family. He knew that Christopher, being a very thoughtful little boy, would understand.

He was very suspicious, but he accepted it.

Many years later, when he was living in Milton Keynes, I found another Kermit. It made him laugh, it's this one, and he kept it for the rest of his life.

In 1984, we came back to RAF Cottesmore, which turned out to be our final posting.

Both the boys settled into their new school and soon made many friends. They always had lots of friends.

Chris always seemed to be in demand.

1990, his father and I took different paths, which meant the boys and I had to leave our married quarter, and move into a house in the village. Neither of them happy at this prospect but they soon adjusted and were able to keep the same friends. The base was only a ten-minute walk away, so they went to the same school, on the same bus, so life carried on as normal.

In the meantime, I'd met someone else. The boys were okay with that and Iain eventually became their stepfather.

The Christmas before Iain and I got married, he took us all out for dinner, something my boys weren't really used to at the time. All Chris wanted was chips. Alas, chips weren't on the menu, so he reluctantly settled for Christmas Dinner.

Iain had bought Sky television for them as a Christmas gift and Chris was miffed at having to leave it. We'd been watching Christmas films before we'd gone out, in particular, National Lampoon's Christmas Vacation, starring Chevy Chase as the haphazard Clark Griswold.

We'd all enjoyed it and chatted about the funny bits whilst eating our meal. As we stood up to leave, Chris caught the tablecloth, and sent everything flying. This prompted Terry to say, "YOU are like the entire Griswold family rolled into one!"

That name stuck with him forever.

This wasn't the first nickname Terry chose. As a baby he was known as "Fur" because Terry couldn't say Christopher. That lasted a couple of years. If you asked him his name, he would tell you he was "Fur".

The boys were at Stamford school, around 10 miles

away. This meant an early start -- he wasn't impressed with that, even though the bus-stop was right outside our house.

His enthusiasm for school started to decline at secondary school. He became the "class clown" imitating teachers and pupils -- no one was safe. This was much more entertaining for him instead of learning.

As he got older, we started to ask him about his plans for the future. He said he wanted to be a chef.

Really? Interesting.

He got himself a job in a very prestigious restaurant in a nearby town but it was a live-in position. Even the fact that all his "roomies" were girls didn't impress him -- he missed his friends.

Come Christmas time, he left the job -- he couldn't believe they expected him to work over the festive period, when all his pals were out enjoying themselves.

Despite his quitting the job, he did actually learn something whilst he was there and turned out to be a very good cook.

While he worked at the restaurant, they provided all his meals. I think it was here that he found his fondness for bacon, having it for breakfast every day. His love of it was legendary.

He came back home and picked up where he'd left off.

Whenever he was coming to visit, he'd ring and say, "Get a pig in bid, I'm coming home!"

When asked what he'd like with his bacon, he'd say -- more bacon! The boys always called me "Bid" or "biddy", Mum was kept for more serious stuff.

When we had mobile phones, we used them to send each other silly photos from the internet, a lot of them about bacon.

No matter how funny the ones I found were, he'd always come back with a better one. He'd laugh and tell me there was no way I would be able to "out-bacon" him.

One picture he sent that sticks in my mind shows a fridge full of bacon, with a tiny jar of apple sauce on the top shelf. The caption read, "seriously, who needs this much apple sauce!"

Another read, "roses are red, violets are blue, bacon!"

Once when Iain and I were going on holiday, we thought we'd leave him something to make him smile. We labelled the kitchen appliances with Post-it Notes, washing machine, oven, microwave, fridge etc.

When we arrived back home, we were in stitches when we saw his response to our notes.

Inside every cupboard, there was a post it note saying:

"You shouldn't be reading this; you should be cookin'

"You're too far away from the cooker!

"Where's mi bacon?

"You haven't got time to read this, there's a pig to cook!

"Get cracking bid!"

Such Happy memories.

He met some new friends when we moved to the village, they all went to a club in Leicester called Diehard. Soon, he started going with them. Apparently, it was some sort of rave venue, but he loved it. We were concerned that he'd be drinking, but we found out that alcohol wasn't served, however, the odd "spliff" was smoked. And Chris being Chris, wasn't going to miss out an opportunity to try it.

He met lots of characters there, some more colourful than others.

He was very good at dancing, and even better as a DJ. Not that we ever saw him dance or DJ, but we were told many times how good his patter was, and he had quite a following. Diehard became his regular Friday night haunt, he never missed it.

Off he'd go, in his white jeans and tee shirt, long hair flowing in a ponytail. He spent many happy hours

at Diehard.

He became a bit of a Diehard legend.

The time came when he wanted to spread his wings, and move out. Like any other mum, I knew it was time to loosen the apron strings, hide my tears and let him go. It wasn't easy.

He moved to Coventry to begin with. He promised to give me a phone number as soon as he had one, and off he went.

I remember calling this number one day to talk to him. A young lady answered the phone and I asked for Chris.

"Chris?" she repeated.

"Yes", I replied.

"I'm sorry, I think perhaps you've dialled the wrong number, we don't have a Chris living here".

Just as I was beginning to wonder if I had written down the wrong number, the girl spoke again.

"Oh, hang on a minute, one of the lads has just come in. I'll see if he knows him. Hey Griswold. Do you know anyone called Chris?"

Needless to say, we broke into fits of laughter.

He met some very good friends whilst living in Coventry, but one in particular had four legs, and answered to the name of Prince.

He said he'd won Prince in a card game. Whether that's true or not, I was never quite sure, but it made a good story.

Prince was an 18 month old Staffordshire Bull Terrier, a shark on a leash, as we mistakenly thought, and he was as crazy as Chris!

He took him everywhere with him -- even to raves. They were inseparable. He changed his name from Prince to Spike after a Labrador we'd had and lost five years previously. He also referred to him as "the dog formerly known as Prince".

It was something Chris always did -- whenever he met someone, he would have to find a suitable nickname for them.

He had a lovely friend who he called Geezer, he came to our house many times. When I asked him why he called him Geezer, he said it was because he can't remember his name.

Geezer was instrumental in getting Chris's hair cut.

They had all returned home, after an evening in the pub somewhat worse for wear. Chris went and flaked out on Geezer's bed.

Geezer threatened him, that if he didn't shift, he'd cut off his ponytail. Christopher carried on snoring, so the ponytail was cut.

They sent it to us in the post, saying that if we wanted the rest of him, we had to pay them a ransom.

We told them that's fine, he's all yours.

I thought he would have been livid that his golden locks were gone, but he wasn't. He saw the funny side. He always did.

Back to Spike.

Spike was his side kick and had his very own fan club. Everybody loved him and he loved everyone. He was so funny.

Spike had this weird thing about water. If he heard running water, he was off to find it. He brought down many a shower curtain through jumping into the bath. Every home he went in, he managed to sniff out the bathroom.

One Boxing Day, he discovered our outside tap dripping, and set about ripping it off the wall. All attempts at bribery failed, he just wouldn't let go. Chris lifted his back legs, but he was having none of it. He was shivering with cold, but he wouldn't leave that tap until he killed it.

An emergency plumber cost us a small fortune, but we had no option but to see the funny side of it. Chris handed over his wallet and laughed. He took him in for a warm bath as he was so cold, but the minute he was in,

he was chancing his paw with the bath taps.

Crazy canine.

Even the mention of the word "bath" was all it took for him to run and jump in, where he'd sit, in a world of his own, gazing at the taps. He truly would sit there as long as you would let him.

Chris used to say Spike wasn't "wired up" right.

They made a perfect team. Only he could get a dog as daft as himself.

One of the many, many stories that springs to mind is about a trip they took. Chris and three of his mates, decided to go to Blackpool. They'd got as far as Birmingham then went to find their next train. Unfortunately, they boarded the wrong one.

Although they were on the right platform, it was one of those times, when passengers were asked to board the front or back train -- depending on where they were going.

They just saw a train and jumped on. Sometime after the train had departed, they realised that they were going south instead of north. As they set about trying to figure out where to get off, they spotted a guard through in the other carriage.

They panicked then because they hadn't got a ticket between them.

One of them had the bright idea of hiding in the loo until the guard had passed. So, four lads and one Spike hid in the loo, and tried very hard not to breathe too loudly.

They heard the swish of the carriage door open and shut again, and the same again as the guard disappeared down the train.

They thought it best to stay put until the guard had gone back down the train. When he came back, they held their breath again, but then, just as they thought they'd gotten away with it -- the guard knocked on the door -- and Spike barked -- game over.

The guard couldn't believe his eyes when he saw them all come out of such a tiny space. Fortunately for them, the guard had a sense of humour. He told them that Spike was the only one travelling legally, so wouldn't get fined, but they would. Another blow came when he told them the train would not be stopping until they got to London.

After they'd chatted a while, the guard thought that going to London was punishment enough, and waived the fine. Chris swears it was because Spike was making a big fuss of him.

Once off the train, they found the guard and thanked him. He asked what they were going to do, and they said

they were going to find the next train to Blackpool.

From Coventry, he moved to Milton Keynes, but sadly, he was unable to take Spike with him, so he came to live with us.

Chris thrived in Milton Keynes, and after a while, he met a young lady who was to become the love of his life: Sarah. I truly believe this was the happiest part of his life.

He was working as a floor/carpet fitter now, and he was extremely good at it. He worked all over the place. One of the most prestigious jobs he did was at a perfume shop in Covent Garden.

On a visit to London with him, he took us to this shop, to look at it. Whilst we were there the manager came over to us, recognised Chris and greeted him like a long-lost friend. He said what a wonderful young man Chris was and what a pleasure it had been to meet him. I thought my heart would burst out of my chest with pride. It truly was a work of art. It depicted a compass rose in black and white tiles. It was stunning.

You wouldn't believe how good he was.

Sadly, his beloved Spike passed away; Chris was devastated, as were we, he was such a little character. Before Spike left us, we'd got another staffy cross, who

was in need of a good home. His name was Nacho, which we quickly changed to Louie.

Chris was eager to come and meet the little guy and changed his name the minute he met him. He said he didn't look like a Louie and thought that Grendel suited him much better. This confused the dog -- who just happened to be crazy too. Chris had him "rewired" within minutes of meeting him.

Louie absolutely adored him, wouldn't leave his side whenever he visited. The silly thing was, Louie thought that Chris was Grendel, and wasn't quite sure what to do, when Chris kept saying Grendel.

We seem to collect crazy animals.

He and Sarah seemed to be made for each other but sadly, it didn't last and they split up. For me, this was the point when Chris' life started on a downward spiral.

Sometime after this -- I can't remember the dates -- he was admitted to hospital in Milton Keynes for self-harm.

He was in an awful mess.

We did everything we could to help him but as any parent knows, there's only so much you can do.

Thankfully, he got himself back to some sort of normality but I knew that he'd never get over the end of

this relationship.

Eventually, he returned to live with us and met another girl but it was a disaster from the start.

She ended up getting pregnant and his daughter was born in March 2013.

Like everyone else, we hoped they'd be able to make things work but it wasn't to be.

She is now 11 years old. None of us have seen her since Christmas 2013 and she has been living with the girl's parents since she was a toddler.

Chris had always wanted to be a daddy, so this really cut him deep, and again, his poor heart took a battering, and he started drinking more.

He had morals and principles and hated to see injustice and unfairness of any kind.

Sometimes he ended up paying for his principles.

He was beaten up very badly whilst in Milton Keynes, for shouting at a chap who was beating up his girlfriend. Chris went to have a word with him but after he turned to walk away, the man jumped him from behind with a brick, his poor face covered in bruises, and it left him with a damaged eyelid.

When I said he shouldn't have got involved, he said there was no way he would stand by and watch a man beat a woman.

He continued to live with us, until a huge disagreement about his drinking forced us to ask him to leave. That's when he moved on to Clacton-On-Sea.

It would be several months before we were in touch again.

We visited him in Clacton a few times but have to say, we weren't too keen on the company he was keeping. He was smoking cannabis, but assured us that all it was and I prayed it was.

We never really saw him the worse for wear through either alcohol, drugs or depression. I had my suspicions but he was very good at hiding things.

In September '21, he spent some time in the hospital at Colchester, due to an accident he had in Clacton. He rang us to say he was in hospital because he'd injured his leg quite badly.

He was running across the road to meet a couple of his friends when he tripped up the pavement. He was wearing flip-flops at the time. We had to laugh; it could only happen to him. We asked if his friends' names were Jack Daniels and John Smith.

I wished I hadn't teased him though when I realised how badly injured, he was.

He landed on his knees and smashed one to bits. So bad was this injury, the doctor he saw thought he'd been

in a motorbike accident. He needed specialist surgery to repair it.

Obviously, there was going to be a long period of convalescence. Not the most patient of people, he wasn't looking forward to this.

The physiotherapist was helping him to get back on his feet, but told him that initially, he was going to need a brace for his leg. It would be a long road to recovery.

Bearing that in mind, he was surprised when one of the nurses came and said he could go home. He thought this was strange and told her about this leg brace, the fact that he could hardly walk and lived alone in a first floor flat but she was adamant he was going home.

The hospital provided "transport" and I use the term very loosely here, as it was a mini bus. The driver had to help him in and position him so that his leg was across the aisle, resting on the opposite seats.

The driver and his two mates from the downstairs flat had to help him up the stairs, all commenting that he should be in hospital.

The following day, the physio rang him to see where he was. He was on the ward with the brace, looking for Chris. No-one seemed to know where he was.

He told him he was at home, and the physio was not happy about this, especially when he discovered how he'd got home.

He sent an ambulance to collect Chris and take him back to the hospital, because he shouldn't have been discharged.

Yet another example of the "care" given by the staff at Colchester and although this doesn't refer directly to the mental health staff, I feel it's important to mention.

He endured months of pain with this leg.

Unfortunately, he was unable to come home to recuperate but luckily, the boys who lived in the flat below him said they would look after him and they did a sterling job.

As Covid restrictions were in place at the time, we couldn't see him. My father-in-law was in our "bubble" and quite vulnerable because of his health, so we were unable to visit him.

Having such a bad injury also meant that he wouldn't be able to do floor fitting any more. A real blow to him.

We never met his last "girlfriend" but I'm glad we didn't.

He'd been talking about her quite a lot and was

considering bringing her up to meet us. However, it wasn't to be.

We both tried to tell him to take it steady with this girl but it fell on deaf ears. After a few weeks, she disappeared.

He was very depressed after this episode. I asked him to move back with us but he said he had to stand on his own two feet. However, when my brother started his own company, he was going to offer Chris a job.

Sadly, I never got to tell him.

Our little village church had standing room only on the day of his funeral. People travelled from near and far to say goodbye to my wonderful son. He would have been thrilled to bits to see it.

We knew the service would be hard for all of us, so we tried to bring a smile, albeit a little one, by inviting Kermit, who sat on top of his coffin in a huge lily pad. We also asked people to wear a splash of green as a nod towards Kermit.

His cousin and some of his friends had even coloured their hair green.

Chris would have wanted to see some smiles within the tears.

Terry read the eulogy; I was so proud of the way he held himself together.

He began by saying:

"Thank you all for coming today, it's great to see so many of you. But I'm guessing some of you may be wondering if you've come to the right place, and who IS Christopher Nichols? Most of you will know him as Griswold, but to me, he was my crazy, amazing little brother."

He told a few anecdotes about the two of them but one story brought a smile to everyone's face.

Terry had been working in Iraq for a while. When he came home, he treated himself to a new car: a TVR. He'd joined an online club of like-minded people and decided to join them on a drive to Italy. He asked Chris to go with him as his co-pilot.

All the drivers met up at a hotel in Dover, where everyone was introduced. Chris was soon holding court in the bar, and making everyone laugh.

The laughter continued throughout the journey but as a co-pilot, Chris was useless. He slept most of the morning due to his entertaining every night, leaving Terry to find his own way. Everywhere they went, Chris attracted a crowd. This became the norm: sleep through the day, entertain at night. Some of the drivers who were there alone asked Chris to travel with them and one time he did -- much to Terry's annoyance. However, when

they met up that night, Chris told him he'd only gone with this chap so he could perfect his Liverpudlian accent.

The evidence was there that night, as he had them rolling in the aisles with his banter.

In a pub in Germany, even the locals came through to where they were sitting, to see who was causing all the laughter. They didn't really speak much English, had no idea what they were laughing at, but Chris had them in stitches.

Terry went on to say, that even though he'd organised the trip, provided the car and spending money, everything else, he was known as Griswold's brother!

Christopher left the church, accompanied by Kermit, singing "The Rainbow Connection". I think everyone broke down then.

I was overruled with the food for the wake by Iain and Terry. They believed we should have bacon butties; they were sure this is what Chris would have wanted. I was horrified, however, we compromised with an all-day breakfast. Considering it was almost 30 degrees outside, it went down a treat and everyone said it was a very fitting tribute to Chris.

The highlight of the wake -- if there could be such a thing -- was being presented with a beautiful,

commemorative, glossy brochure all about Chris from his friends at Diehard and others who wanted to pay their respects and share their memories.

They had all clubbed together to produce it and his friend Antony (aka Sock) had produced it and printed enough copies for all his family and close friends.

He spent an awful lot of time contacting all these friends, collating their accounts, memories and photographs before turning them into something very special for everyone to treasure.

We were overwhelmed and comforted to see how much love all these people had for him.

How can I put into words the impact Chris' death has had on his family and his friends?

Nothing can prepare you for a goodbye you never dreamed you'd have to say, nor suffer the heartache you never thought you'd have to bear.

The worst day of my life was the last one of his.

The terrible sinking feeling, hearing the knock at the door by the police to tell us the news. It's never going to be good news at that time of night.

"Deceased", that's what they said, "he's deceased".

Every time I hear that word, my blood runs cold.

How do I describe the pain, when it felt like my heart was being ripped out of my chest and crushed into

millions of pieces when I was told my wonderful boy had ended his life?

Truth is, I can't -- it's impossible. There just any words -- I wanted to go with him.

I was inconsolable when I realised that never again would I hear his voice, see that smile, hold his hand, have a hug and talk rubbish on the phone, while laughing at "bacon" memes.

He tried many a time to "get me" on the phone, posing as a salesman using his silly accents. From incontinence pants to tartan coloured paint, second hand windows: I don't know where he got his ideas from.

To be told your child had decided to end his life is agonising enough. Yet when you then discover the circumstances surrounding his death; how he was totally failed by Essex Mental Health, that pain turns to disbelief and anger. Only another bereaved mother can truly understand how this feels.

Imagine again how it felt to discover that your child had been at the very same hospital the week before, after taking an overdose. Sadly, we knew nothing about this.

Just a few days later, he was back again to the same hospital, with cuts to his wrists. My boy was desperate for help.

We spoke to him the Sunday evening when he was at the hospital. He told us what had happened but said we didn't need to worry because the mental health team were going to take care of him. He was finally getting the help he needed and deserved.

Imagine how we felt when we rang him on Monday morning to see how he was, only to be told he'd been sent home in the early hours.

None of us could quite believe it.

Despite the fact that both the paramedics and the triage team had red flagged him, the mental health nurse thought he was to quote "a cheeky chappy" and sent him home.

Despite the fact he was hearing voices and despite the fact that he'd only been there a few days before for help, they sent him home.

All this was documented in the statements made by the paramedics and the triage team.

No notice was taken of these.

No help.

No plan.

No idea what to do next.

No hope.

He felt totally abandoned.

I can only try to imagine the turmoil his poor soul

was in.

He assured us that one of his friends was going to stay with him and we didn't need to rush down.

I took him at his word and told him we'd probably pop down to see him at the weekend.

I spoke to this so-called friend of his, who assured me that he'd take care of him and not to worry but then told me that Chris had no money. I didn't want to give him money, didn't want to put temptation in his way with alcohol, so I arranged for a local supermarket to deliver him some food -- with lots of bacon.

The day after, the friend rang again, saying that Chris needed money for petrol but didn't like to ask.

We duly transferred money to Chris' account.

What we didn't know, was that this money we'd transferred had gone.

On the Wednesday when Chris and I spoke for the last time, he asked me for some money. I asked had he already spent the money I'd sent the day before?

I could tell by his response that he knew nothing about the money I'd sent, nor did he know about the conversations I'd had with the "friend".

Halfway through our conversation, he abruptly butted in and said "Bid, can I call you back later"? He was gone before I could reply.

We never, ever ended a call, without saying, "luvs ya" but this time we did. How sad, considering this would be the last time we ever spoke.

Why he had to rush, I'll never know. It was just like someone had arrived that he needed to speak to.

He never called back.

Over the next two days, I texted, rang, texted again: but nothing.

I told him I was going to get the police to do a welfare check if he didn't reply.

But he didn't.

Finally, when I went to bed Friday night, I rang him, and said I was upset with him.

I didn't know that by the time I'd made that last phone call, my son had already gone.

He'd told me in an earlier conversation, on the Monday before he died, that Essex Mental Health were useless:

"What do I have to do in order to get some help? Don't I tick enough of their boxes? Why don't they take me seriously? How do they decide who desperately needs help and who doesn't? How much distress do I need to be? I need help Mum!"

Because of the lack of care, we will never know what exactly what was wrong with Chris but I believe if he'd

been given the chance, the symptoms of psychosis he had described could have been treated and, with the right sort of treatment, he could have gone on to lead a normal life.

However, Colchester hospital denied this chance. I know he was frightened because he'd been hearing voices. This was on the notes which, we believe, were not read by the attending staff.

Another point worth mentioning is that we didn't have a Family Liaison Officer until the end of March. We were not aware that we should have had one. No-one except the coroner's assistant contacted us about anything; we were totally alone.

We were introduced to our Family Liaison Officer on 22 March, nine and a half months after Christopher had died.

Whilst talking about things to mention, although it doesn't really relate to EPUT, it was part of the harrowing experience we had.

My husband was talking to a policeman on the phone. He was trying to claim Christopher's belongings. He asked if there was anything else besides his phone. Did they have his wallet?

He was told, "No, there's nothing else. There's a belt here if you want it".

Considering the manner of Christopher's death, that remark was cruel.

We lodged a formal complaint against EPUT in October '23. We were told this procedure would take a few months, six at the most.

Not to decry the person who looked into this too much, as I appreciate there seemed to be a lot of obstacles in his way, it took 10 months to get the report. During this time, the investigator kept in touch with us but it got to the point where it seemed we were getting a "rehashed" version of the same email each month.

We were not happy with his findings: it left a lot of unanswered questions due to the lack of record keeping by the mental health team.

Because of this, we (Iain, Michael my brother in law, Beverley my sister and me) prepared a response saying the report was unacceptable. This was sent 18 August.

We received a reply on September 21 saying it was under review and they'd get back to us. We are still waiting.

We were unable to get a straight answer at the inquest, which was held in Chelmsford on 15 November 2023.

Chris wasn't referred to the "care at home" team, the nurse saying he didn't realise he could. Knowing how much Chris loved to chat, he would have welcomed someone to call at his house on a regular basis.

So frustrating.

Either way, the decision to send him home was categorically wrong.

Incidentally, none of the NHS trusts talk to each other. One would assume that if you entered a name, address, date of birth and the NHS number, that you would be able to gain access to that person's medical information but alas, no. They keep all this information to themselves eg each trust. So, if, for example in Christopher's case, someone had had a similar episode in a different county, like him, this information was unavailable.

If staff were able to access this medical history through a nationwide system, it would give them some insight into the patients' health, even draw attention to any particular recurring condition.

This could really help with diagnosis/medication. It's easy for a patient to forget/omit things when in a state of anxiety.

I don't believe my son wanted to die; he just couldn't get the help he needed in order to stay.

And for that, we -- and the entire family -- hold EPUT and Colchester hospital responsible.

Some things cannot be mended. Even if the heart mends, it will always bear the scars and feel the pain.

For the rest of our lives, we will have to try hard to focus on the way Christopher lived, not how he died.

His daughter will never have the chance to meet her dad. I can only hope that in time, I will be able to tell her all about the amazing man who was her father.

We lost our son, Terry lost his brother, the rest of the family lost a valued, much beloved member.

Christopher would not want revenge, but he would want justice and not just for himself. It is our sincere wish that he, and all the other poor families and friends who have suffered this unimaginable heartache, get it.

Depressed people do not feign being depressed, they try hard to convince you they are okay. These so-called mental health professionals should know this.

Staff referred to Chris as "A cheeky chappy".

A cheeky chappy is not a diagnosis nor a good reason to send anyone home.

Its high time mental health was taken more seriously. More help made available and policies put into place to ensure that all medical notes are read.

I'm sure this inquiry will be paramount in helping each and every one of us to feel some kind of solace.

We bereaved will never get over, through or around losing our loved ones. Somehow, we manage to function day to day but it's very hard and painful when part of you is missing.

Thank you to all involved.

Finally, I cannot end without mentioning Melanie Leahy. Without her diligent, relentless, campaigning, I doubt we would be here today.

From the bottom of our hearts, thank you Melanie.

MR GRIFFIN: May we now see the further photographs, please.

(Photographs were displayed)

Chair, that is the end of this account.

THE CHAIR: I'm grateful to Christopher's mother for her incredibly vivid reflections of her son and I hope somebody will pass my gratitude on.

MR GRIFFIN: Thank you. We'll now hear about Hannah Webster in an account given by her mother, Deborah Webster. I will ask Amanda to play the video and to put up the further photographs afterwards.

Chair, this will be the last account that you'll hear today, and the hearing will resume tomorrow at 10.00 am.

THE CHAIR: Can I reiterate my thanks to everybody who has

contributed to today's hearings, and my gratitude to those who are going to give us hearings over the rest of this session.

MR GRIFFIN: So if the video can be played.

Pre-recorded statement by DEBORAH WEBSTER

MS WEBSTER: My name is Deborah Webster, thank you for giving me the opportunity to tell some of Hannah's story, thank you. Friday 13th 1996, my third baby Hannah Louise was born. She was so tiny, she was so perfect. Hannah was the baby of the family and had two older siblings, Leah who was 7 and Simon who was 3. Our family was complete. Hannah was a good baby and even from a young age she was eager to learn. Her hair was so blonde she looked like she was bald, when it did grow it was so fluffy it looked like candy floss, so I gave her the nickname floss.

Hannah was always forward for her age. When she started nursery, she instantly took to it. Her first Christmas at nursery she played Mary in the school nativity, she looked so cute and I was so proud I cried. Hannah started infant school, although she was a bit shy, she soon fitted in and made friends. These friends she has had her whole life.

When they were small, on a Saturday, Hannah, Leah, Simon, and her cousins would all sleep at their

grandparents' house. Every Sunday, my mum would say they're not staying again, but the following Saturday she'd have them all over again. They all formed a strong bond together and were really close, especially with her cousin Rebecca, who was nearly the same age.

When Hannah was about 7 she was doing so well at school. The teacher said she was a gifted child and was in the top four per cent in the country. My Hannah was unique. Even though she was a dream child she also had a stubborn streak -- if you upset her, you'd certainly know about it. When Hannah was 11, she had her prom at junior school. Leah decided to do her hair and it didn't turn out quite right, boy, did Leah know about it.

Hannah then went to Earlseaton High School. She loved learning and was adored by both pupils and teachers.

Hannah was a free spirit, she did what she wanted to do. One Christmas she decided she wanted a guitar. Noone could show her how to use it, for months we had to listen to her strumming it while singing to the cat.

Hannah's grandparents had a caravan at Flamborough. These were some of the best holidays we ever had. We'd all go, aunties and cousins, how we all fitted in I don't know, but somehow, we did. One year, her

grandad paid for all the family to go to Disneyland; 13 of us went. We had such a good time, that we all then went to Spain. Hannah decided it wasn't warm enough and kept her coat on for three days. In Hannah's short life, she did see a bit of the world: Disneyland, Spain, Crete, Greece, Portugal and a cruise down the Nile. Hannah had caught the travel bug. She knew we wanted to go to university, and she knew she wanted to work abroad.

As Leah was a few years older than Hannah she took on the role of being her second mum. Everywhere her sister went, so did Hannah. If I said no to something, she would go to her sister, who always said yes.

Hannah was 10 when her first nephew was born. Over the next few years, she was aunty to 2 more nephews. Hannah idolised all three of them.

Hannah loved spending time with just me and her. Shopping and a meal at Nando's. We would put the world to rights, but Hannah's favourite meal was homemade stew and pancakes.

Hannah loved music and she enjoyed going out with friends, but she never let her schoolwork slip. She sailed through school and passed all her exams.

When Hannah was 18, I started to see a change in her. She was struggling with her sexuality and pressure

of college. She told me she'd been using recreational drugs after a suicide attempt. She was under mental health services, Hannah was diagnosed with BPD a few weeks later.

Hannah went on to be a bridesmaid for her sister, we all had a fantastic day, and both my girls looked radiant. Soon after that Hannah got a letter she'd been waiting for. She had got a place at Essex University; she was over the moon. I had my doubts, I wanted her to take a year out, but there was no stopping her. Hannah did seem to be coping, so I gave my blessing. Hannah was the first person in our family to go to university, I was so proud of her, after all the hard work she had put in she deserved her place at uni.

Hannah decided she was going to take driving lessons. All of a sudden she changed her mind, she wanted a motorbike instead. So she passed her bike exam and got a motorbike: a big motorbike. How she rode it I don't know, but somehow, she did. University was everything she thought it would be. She loved the diversity of it all. It wasn't long before her bike followed her to Essex. I used to go visit Hannah at University and I stayed in student accommodation with her a couple of times. She couldn't wait to show me around, pretend you're a student, she would say.

We would go clothes shopping in Colchester town. Not to the big shops -- she loved the second-hand shops. She had a thing for vintage clothes and quirky jumpers. She got a shell suit one time, I told her I had one like it 20-odd years ago, but it never suited me like it suited her. I've still got it to this day, same as her favourite perfume, Ghost. I still buy it now.

Another time, we went food shopping. Hannah wouldn't let us get a taxi back to the University, so we had to walk about a mile with the shopping trolley. We couldn't stop laughing.

Hannah loved festivals but couldn't afford to go to them all, so she became a marshal so she could get in for free. When Hannah wasn't at University, she loved to go to Castle Hill at Huddersfield. She thought it was like being on top of the world, and she would spend hours there.

Hannah had a thing for elephants she loved them. An elephant never forgets she said. She even had a tattoo of one. Hannah also had a thing for Post-it Notes, they would be everywhere. I've still got loads of them now, with little notes she'd written.

For a while, Hannah seemed her normal self. Then she had to find her own student accommodation off campus. Hannah's mental health started to deteriorate.

I asked Hannah to come home, but she wouldn't. One minute she would talk to me, the next minute she wouldn't.

Over a couple of years, Hannah had been to hospital and seen doctor's numerous of times, but felt she wasn't getting any help. Early in 2017, Hannah was told she was dyslexic.

On 12th March 2017, Hannah ran the Colchester marathon. We never knew about this until after her passing. She was also having relationship issues. Hannah was in crisis, she was embarrassed about her mental health, but she shouldn't have been, but she was. She had been let down so many times by the NHS, it took a lot of persuasion to let the police take her to hospital. After an assessment she was sent home. Once again, she was let down.

On 11 May 2017, Hannah went missing. On 12 May 2017 Hannah was found. Her life had ended. She was 20 years old. That day a part of me died too. Hannah might have been 20, but she was still my baby. My Hannah was beautiful inside and out. She was intelligent and funny. People loved to be in her company. My Hannah was unique. I wish she could have seen that in herself. Hannah didn't need to and shouldn't have died.

My life had now changed forever. Words can't ever

express the heart ache and devastation I feel. Time doesn't heal and the pain never goes away. Every day is a challenge, trying to get through each day without breaking down takes its toll and by the end of each day I'm exhausted. I can't watch certain things on TV and I can't listen to certain music, as so many things trigger me.

Hannah was a funny, kind, thoughtful and beautiful young girl. I have never heard anyone say a bad word about her. So many things remind me of Hannah. One minute I am OK, and then the next I'm fighting off tears. People think after 7 years I should be over it, so now if I get upset I pretend it's for another reason. Some people think I should celebrate Hannah's life. Maybe one day I will, but for now I'm still grieving. I can't help how I feel.

I will never see Hannah get married or have children. I will never see her smile or her moody face again. Family gatherings are one of the worst times for me. Someone always says, "isn't it nice we are all here", I just want to scream, "no we're not all here".

I've still got all of Hannah's clothes. Her coat at the back door, her motorbike in the shed, her phone in the drawer. I still have her computer, but I haven't ever been able to look at it.

Hannah would have been 21 on 13 December 2017. Instead of having a party, Essex University planted a memorial tree in memory of Hannah. It was a lovely day, but not what you should have for your 21st birthday. Because the media reported when Hannah went missing, they also reported when she was found. We didn't want to tell her nephews how their aunty had died until we thought they were ready but some of the headlines were not sensitive. In fact they were awful, so we had to tell them before they were ready. We were already devastated, this just impacted us even more.

It hit Hannah's sister, Leah, really hard and the pain I've had to see her in is heartbreaking. She is doing better now after the birth of her daughter 2 years ago; she has helped with some of that heartache. A niece for Hannah, a niece she won't ever get to meet. We do talk about Hannah all the time and [my granddaughter] knows her aunty, and she's even got her aunt's name.

She's our sunshine on our darkest days. Hannah's brother Simon's way of coping is not to talk about any of it. Another special person in Hannah's life who took it hard was Jamie, her brother-in-law. One time, Hannah was at University. It was nearly her birthday, and we realised Hannah was on her own. Jamie jumped in his car

and drove 4 ½ hours. He picked Hannah up and drove 4 ½ hours back. It's still Jamie that takes us down there now, and I'm so grateful to him.

Hannah's friends from home asked if they could have a tree planted at Earlseaton High School. As Essex is so far away, they planted a beautiful blossom tree for her. I never thought Essex would be part of my life, but it is. We try to get down there a couple times a year. It brings me a sense of peace. Hannah absolutely loved Colchester, especially Castle Park. One of the last photos Hannah took was of a squirrel in the park, so we've now renamed the park, squirrel park.

In 2019, I needed to run in Hannah's footsteps. So, me, some family and friends did the Colchester marathon. Losing Hannah is sometimes like a dream. For a moment you think it's not true, and then it hits you like a ton of bricks and all you want to do is scream, "it's not a dream, it's a nightmare".

I can't ever express how much I love and miss my daughter. It's an honour and a privilege to be Hannah's mum and I am so proud she is my daughter. One of the things that keeps me going is knowing one day I'll be reunited with my baby. Hannah wrote this poem when she was 12, I've always treasured it. I think it sums Hannah up and I'm going to read it now:

"At school, at home, everywhere, people look, people stare. Just because the way I dress, it doesn't make me weird. Just because I'm shy, doesn't make me not heard. Just because I listen, doesn't make me a swot. Just because I'm interested in different things, doesn't make me boring. Just because I have different answers doesn't make me wrong. Just because I don't stand out, it doesn't make me a copycat. I am different there is no one like me. Because if there was, I wouldn't be me."

Hannah was under EPUT mental health services. All she wanted from them was to be kept safe from herself. They failed.

MR GRIFFIN: The photos are just going to come up in a second.

(Photographs were displayed)

Chair, that is the end of the account, and of the day.

THE CHAIR: My thanks to Mrs Webster for the account of her obviously very beautiful and wanted daughter.

(5.16 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X