IN THE LAMPARD INQUIRY

OPENING STATEMENT ON BEHALF OF THE FAMILIES REPRESENTED BY LEIGH DAY

A: Introduction

1. This opening statement is made on behalf of the three Core Participant ("CP") families currently represented by Leigh Day in this Inquiry: the Leader family, the Pimm family and the Elliott family. Each family has suffered the immeasurable loss of a loved one: Joshua ("Josh") Leader who died in 2020, Terrence Joseph ("TJ") Pimm 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 ones' deaths were, or may have been, preventable, makes 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.

2. To learn that there may be thousands of families in a similar position brings little comfort. 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 are that they are afforded answers, and the assurance that no other family will suffer like they have in the future. These are twin expectations, not hopes. Otherwise, this process will be for nothing.

3. As others have already said, the provision of mental health care in Essex has been the subject of long-standing and robust criticism for the past several decades, from a range of independent bodies, including the Care Quality Commission ("CQC"), the Nursing & Midwifery Council ("NMC") and other professional regulators, the Coroner's courts and criminal courts, and the Parliamentary and Health Service Ombudsman. Despite these investigations identifying significant and similar failures in respect of patient safety, the relevant NHS Trusts in Essex ("The Trusts") 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. 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 unpick the true scale of the systemic failures which prevailed between the years of 2000-2023, and continue to prevail within the Trusts, and making recommendations which will make a tangible difference.

4. 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 investigation as they arise.

5. Our clients welcome the Chair's indication that, if the evidence reveals issues of urgent concern, she will move quickly to ensure the relevant healthcare bodies are notified and action taken. We also invite the Chair to reconsider the value of issuing an interim report of her factual findings and recommendations, in view of the dynamic context within which the Terms of Reference will be interrogated.

6. The Chair's indication that she will use the full extent of her statutory powers to compel the production of all necessary evidence from corporate CPs is welcomed. 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 for this Inquiry being placed on a statutory footing.

7. 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 the Chair's more expansive interpretation of an inpatient death to that adopted in the non-statutory phase of this Inquiry[1]. 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

[1] Explanatory Note on Scope: see (g) under definition of inpatient death.

observations in what is described as "seclusion". Despite these patients being on either side of the hospital threshold, and the timeframe of their deaths in total spanning nearly two decades (from 2002-2000), their communality of experience, in respect of the lack of basic safeguards and clinical decision-making, is significant.

B: Background to our Core Participants

8. Given the early stage of this Inquiry, we do not propose to rehearse the detail of the evidential background, in so far as it is known to us, in relation to each of our three CP families. The extent of the information that each family has about what happened to their loved one 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 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 and make mental health professionals listen to them.

Joshua Leader

9. Joshua Leader ("Josh") was 35 when he died. He leaves a young son and a loving, grieving family. His family, who will deliver a commemorative statement in respect of Josh during the November hearings, have said about him that: "*His enthusiasms were infectious, and [they] hoped they might have carried him onto more stable ground. His laughter – goofy, seismic -- seemed to rise up from the ground he stood on*".

10. 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 living arrangements.

11. 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 co-ordinator. Josh's family report that he was fairly stable around this time and moved out of his parents' 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 familiar to his family.

12. 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 antipsychotic 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 co-ordinator and the CT level doctor during which various changes were made to Josh's medication.

13. In May 2020 Josh's mother contacted his care co-ordinator on multiple occasions expressing concerns about Josh behaviour and symptoms, including that he was not taking his medication. Josh's brother also raised the absence of a s.117 Mental Health Act 1983 ("MHA 1983") assessment, care plan and funding as a mechanism to secure Josh the support to which he was entitled (and never received).

14. 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 antipsychotic 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.

15. 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 co-ordinator. Josh also wrote around this time to the professor in neuropsychology: "*The NHS and councils here in the UK have shown they are not at all interested in helping me*".

16. On 18 September 2020, a Consultant Psychiatrist from the EPUT 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 to take his antipsychotic medication. They felt that Josh needed to try antipsychotic depot injections due to repeated problems of non-compliance. They told his care co-ordinator 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.

17. 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 co-ordinator to ask for help. Josh's family felt his situation was becoming desperate.

18. 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.

19. In the event, Josh was then referred to EPUT's Home First Team ("HFT"). He had a video consultation with a consultant from the Home First team on 20 October 2020, of which Josh's family were not aware and to which they were not invited.

20. Josh still continued to express suicidal intent to his family, and on 24 October 2020 his mother contacted EPUT's Home First Team 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.

21. 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 was cancelled on the evening before the meeting on the basis that Josh was now under the care of the Home First Team. 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 antipsychotic medication.

22. Josh continued to be seen daily by EPUT's HFT in early November and self-reported an improvement in his 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 EPUT's HFT.

23. Josh's care co-ordinator visits were then reduced to every other day, with a joint review planned 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 risk 'RAG' rating, despite the family's view to the contrary.

24. 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 invited to and were unaware of this appointment.

25. 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 run by EPUT. 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.

26. 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 Joshua's medical notes before conducting the assessment as to whether to admit him and also said that during the assessment process 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 this assessment, that "*there is no psychiatrist in the world who would prescribe [Josh] antipsychotic medication"*. Yet, only days before, a plan had been agreed to explore depot antipsychotic medication with a Consultant Psychiatrist.

27. 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*".

28. Josh's brother sent a text message to the care co-ordinator explaining that the weekend had been "*very difficult with Josh who was again threatening suicide*". He repeated his request for antipsychotic medication to be prescribed 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 co-ordinator stating: "*can we speak today? I need a prescription from the dr for an antipsychotic*". The same day Josh's mother sent a text message to the care co-ordinator saying she felt that her son was on "*the very edge of taking his life… We are utterly stuck and Josh will die*". That morning the care co-ordinator 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 co-ordinator visited Josh at just after 11am that day and noted that Josh denied suicidal thoughts and "*felt safe*".

29. Josh was found having ended his life using a ligature later that day some five hours after the care co-ordinator's visit.

30. 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, H.M. Area Coroner for Essex concluded Josh's inquest on 11 July 2024 by recording an extremely critical narrative conclusion and finding that Josh died by suicide contributed to by neglect. Neglect in this context is a high legal test to satisfy and signals a gross failure to provide basic care which is causative of death.

TJ Pimm

31. TJ was 30 years old when he died. His mother, Karon Pimm, gave a moving commemorative statement about her son in the October hearings, 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.

32. TJ had a long-standing 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 probation. 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.

33. 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 officers and warned them 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 s.136 of the MHA 1983. 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 remained unexplained, he was not assessed there, nor did the hospital have any records of his admission.

34. 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, 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 dissemble and downplay the extent of his symptoms. The mental health assessment (conducted by an Approved Mental Health Practitioner ("AMPH") and Consultant Psychiatrist) proceeded on 9 August 2016 without seeking Mrs Pimm's involvement or even notifying her that it was taking place. 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 evidenced indication 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.

35. Over the next several weeks, TJ spiralled further. 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 the Colchester Hospital for an urgent assessment, notifying Mrs Pimm who met them there. TJ was seen by a Mental Health Liaison Team ("MHLT") Nurse, a part of the Access and Assessment Team which was run at the time by the North Essex Partnership University NHS Foundation Trust ("NEP")and latterly EPUT. The nurse was briefed on TJ's s.136 MHA 1983 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 there was an outstanding warrant against TJ, the Nurse insisted, in 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 hospital.

36. In her evidence to the inquest, the MHLT nurse stated she felt "*compromised"* by the fact there was an arrest warrant in play, and maintained that, despite being aware of TJ's suicidal disclosures, 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.

37. 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 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.

38. The subsequent Serious Incident 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 use as a significant contributory factor to his death, despite the fact that he was not under the influence at the time of his death.

39. 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 Deaths 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 co-ordination, family involvement in mental health assessments, and training for mental health practitioners on patients subject to a warrant.

40. 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 their experience, is how close they feel they came to getting their son the protection he needed. TJ's sole points 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 characterise the experience of the Leaders.

41. We now 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. 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.

Richard Elliott

42. 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, Clacton Hospital (run at the time by NEP). 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.

43. 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. A36-paged bundle of witness statements is all that she received from the Coroners' Court. She is yet to receive the underlying medical records and witness evidence from key clinicians involved in the events preceding his death. She hopes this Inquiry will, amongst 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 a properly conducted inquest can sometimes bring.

44. Richard had a long-standing history of severe mental illness, suffering from bipolar disorder with acute psychotic episodes which led to numerous inpatient admissions, including previously to 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 were repeatedly rebuffed, which the family feels significantly impacted on Richard's willingness to engage with these services and on his subsequent deterioration.

45. In May 2002, Richard suffered a serious relapse in 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 s.3 of the MHA 1983. Given concerns over a possible escalation in risk, police decided to assemble a 'Level Two entry', which appears to have meant convening numerous officers (possibly up to eight, and possibly in riot gear: the facts remain unclear) to effect his transfer to hospital. Richard however complied and went voluntarily with the officers.

46. 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 inquest evidence available would suggest around 15 minutes) the decision was made to administer Richard two different antipsychotic 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 appears to only to have detected presence of the benzodiazepine, Lorazepam, which was found to fall above the therapeutic concentration, (just) into the toxic range. It also remains unclear as to whether and to what extent manual

restraint was used against Richard, the limited available evidence from the inquest appearing inconsistent on this.

47. 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 4-5 hours in, despite the fact he was observed to be highly sedated, non-conversant and repeatedly incontinent. 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 incontinent and restless, requiring several staff 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 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 were taken to monitor his vital signs in this period or to maintain his dignity given his vulnerable physical state. It was only at around 05:20 that staff noticed his breathing had 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 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 cardiac complications i.e. "natural causes".

48. 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 unprobed, 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 investigations 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.

C: Thematic Concerns for our Core Participants

49. Drawing from these experiences of our clients and their loved ones, as outlined above, we seek to emphasise at this stage some of the core thematic concerns they hold, which reflect and inform the Chair's Terms of Reference and her Provisional List of Key Issues. Given the incipient stage of this Inquiry, we provide only a general outline of such concerns, recognising that these may well evolve or change as the evidential picture develops.

Admission Assessments

50. 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 following inadequate assessments which resulted in decisions not to admit them as an inpatient, nor to provide them with the necessary support in the community.

51. The nature and appropriateness of these admission assessments will require careful and nuanced consideration by this Inquiry. We believe that the Inquiry should also 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, 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. It is 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 which prejudges the individual's problems based on, for instance, concomitant substance misuse issues, or their socio-economic circumstances. Families – who so often know their loved ones and their challenges better than any clinician – must be pro-actively involved, rather than be treated with hostility or suspicion, as unwelcome "meddlers" or as an adjunct or afterthought. Even when, for whatever reason, consent is not provided by a patient for clinical information to be shared with third parties, this should not obviate the need to listen to families' "expert" knowledge of their loved ones.

52. Moreover, proper and advance consideration must be applied to the type of assessment required for a particular patient. As the Provisional List of Issues recognises, there is a significant difference between assessments for detention under the MHA 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 in accordance with specific legislative criteria and processes as 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 s.12(2) of the Act, as well as review 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 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 increases, rather than reduces, the need for such assessments to be scrutinised in the context of this Inquiry.

53. Neither of the assessments that Josh and TJ underwent, in the days before their death, were conducted under the MHA 1983. In Josh's case, 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 MHA 1983. Similarly, the MHLT nurse who reviewed TJ on 25 August 2016 failed wholesale to consider whether he required admission, either under the MHA 1983 or informally, instead erroneously determining that he could not be assessed at all given the outstanding warrant for his arrest.

54. 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, in so far 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.

55. The shortcomings in the assessments 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 admission was required but, in the alternative, the critical question of what safeguards were needed to manage their risk on discharge. Both Josh and TJ 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 the community mental health services.

56. The importance of ensuring that robust safety plans are in place for at-risk individuals is a matter of core clinical practice, as recognised by the Royal College of Psychiatrists.[2] 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.

57. It is noted that the Chair has indicated that she is minded identifying a 'sample' of cases, which you consider representative of the various issues, which will be investigated in greater detail in order to draw wider conclusions. We invite the Chair 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 inpatient admission for many patients in Essex.

Involvement of Family Members in Patients' Care

58. 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

[2] Royal College of Psychiatrists, 'Self-harm and suicide in adults', July 2020 CR229. Accessible here.

relatives has been a long-standing feature raised repeatedly in the Trusts' internal post-death investigations and in Coroners' inquests, including by way of Prevention of Future Death reports. Despite this, families continue to face a system indifferent, suspicious and hostile to their views and concerns.

59. 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[3] 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 front-loaded, not reactive, their input being sought at an early stage in a patient's care, as opposed to leaving them fighting to be heard.

60. The Provisional List of Issues places particular emphasis on the engagement of family members and carers "*from the point of admission through to discharge*".[4] The exclusion of family members from a patient's care, however, significantly predates the point of inpatient admission. 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 re-started on antipsychotic medication (which were known to stabilise him) were simply not registered, or worse, were actively discounted by the Trust. Despite the family's decades-long insight into Josh's cyclical pattern of illness, they were never invited to undertake a carer's 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 warnings that Josh was seriously psychotic had severe consequences – directly informing the decision not to admit him for inpatient care.

[3] Nice Clinical Guidance [CG136] Service User experience in adult mental health, 14 December 2011
[4] Provisional List of Issues, §38.

61. In TJ's case, the failure to involve his mother in his s.136 MHA 1983 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 they did not consider 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 the 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.

62. 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 a 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. 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.

Patients who have contact with the criminal justice system

63. The intersection between the criminal justice system and mental health services is well-established. Extensive research and studies have confirmed that people with various forms of mental illness are highly over-represented in the criminal justice system[5]. That people who are subject to criminal proceedings have the same rights to psychiatric assessments and treatment as anyone else ought to be uncontroversial. However, this is all too frequently not reflected in practice, with healthcare agencies failing to work effectively with the police,

[5] See for instance the HM Inspectorate of Probation: 'Effective Practice Guide on Mental Health, Based on a thematic inspection of the criminal justice journey for individuals with mental health needs and disorders', February 2022.

prison and probation services to ensure that vulnerable individuals involved in the criminal justice system have their mental health needs promptly assessed and met.

64. TJ's case exemplifies the disjunction between the mental health and criminal justice services. His A&E assessment on 25 August 2016 was cut short due to the nurse's erroneous belief that she could not assess or admit TJ as he was subject to an arrest warrant. This betrays a fundamental misunderstanding as to the primacy of professional clinical duties, with TJ's suspect status being prioritised over his mental health 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[6]. This is especially so where the patient, in active crisis, 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 the Chair's consideration of the interaction between the Essex Trusts and other public bodies, including (but not limited to) the police and HMPPS.[7]

65. In the Chair's Explanatory Note on Scope, she indicates that she will consider, as appropriate, the particular circumstances which may inform an individual patient's experiences within the Trust(s), listing various examples including physical health issues, drug and alcohol addiction and "*other social and economic factors"*. The Chair is invited to expand such consideration, impliedly or otherwise, to include any contact / 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.

<u>The use of restrictive practices in the inpatient mental health setting</u>

[6] See for instance §§ 22.2-22.4 of the Mental Health 1983: Code of Practice
[7] Terms of Reference, §2(k) and Provisional List of Issues, §§100-101.

66. The use of restrictive practices, including restraint and seclusion, 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 to a 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 clinical literature[8] 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.[9] 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.

67. 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. The high reliance on agency and non-regular staff, who are less adept at de-escalation and less familiar with the patients, may appear to be a relevant factor informing this, though this will be a matter for the 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 is 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.

Lack of availability of psychological treatment

68. 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 parts of the country for psychological treatment (including in Essex),

[8] NICE Guideline Number 16: "Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care", 2004.
[9] Brook House Inquiry Report, Volume 2, Part D.6.

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 should be considered carefully by the Inquiry.

D: Looking Ahead

69. Given the early stage of this Inquiry, we do not propose to set out a detailed or definitive position on proposed recommendations, which must necessarily await the conclusion of the evidence. We offer here only a general indication as to what our clients expect to gain from this Inquiry and how that might be achieved.

70. First and foremost, as set out above, 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. Even for those who have gleaned some answers from previous investigations, the full picture remains incomplete. It is hoped that this Inquiry will fill such gaps through its own, wider evidence-gathering processes. Similarly, that, in bringing their own individual experiences forward to this Inquiry, our clients can assist the Chair in her role in understanding the true extent of any systemic failures and of the preventative action required.

71. We fully support the indication given by the Chair in her opening statement that she 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, "*Public Inquiries: Enhancing public trust"* [10], reflects the vexed difficulties public inquiries face in ensuring that their recommendations, despite being accepted by the government, are actually implemented. The 'inexcusable' torpor of public institutions, in the wake of such investigations, risks both undermining the central purpose of the inquiry, as well as the recurrence of further avoidable tragedies. Drawing from such cautionary learning, this Inquiry is invited to consider convening a further hearing following (and within 12 months from) the publication of the Chair's report in order to hear evidence as to the implementation of, and compliance with, such recommendations. We note the robust approach adopted by Sir Brian Langstaff in the

[10] House of Lords Statutory Inquiries Committee, Report of Session 2024-25, published 16 September 2024.

Infected Blood Inquiry and invite the Chair to keep the Inquiry open until and unless she is satisfied that the government and relevant NHS bodies have responded adequately or provided sufficient reasons as to why any recommendation will not be implemented[11]. 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.

72. The scope for making national recommendations, where appropriate, is also strongly encouraged[12]. The standard and adequacy of mental health inpatient care and treatment in Essex cannot be considered in silo. As the Chair recognises in her Provisional List of Issues, 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. The Chair's willingness to make such recommendations on a national level, where necessary, is supported.

73. In the context of potential national recommendations, we firmly endorse the (long-standing) 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 Deaths Reports and ensuring that recommended changes from inquiries are not forgotten or stalled. The identification of the same thematic concerns, again and again, within Coroner's and inquiry reports, is a stark indication as to the need for such an independent mechanism to ensure that lessons are learnt and preventable harm avoided. The nature of the Inquiry 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.

[11] Infected Blood Inquiry Final Report: Overview and Recommendations, 1 of 7, 20 May 2024, pp.280-284.
[12] Terms of Reference, §5, List of Issues, §106.

74. 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 Trust ("NELFT"), a CP to this Inquiry, will stand trial for corporate manslaughter over the death of a mental health inpatient at Goodmayes Hospital, East London, together with a former ward manager charged with gross negligence manslaughter[13]. As we know from the passage to this Inquiry, there have been several prosecutions brought by the CQC and the Health and Safety Executive ("HSE") in this area, however 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 his course is rarely taken in subsequent police investigations, and where it is, it is rare for a resultant charge to be brought by the CPS. 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.

75. We invite the Chair to consider how criminal proceedings can be more effectively deployed in this arena. 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 organisation.

76. We note the overtures from various corporate CPs, 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 many others in this Inquiry, of the Trusts' institutional defensiveness and lack of candour, such assurances cannot be taken at face value. Our clients' trust in these public bodies has been fundamentally undermined. These State CPs, in particular the Trusts, will need to make good their words through their actions in this Inquiry and in effecting the necessary change beyond.

[13] See *The Independent* news article here, 24 October 2024.

E: Conclusion

77. Our clients look forward to the opportunity to engage with the Inquiry, all CPs, and other interested parties, and to assist the Chair to conduct a full and robust investigation into matters falling within her Terms of Reference. As the Chair noted in her 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 that it will carry through the work done here to bring an end to the repeated cycle of institutional failure and avoidable tragedy.

MAYA SIKAND KC

TOM STOATE

LAURA PROFUMO

4 NOVEMBER 2024