IN THE LAMPARD INQUIRY
INVESTIGATION MENTAL HEALTH DEATHS IN ESSEX

OPENING STATEMENT ON BEHALF OF THE FAMILIES REPRESENTED BY BINDMANS LLP

A: Introduction

1. This opening statement is made on behalf of the two Core Participants ("the CP families") represented by Bindmans LLP in the Lampard Inquiry: Tammy Smith, the mother of Sophie Alderman and the family of Edwige Nsilu.

2. The CP families each lost their loved one after entrusting their care to Essex mental health services – expecting that their vulnerable child or sibling would receive support, compassion and care, but most of all that they would be kept safe.

3. While every family's bereavement, and the memories that they treasure of their loved ones are unique, the failures experienced by the CP families in this Inquiry, share all too many commonalities.

4. Mental health services in Essex have been seriously criticised by numerous Coroners and Inquest juries, in criminal proceedings,[1] by the Care Quality Commission, by the Nursing and Midwifery Council and by the Parliamentary and Health Service Ombudsman.[2] The Lampard Inquiry itself is a re-launch of the work of the Essex Mental Health Independent Inquiry, which was established on a non-statutory basis in 2021– but which could not meet its terms of reference when only 11 out of 14,000 Essex mental health staff agreed to attend an evidence session.[3]

5. Time and time again, failures have been identified: failures in care management and planning; serious staffing and training issues; failures to ensure physical and sexual safety of vulnerable patients; failures in record keeping; failures in family engagement; and vitally, failures in responding to serious incidents and deaths, and in learning lessons to prevent future deaths.

6. At the heart of these failures, of course, are the deceased and the families that have been bereaved. Essex mental health services failed to keep vulnerable patients safe. Essex mental health services failed to deliver upon the great trust the CP families placed in them. Compounding their grief after the loss of their loved ones, Essex mental health services failed to treat the CP families with sensitivity and respect. They failed, far too often, to respond sensitively, transparently, and effectively, to post death investigations including Inquests. These failures are circular – Essex mental health services continue to fail in caring for the vulnerable, they fail in learning lessons from their failures, and therefore they fail in the same ways, all over again, repeatedly. The CP families grapple with the devastating realisation that, not only were the deaths of their loved ones avoidable,

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[1] R (Health and Safety Executive) -v- Essex Partnership University NHS Foundation Trust, Sentencing Remarks Available at: https://www.judiciary.uk/wp-content/uploads/2022/07/R-v-Essex-Partnership-NHS-Trust-sentencing-remarks-16Jun21.pdf

[2] Ombudsman.org.uk. (2022). *Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust | Parliamentary and Health Service Ombudsman (PHSO).* [online] Available at: https://www.ombudsman.org.uk/missed-opportunities

[3] Fox, N. (2024). Essex mental health trust 'sorry' for 'failing' patients, families and carers. *BBC News.* [online] 11 Sep. Available at: https://www.bbc.co.uk/news/articles/c36ngew4z19o

but lessons do not appear to be learnt from their deaths. As a result, the failures that devastated the CP families are doomed to repetition, and to be inflicted on yet more families.

7. The CP 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.

B: The CP Families

Tammy Smith

8. Tammy Smith is the mother of Sophie Alderman. Sophie was the eldest of her three siblings, and was born on 26 June 1995. Sophie is remembered by her family for her wonderful sense of humour, positivity, and massive heart.

9. Sophie died, aged just 27, on 19 August 2022 while detained in the care of Essex Partnership University Foundation Trust ("EPUT") on Willow Ward at Rochford Community Hospital. Only weeks before Sophie's admission, an undercover documentary reporter for Channel 4 filmed shocking footage of poor care and abuse of other patients on the ward which was later broadcast on Hospital Undercover Are They Safe? Dispatches.[4] A short time later, in October 2022, the Care and Quality Commission ("CQC") inspected Willow Ward and identified risks including staff failures to follow policies and procedures for patient observations and engagement, issues with accessibility of ligature cutters, poor staffing levels, and failures to complete risk assessments.[5]

10. Mrs Smith was represented at the Inquest into Sophie's death, which took place in April 2024, and heard evidence regarding the month that Sophie spent on Willow Ward – the repeated restraints, staff shortages, and distress and continuing paranoia that sadly characterised her time there.

The family of Edwige Nsilu

11. Edwige Nsilu was born on 29 October 1999, the third of seven siblings to her parents – Joyce and Flavien Nsilu. She is remembered by her family as loving, warm and nurturing, with a strong affinity to her Congolese background and African culture.

12. Edwige died, aged only 20, on 5 February 2020 while detained in the care of St Andrews Healthcare Essex. In the week after her death, an inspection of the ward on which she was detained – Colne Ward – by the Care and Quality Commission identified numerous risks including staff shortages, and failures to assess, manage and record patient risks adequately.[6]

13. Edwige's family were represented at the inquest into her death, which took place in June 2023. They heard evidence about staff failures to enter episodes of self-harm in Edwige's records, failures to update her care plan, and delays in the emergency response when Edwige was found unconscious. The senior nurse who found Edwige, and the nurse who joined, both believed she was "*feigning unconsciousness*" and left her on the floor. The senior nurse gave evidence that he believed it had been a means of luring staff before attacking them. There was no evidence that Edwige had ever feigned unconsciousness in order to attack staff. On the contrary, the evidence

[4] www.channel4.com, *Hospital Undercover Are They Safe? Dispatches | All 4*. [online] Available at: https://www.channel4.com/programmes/hospital-undercover-are-they-safe-dispatches
[5] CQC (2023). *Essex Partnership University NHS Foundation Trust: Inspection Report* | Available at: https://api.cqc.org.uk/public/v1/reports/15b9708f-b8af-43a0-8033-49affd35724d?20230712070332
[6] CQC (2020). *St Andrew's Healthcare Essex: Quality Report* | Available at: https://api.cqc.org.uk/public/v1/reports/f976029b-9ddd-46f2-a282-250ab0188e36?20210113035645

heard at the Inquest gives rise to concerns on the part of Edwige's family that structural and institutional racism impacted her care, and her death.

14. The Inquest ultimately concluded that Edwige's death was contributed to by neglect.

C: Relevant issues and concerns

15. The CP families have provided their accounts to this Inquiry, and they speak in their own words to their memories of their loved ones, the circumstances of their deaths, their own experiences of engagement by the Essex mental health services following those deaths, the lasting impact upon them, and their hopes for this Inquiry.

16. However, at this preliminary stage, we take this opportunity to highlight a number of key concerns which the CP families wish to draw to the early attention of the Inquiry:

Care, risk and safety management

17. The CP families welcome the inclusion in the Chair's Provisional List of Issues of issues related to care, risk and safety management. These questions go to the egregious failures that ground this Inquiry. Guidance produced by the Department of Health makes clear that:

> *"As a basic principle, all mental health professionals recognise that reducing the risk of self-harm, suicide, and self-neglect is part of the practitioner's fundamental duty to try and improve a service user's quality of life and recovery"*[7]

18. There are stark statistics at play here – the deaths of over 2,000 people in Essex mental health services in a 20-year window, equates to approximately 100 lives cut short every year between 2000 and 2020. 100 deaths per year is 8 deaths per month, or approximately 2 deaths every single week – an unthinkable statistic and yet the true picture is likely to be worse. CP families have been warned to expect that the Inquiry will uncover "significantly in excess" of 2,000 deaths. The possibility remains that the Inquiry may never be able to say for certain how many people died within the remit of this Inquiry. These stark figures alone provide significant support for the CP families' central concern that Essex mental health services is not fit for purpose and demonstrates institutional incompetence in caring for vulnerable individuals, managing their risks, and keeping them safe.

19. This belief is further reflected in the individual circumstances of the CP families who are fundamentally concerned that:

    A. Vital information in respect of their loved ones' care and risk was not adequately recorded, or not recorded at all;
    B. Changes in their loved ones' risk did not lead to appropriate reviews or adjustments to their care or supervision;
    C. Mental health services failed to safeguard the physical and sexual safety of their loved ones.

Record keeping

20. Paucity of record keeping is a common thread in respect of Essex mental health services. In February 2020, following their inspection of care quality at St Andrews Healthcare, the CQC noted

[7] Department of Health (2009). Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. [online] Available at: https://assets.publishing.service.gov.uk/media/5a8020a840f0b62302691adf/best-practice-managing-risk-cover-webtagged.pdf p.18

that staff *"were not completing intermittent observation records in line with the provider's policy and procedures"*, *"did not record the levels of observation accurately"*, *"had not completed"* sections on forms, *"did not record all risks"*, and *"did not always report incidents appropriately"*.[8] Likewise, following various inspections of EPUT wards in 2022 and 2023, the CQC found *"gaps in record keeping"* in respect of *"risk assessments, care plans, consent to treatment forms and administration of medicines"*.[9]

21. This is a thread which runs through both Sophie and Edwige's experiences.

22. In Sophie's case, this included a failure to update her care plan and risk assessments with information she disclosed in respect of flash points in her symptoms, or irritability and altercations with other patients. EPUT were also unable to produce any records of having trained Willow Ward staff in the use of the Oxevision system (discussed further below at §65).

23. In Edwige's case, her care plan was not updated at all in the month preceding her death, though numerous serious and dangerous incidents including self-harm attempts took place. There was no record made in her medical records to reflect apparent staff assessments in respect of her observation levels.

24. However, concerns about record keeping extend beyond the absence of vital information, to the equally concerning inclusion of inaccurate or outrightly false information. On the day Edwige died (3 February 2020), a senior ward nurse retrospectively made an entry into her observation record indicating that Edwige had been seen at 15.45 hours – at which time she would have been unconscious on the floor. The Nsilu family believe the nurse knowingly falsified the records. This stark example of possible manipulation of patient records, raises real concerns about the accuracy of other records and the reliability of the data that Essex mental health services produces.

25. NHS England guidance is clear that:

> *"High-quality patient records are the foundation of good clinical care delivery. Delivery safe and efficient patient care depends on having high quality patient records and, therefore, the right information available when clinical decisions are made.*
> *[…]*
> *Missing, inaccurate, or non-standard information can, however, lead to inconsistent care, or risk the quality, and safety, of care delivered."*[10]

26. Where records are incomplete, or inaccurate, the cornerstone has already been laid for the failures in care, risk and safety management which place vulnerable individuals like Sophie and Edwige at serious, and tragically ultimately fatal risk.

Risk response and management

27. The Department of Health has issued guidance on best practice in risk management in mental health services, which states:

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[8] CQC (2020). *St Andrew's Healthcare Essex: Quality Report* | Available at: https://api.cqc.org.uk/public/v1/reports/f976029b-9ddd-46f2-a282-250ab0188e36?20210113035645 p.1
[9] CQC (2023). *Essex Partnership University NHS Foundation Trust: Inspection Report* | Available at: https://api.cqc.org.uk/public/v1/reports/15b9708f-b8af-43a0-8033-49affd35724d?20230712070332 p.134
[10] NHS England (2022). NHS England» High quality patient records. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/long-read/high-quality-patient-records/

"Risk management is a core component of mental health care and the Care Programme Approach. Effective care includes an awareness of a person's overall needs as well as an awareness of the degree of risk they may present to themselves or others"[11]

28. Failures in Essex mental health services' risk management go beyond a failure to record changes in risk. They include serious failures to respond adequately or appropriately to changes in risk indicators.

29. The failure to ensure adequate monitoring or management of patient risks by staff was raised by the CQC in its most recent report on EPUT's services, published on 12 July 2023 following inspections conducted between November 2022 and January 2023. The report noted that EPUT staff *"did not always know about risks to each patient"* and did not always act *"to prevent or reduce risk"* – with Willow Ward, the ward on which Sophie was detained, identified by name in this context.[12] Similarly, the CQC's inspection report for St Andrew's Healthcare Essex identified that *"Patients were at risk of avoidable harm"* and *"Staff did not always assess and manage patient risks"*, noting that *"staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk of harm to themselves or others"*.[13]

30. Once again, these are issues which are reflected in the CP families' experiences. In particular, the CP families are concerned with questions identified by the Chair in her Provisional List of Issues relating to how decisions as to risk, and vitally, observation levels were made.

31. The Nsilu family are devastated that Edwige's observations were not reviewed or increased, and no other risk management measures were implemented in light of multiple episodes of self-harm preceding her death. Given the absence of record keeping in this regard, the Nsilu family urge the Chair to explore this matter in oral evidence.

32. The Nsilu family also ask that the Chair explore the issue of risk management in relation to patient leave. While Edwige was able to contact her family while under the care of St Andrew's, the family are concerned about the lack of meaningful information which they were provided in respect of Edwige's mental health condition, vulnerabilities, or care, which might have assisted them in considering and mitigating any risks to Edwige while on leave, as well as about how risks to Edwige which might arise following her return from leave were managed by the ward.

33. In Sophie's case, her final admission to hospital was preceded by a brief failed discharge back into the community, which Mrs Smith is concerned was significantly flawed, having taken place without proper planning, and without aftercare in place. Mrs Smith is keen for the Inquiry to explore the nexus between, what appears to have been an overreliance on medication to stabilise Sophie within the hospital setting, and the failure to plan for how compliance with medication and risk would be managed when Sophie was released from the community setting.

34. Mrs Smith is also concerned about the decisions to reduce Sophie's levels of observations on Willow Ward in view of her continued unsettled and delusional presentation, and is especially concerned about the lack of clear clinical rationale or structured risk assessment in those decisions.

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[11] Department of Health (2009). Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. [online] Available at: https://assets.publishing.service.gov.uk/media/5a8020a840f0b62302691adf/best-practice-managing-risk-cover-webtagged.pdf p.8

[12] CQC (2023). *Essex Partnership University NHS Foundation Trust: Inspection Report* | Available at: https://api.cqc.org.uk/public/v1/reports/15b9708f-b8af-43a0-8033-49affd35724d?20230712070332 p.93

[13] CQC (2020). *St Andrew's Healthcare Essex: Quality Report* | Available at: https://api.cqc.org.uk/public/v1/reports/f976029b-9ddd-46f2-a282-250ab0188e36?20210113035645 p.1

Mrs Smith is concerned that Sophie's Responsible Clinician appears to have relied upon what he described as a lack of incidents, and apparent compliance with medication, in justifying the decision to reduce observation levels for Sophie. There would appear to be an inconsistency between this description and Sophie's actual presentation which included continued paranoid ideation, reports of auditory ideation, and refusal of medication.

35. Mrs Smith's concerns extend to and crystallise further around the day of Sophie's death. On that day, there were clear indicators of increased risk – including an altercation with another patient, expressed frustration at a refusal of leave, a request for 1:1 support which was not facilitated, and an episode of headbanging. These were met with a woefully inadequate response. The headbanging episode for example, which shortly preceded Sophie's ultimately fatal ligature, was responded to by staff who attended for less than two minutes in total, only to leave without formally assessing Sophie, the risk she presented to herself or putting in place additional protective measures.

Physical and sexual safety

36. The CQC, in a report on sexual safety on mental health wards, state:

> *"People whose mental ill health is so severe that they require care on a mental health ward are often at the most vulnerable point in their lives. Many will not have consented to being treated in hospital and will have been admitted against their will. Given this, mental health services have a heightened responsibility to protect people using inpatient care from harm."*[14]

37. Consider in this context, that the CQC's *"biggest concern"* in its report on the state of care in mental health services 2014 to 2017 was patient safety,[15] and in their 2023 to 2024 report, they observed *"The safety of mental health wards continues to cause concern"*.[16] Research published by the mental health charity, Mind, noted in 2004 that 18% of respondents had experienced sexual harassment, and 5% had experienced sexual assault while inpatients.[17] It is understood that between January and August 2023 almost 4,000 sexual safety incidents were reported by mental health inpatient settings.[18]

38. This national concern is reflected in Essex mental health services. Shortly after Edwige's death, both patients and staff at St Andrew's Healthcare reported to the CQC that they *"didn't feel safe"*.[19] Managers were noted not to have *"sufficient oversight of key elements that related to patient safety"*, and the CQC had not been notified of various safeguarding incidents including physical abuse between patients.[20] EPUT, meanwhile, was rated as requiring improvement in respect of service safety in 2023, with the CQC requiring the trust to *"assess risks to the health of safety of patients receiving care and treatment, including patient's sexual safety"*.[21] In response to a freedom of information request in January of this year, EPUT disclosed that there were 171 reported sexual safety incidents in 2021, 176 in 2022 and 221 in 2023.[22] The real figure, we suggest, is likely to be significantly greater.

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[14] CQC (2018) *Sexual safety on mental health wards* | Available at: https://www.cqc.org.uk/sites/default/files/20180911c_sexualsafetymh_report.pdf
[15] CQC (2017) *The state of care in mental health services 2014 to 2017* | Available at: https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf p.29
[16] CQC (2024) *The state of health care and adult social care in England 2023/24* p. 9
[17] Mind (2004) *Ward watch: Mind's campaign to improve hospital conditions for mental health patients: report summary* p.3
[18] Rape Crisis England & Wales (2024) *Alarming scale of sexual violence and abuse on mental health wards.* | Available at: https://rapecrisis.org.uk/news/alarming-scale-of-sexual-violence-and-abuse-on-mental-health-wards/
[19] CQC (2020). *St Andrew's Healthcare Essex: Quality Report* | Available at: https://api.cqc.org.uk/public/v1/reports/f976029b-9ddd-46f2-a282-250ab0188e36?20210113035645 p.1
[20] Ibid p.2
[21] CQC (2023). *Essex Partnership University NHS Foundation Trust: Inspection Report* | Available at: https://api.cqc.org.uk/public/v1/reports/15b9708f-b8af-43a0-8033-49affd35724d?20230712070332 p.1-8
[22] EPUT (2024) *Reply to FOI Request* | Available at: https://eput.nhs.uk/media/p4hcdai2/eput-foi-24-3348.pdf

39. The Nsilu family were highly distressed to learn, only after Edwige's death, that a staff member at Edwige's placement before St Andrews was under criminal investigation for the offence, under *s.38 of the Sexual Offences Act 2003* of 'Care Worker engaging in sexual activity with a 'person with a mental disorder' It was only in July 2022, over two years after Edwige died, that Essex Safeguarding Adults Board ('ESAB') concluded a Safeguarding Adult Review which outlined evidence that Edwige had been sexually assaulted and raped in 2018 by a member of staff at Oaktree Manor in Clacton-On-Sea, run by Partnerships in Care Ltd. She was 18 years old at the time. The family are deeply troubled not only by the egregious failure to safeguard Edwige from sexual assault and rape at Oaktree Manor (which is also in Essex), but also with the conduct of the subsequent investigation which, it is submitted, should be interrogated by this Inquiry as part of consideration of Section E in the Provisional List of Issues, regarding safety.

40. Moreover, concerns in respect of ensuring physical and sexual safety on wards extend to ensuring wards are sensitive and responsive to the particular needs of survivors of abuse. Various studies have identified a range of potentially long-term mental health problems in survivors following incidences of sexual violence, and survivors of childhood sexual and / or physical abuse have been reported to account for between 50-60% of all mental health inpatients.[23]

41. In Sophie's case, Mrs Smith has overarching concerns about the reliance on restraint of any in-patient, but particularly of young women who have survived sexual violence. Sophie was subjected to a number of restraints in the lead up to her death, particularly to administer very strong antipsychotic medication that she did not consent to taking. NHS England Digital published data in their Mental Health Bulletin 2020-21 Annual Report that, between October 2020 to March 2021, women were restrained significantly more often (53.55%) than men.[24] Mrs Smith is also concerned that, throughout Sophie's treatment under mental health services, there was an increasing reliance on medication rather than therapeutic support, and that this was being administered by force and without Sophie's consent.

42. The CP families look to the Chair to explore issues of physical and sexual safety on wards, and in particular, the sexual safety of women on in-patient wards, and including whether any failings amount to systemic discrimination against female in-patients.

Staffing and training

43. In its opening statement to this Inquiry, EPUT sought to highlight the significant stress which has affected the mental health workforce nationwide and its ongoing recruitment drive. The CQC reported this year that while recruitment of full-time members of staff in mental health services has grown over the last five years, *"we remain concerned about the impact of difficulties in recruiting staff to specific, skilled roles"*, and there remain concerns about staff shortages and the *"huge impact on the safety of people who use services and the quality of care they receive"*.[25]

44. Data from Freedom of Information requests indicate that 11,073 incidents referencing staff shortages on mental health wards were made in 2022 on the Datix systems of 39 Trusts across the country.[26] The Office for National Statistics revealed that between January 2021 and October 2022, inadequate staffing of health and public services was a contributing factor in the suicides of 17

[23] HM Government (2007) *Cross Government Action Plan on Sexual Violence and Abuse* | para 2.12 - 2.14
[24] NHS Digital. (2021) *Mental Health Bulletin 2020-21 Annual report* [online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2020-21-annual-report
[25] CQC (2023) *Mental health - Care Quality Commission*. [online] Available at: https://www.cqc.org.uk/publications/major-report/state-care/2023-2024/access/mh
[26] Bowie, K. (2023). *Revealed: Thousands of incidents related to staffing on mental health wards* | Nursing Times. Available at: https://www.nursingtimes.net/mental-health/revealed-thousands-of-incidents-related-to-staffing-on-mental-health-wards-07-08-2023/

people in England and Wales, and inadequate staff training was a factor in 38.[27] It is plain that there are fatal consequences of the failure of mental health service providers to ensure they have adequate staffing levels, and appropriately trained staff.

45. In this regard, the CP families take this opportunity to raise concerns in respect of 3 issues that they ask this Inquiry to explore:

    a. Staffing levels;
    b. Training of staff; and
    c. Recruitment and monitoring of bank and/or agency staff.

Staffing levels

46. Both Colne Ward, and Willow Ward had problems with staffing levels. On Colne Ward, the acute understaffing was universally acknowledged by the witnesses at the Inquest touching upon Edwige's death. The under staffing that was present in Edwige's case was presented by St Andrews Healthcare as the result of an unfortunate coincidence of staff vacancies in key roles on the ward, all of whom were subsequently replaced. However, this Inquiry should interrogate whether there were underlying structural reasons why temporary cover was not obtained for key staff members, given the apparent pressures at the time.

47. Willow Ward was identified by the CQC in its most recent inspection report as having the second highest use of temporary unqualified staff across the entire EPUT estate, at an average of 12 temporary staff per day.[28] Notwithstanding this, in Sophie's inquest, it was maintained that staffing levels on the day of her death had been appropriate. Mrs Smith is concerned that the maintenance of this position is untenable – the complement of two qualified members of staff on shift on 19 August 2022 was made good only by reliance on a bank nurse and upon the ward manager acting down in addition to completing her managerial role. Moreover, staff acknowledged in evidence that the high level of restraint on the ward reduced the amount of time which staff had to engage therapeutically with patients, with one HCA attributing her inability to engage with Sophie's request for 1:1 support on 19 August to the need to respond to another incident on the ward.

Training

48. Ensuring adequate staffing levels is foundational for ensuring a safe and therapeutic environment, but it is not sufficient. Staff on mental health wards should be appropriately trained for the roles they undertake. This has not been the case in the CP families' experience.

49. Between January 2021 and October 2022, 50 concerns were raised about staff training across 30 PFD reports in respect of deaths by suicides in England and Wales. Of particular concern were 11 incidents of Coroners raising concerns in respect of failures to implement improvements in information, guidance and training for staff.[29] Of 12 EPUT wards visited by the CQC in 2023, four

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[27] Office for National Statistics (2023) *Prevention of Future Death Reports for Suicide submitted to coroners in England and Wales: January 2021 to October 2022* | Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/preventionoffuturedeathreportsforsuicidesubmittedtocoronersinenglandandwales/january2021tooctober2022

[28] CQC (2023). *Essex Partnership University NHS Foundation Trust: Inspection Report* | Available at: https://api.cqc.org.uk/public/v1/reports/15b9708f-b8af-43a0-8033-49affd35724d?20230712070332 p.90

[29] Office for National Statistics (2023) *Prevention of Future Death Reports for Suicide submitted to coroners in England and Wales: January 2021 to October 2022* | Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/preventionoffuturedeathreportsforsuicidesubmittedtocoronersinenglandandwales/january2021tooctober2022

were not up to date with their mandatory training. Willow Ward particularly stood out in this regard.[30]

50. The CP families are acutely concerned about emergency response training of staff on both Willow Ward and Colne Ward. The emergency response in Sophie's case was described by an independent Emergency Medicine Expert "as confused and disorganised".[31] Having been discovered lifeless and not breathing at 17:35, it was over 60 seconds before the ligature was removed from Sophie's neck; compressions were not commenced for over another minute; the East of England Ambulance Service was called only 3 minutes and 40 seconds after Sophie was found; oxygen was not administered until 5 minutes after she was found; and defibrillator pads were not attached until 7 minutes after she was found – all of which was contrary even to very basic St John's ambulance training.

51. Perhaps the most shocking aspect of Edwige's case was the response of staff who found her with ligatures on 3 February 2022: as noted above, the senior nurse who found Edwige, and the nurse who joined, both believed she was "*feigning unconsciousness*" and left her on the floor. When the senior nurse returned, several minutes were wasted trying to record her oxygen levels on an oximeter and her blood pressure on a monitor, neither of which processes are required when finding an unresponsive patient.

52. Whilst there are questions in the Inquiry's Provisional List of Issues about training, it is submitted that these must specifically include training in emergency response, given the clear and obvious risks involved with such a vulnerable patient population, and the evident want of training highlighted by Sophie and Edwige's deaths.

Recruitment and monitoring of bank and agency staff

53. In a report published in March this year, the CQC raised concerns that:

> *"To fill vacancies, many [mental health sector] providers are turning to agency and bank staff. This increases the risk to people using services as it can be difficult for agency staff to build meaningful therapeutic relationships and provide personalised care to patients they are not familiar with"*[32]

54. A study of inpatient views in respect of staffing in 2015 found that these concerns are reflected by patients themselves:

> *"Bank or agency nurses were used to fill in for absent staff at times but patients did not feel they benefited from this arrangement. Bank nurses mainly appeared to serve an instrumental role rather than an interpersonal role. The patients perceived the bank nurses as not as interested in their work as regular staff and as unaware of usual ward routines and procedures. This was compounded by patients feeling uncomfortable about developing rapport with a person who only worked on the ward temporarily."*[33]

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[30] CQC (2023). *Essex Partnership University NHS Foundation Trust: Inspection Report* | Available at: https://api.cqc.org.uk/public/v1/reports/15b9708f-b8af-43a0-8033-49affd35724d?20230712070332 p.91

[31] Inquest touching upon the death of Sophie Alderman, Day 4 Evidence of Dr Jasmeet Soar, (8 April 2024)

[32] CQC (2024) *Workforce and staff wellbeing - Care Quality Commission.* | Available at: https://www.cqc.org.uk/publications/monitoring-mental-health-act/2022-2023/workforce

[33] Mistry, H., Levack, W.M.M. and Johnson, S. (2015). *Enabling people, not completing tasks: patient perspectives on relationships and staff morale in mental health wards in England* BMC Psychiatry, 15(1). doi:https://doi.org/10.1186/s12888-015-0690-8.

55. In respect of staffing on EPUT wards, the CQC identified that there was *"poor management of agency staff which increased risks to patients*".[34] At the inquest touching upon Sophie's death, the ward manager acknowledged that there may have sometimes been a link between the high level of restraints on the ward (which had the highest level of restraints across the EPUT estate according to the CQC),[35] and the high reliance on bank and agency staff, some of whom may not have been experienced enough in de-escalation tactics or in the patient's clinical profile, resulting in more ready recourse to restraint. This concern is one reflected by the CQC, who have *"emphasised that reliance on agency staff who do not have an ongoing therapeutic relationship with patients can increase the risk of services using excessive levels of restraint and seclusion"*.[36]

56. The ready recourse to agency staff, deployed across the EPUT estate, was one of the issues vividly exposed in the Channel 4 Dispatches investigation: *Hospital Undercover, Are They Safe?*. The Chair will readily recall that the undercover reporter in that investigative documentary was deployed to various wards across the EPUT estate, including Willow Ward, with little prior understanding of the needs of patients on those wards and no questions posed from full time ward staff as to her level of experience or her understanding of ward procedures. As has already been noted, the undercover reporter worked shifts on Willow Ward a matter of weeks before Sophie Alderman's admission and her subsequent death.

57. That documentary, which has been recognised on behalf of the Inquiry in CTI's opening note as *"a stark but important piece of reporting"* which *"covers issues of great relevance to this Inquiry",* is therefore of particular importance to Mrs Smith. It remains possible that unedited footage held by Channel 4 (which the Inquiry is invited to obtain) includes evidence of the conditions on Willow Ward – including staffing levels, professional conduct and the use of physical restraint – in the period shortly prior to Sophie's death.

58. The CP families therefore ask that the Chair includes within her consideration of issues relating to staffing, the exploration of the recruitment of bank and agency staff, including why there appears to be significant reliance on agency staff, the impact of that reliance on agency staff on the treatment of inpatients and what alternatives to the employment of agency staff might be available.

59. In relation to those agency staff, the Chair is asked to explore where they are recruited from, what criteria is applied to their recruitment, their levels of training including how their training was verified and subject to ongoing review and how their performance and compliance with relevant policies and procedures is monitored.

Independent providers

60. The CQC defines "independent healthcare services" as those provided by organisations which are not NHS trusts or NHS GP services.[37] This includes all private providers, from limited liability companies such as Partnerships in Care Ltd, to registered charities, such as St Andrew's Healthcare.

61. In 2022, reports emerged that the NHS was paying £2 billion a year to independent healthcare service providers for mental health patients due to bed shortages – representing around 13.5% of all NHS expenditure on mental health in Essex. Nine out of every 10 of the mental health beds

[34] CQC (2023). *Essex Partnership University NHS Foundation Trust: Inspection Report* | Available at: https://api.cqc.org.uk/public/v1/reports/15b9708f-b8af-43a0-8033-49affd35724d?20230712070332 p.90
[35] Ibid p95
[36] CQC (2022). *Staff Shortages and the Impact on Patients - Care Quality Commission* | Available at: https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022/staff-shortages
[37] CQC (2022) *Independent healthcare services* | Available at: https://www.cqc.org.uk/guidance-providers/independent-healthcare/independent-healthcare-service

run by private operators were occupied by NHS patients, within independent mental health care providers making 91% of their income from the NHS.[38]

62. In light of the immense costs to the taxpayer associated with these placements, questions naturally arise as to the quality, and vitally, the safety of the services provided. The most recent CQC inspection report for St Andrew's Healthcare rated it as requiring improvement overall, including in respect of safety and leadership.[39] Of the 8 independent mental health services run by St Andrews, the CQC has currently rated 7 as requiring improvement. [40]

63. Although it is not explicitly confirmed in any of the documents available to her family, it is believed that Edwige's placements were funded by NHS England. Edwige's experience of placements with St Andrews Healthcare and Partnerships in Care are examples of how NHS-funded care operates in independently-run hospitals in Essex. It is unclear at this stage whether the Nsilu family are the only bereaved Core Participants whose relative died in St Andrew's Healthcare or even a privately or independently-run hospital. Whether they are alone before this Inquiry in their experience of St Andrew's Healthcare or whether other bereaved families had similar experiences, what happened to Edwige will have a direct bearing on this issue.

64. The Inquiry is urged to explore processes for selection and oversight of placements with independent mental health providers in Essex.

Oxevision

65. Question 15 of the Inquiry's Provisional List of Issues (July 2024) states: "*What, if any, impact did the ward environment (including, but not limited to, ward layout and / or the use of technologies on a ward) have on inpatients?*"; and question 49 asks "*More broadly, what other technologies were utilised during the relevant period? Did these improve the provision of mental health inpatient care and treatment?*" It is submitted that these questions must involve examination of the use of Oxehealth's Oxevision system in Essex.

66. Oxevision, manufactured by Oxehealth, is a vision-based patient monitoring system (sometimes referred to as 'VBMS') which uses infrared-sensitive cameras in inpatient bedrooms on mental health wards. The system is in use across the EPUT inpatient estate, and is also used by other Trusts nationally.

67. The unit, which is installed in bedrooms, is able to detect the presence of a person or persons within a room, and their location in the room, and feeds this information in real time to screens and tablets in use by staff on the ward. The display for these devices shows a tile for each room on the ward where Oxevision is installed. These tiles are colour coded to indicate various states, and include text indicating where the system detects someone (e.g. in bed, in room, in bathroom), and a timer to indicate how long they have spent in that space. The colour coding includes various shades of green which indicate a person is in their room or in bed, amber which indicates a warning state – for example if someone is in their bathroom which is out of the camera's range – and red, which indicates an alert state.

68. By selecting a room tile, ward staff are presented with an option to take a patient's vital signs (breathing and heart rate). Selecting this option allows staff to view a 15-second live clip of video

[38] Campbell, D. and Bawden, A. (2022) *NHS Paying £2bn a Year to Private Hospitals for Mental Health Patients* [online] The Guardian. Available at: https://www.theguardian.com/society/2022/apr/24/nhs-paying-2bn-pounds-a-year-to-private-hospitals-for-mental-health-patient

[39] CQC (2020) *St Andrew's Healthcare: Quality Report* | Available at: https://api.cqc.org.uk/public/v1/reports/5ff1244d-f23b-420c-bbd7-ceb2c2acc5ee?20210114200411

[40] CQC *St Andrew's Healthcare - Services* | Available at: https://www.cqc.org.uk/provider/1-102643363/services?page=1

footage from the room in question, following which staff are prompted to indicate whether the conditions are met for a vital signs observation (such as the person being sufficiently visible, and enough skin being visible to the camera) to be taken, or staff can abort the process at that stage.

69. Oxevision can also be customised by Trusts to provide various "alerts". These alerts are raised to bring to staff's attention potentially risky situations. EPUT has their system configured to raise an alert if a patient has been in a bathroom for more than 3 minutes. When an alert is raised for a room, the tile on the displays turns red, and there is a pop up in an alert box at the side of the screen. An audible message plays repeating "Oxehealth alert" until the alert is reset. EPUT policy dictates that an alert must not be reset until a physical check of patient safety has been conducted.

70. The CP families wish to take this opportunity to draw the Chair's attention to a number of gravely held concerns in respect of the operation of the Oxevision system, including:

    a. Concerns regarding data protection and patient consent;
    b. Concerns regarding the impact of sustained surveillance upon vulnerable patients; and
    c. Concerns regarding the safety and efficacy of Oxevision.

71. The concerns outlined above and detailed further below, are of even greater importance to this Inquiry in light of the significant reliance on its use of Oxevision to support its remedial programme in respect of patient safety, as reinforced EPUT's opening statement to this Inquiry on 11 September 2024.

Data protection and consent

72. Studies in respect of CCTV on mental health wards have shown that contrary to the code of practice in respect of surveillance cameras issued by the Information Commissioner's Office, patients are often not told about CCTV cameras on wards, and that patients and staff when questioned, did not believe they were able to do anything about cameras, including complaining about them, despite feeling uncomfortable with cameras on the ward.[41]

73. These concerns about ordinary CCTV must extend, with even greater force, to Oxevision. The 2023 CQC Report on EPUT, which refers to Oxevision as *"contact-free patient monitoring"*, 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-free patient monitoring and management system"*.[42]

74. On 7 September 2023, NHS England sent a letter to all mental health trusts on the use of Vision Based Monitoring Systems in mental health inpatient settings. That correspondence raised concerns about the blanket utilisation of VBMS in inpatient mental health settings and the issue of informed consent. The letter stated:

> *"**It is our view that any VBMS which operates as a form of surveillance should never be implemented in blanket way and that any decisions to use VBMS in patient bedrooms should be made in a person-centered way, with the patient themselves where they have the capacity to make a decision or through a Best Interest process compliant with the Mental Capacity Act 2005 where they lack capacity to consent to the monitoring system**. The use of such systems should be carefully considered on a case by case, patient by patient basis to ensure that any decision to use such systems has a legitimate aim and is both*

[41] Desai, S. (2022*) Surveillance practices and mental health: the impact of CCTV inside mental health wards* Milton Park, Abingdon, Oxon: Routledge
[42] CQC (2023). *Essex Partnership University NHS Foundation Trust: Inspection Report* | Available at: https://api.cqc.org.uk/public/v1/reports/15b9708f-b8af-43a0-8033-49affd35724d?20230712070332 p.114

lawful and fair. Their use must also be proportionate to the aim. We are, therefore, asking all services to please review, clinically and ethically, current VBMS practice without your organisation to ensure your use of these technologies aligns with principles of least restrictive, compassionate, therapeutic and personalised care" [43] (emphasis added)

75. It is 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 British Institute for Human Rights.

76. The CP families note that as of May 2024, EPUT's policy in respect of the use of Oxevision states:

> *"[A]ll patients are opted in upon admission as part of the standard ward practice. The patient is encouraged to raise questions and concerns and there are regular opportunities for the patient to engage with staff. Objections can be raised at any time during the admission episode.*
>
> *However if a patient refuses the use of the Oxevision system in their room, the responsible clinician must be informed. The system is not to be switched off until an MDT meeting within 72 hours has taken place, here the team will decide whether to withdraw the use of the assistive technology if it is in the best interest of the patient, taking into account the balance with individual preference, safety management, mental capacity and other alternatives, just as they would for other treatment approaches. This approach needs to be open and with honest communication including the frequent reiteration of the existence and purpose of the system so staff can be sure that patients informed implicit consent remains in place"*

77. The Inquiry is invited to explore how that policy is being implemented in practice across the EPUT estate including whether, in fact, Oxevision is being employed on a routinely blanket basis on EPUT wards. The CP families are concerned that the policy does not ensure the informed consent of patients, comes with a heavily caveated opt-out option and does not guarantee that the system will actually cease being used, particularly in circumstances where the constant surveillance contributes to paranoia or distrust on the part of patients.

Impact of surveillance

78. Sophie, who had hated having her photograph taken from a young age, felt a deep discomfort around cameras. They triggered acute paranoia for her. She consistently believed and expressed that she was under surveillance by the Government. During Sophie's early admissions into mental health units, Mrs Smith has explained that she would want to know the exact placements of cameras on wards. Mrs Smith is deeply concerned that the continual presence of an Oxevision camera in Sophie's room would have caused her real and significant distress. Mrs Smith was very upset to learn from Sophie's records in the months before she died that she was complaining about a camera in her room which (she believed) the Government had hacked into and were watching her.

79. The potentially exacerbating impact of VBMS on vulnerable individuals receiving mental health treatment – particularly in circumstances where they are, or may feel, unable to opt out of such systems – is an area which the CP families urge this Inquiry to full explore. While academic literature in this regard is limited at present, there are indications that the use of surveillance-based technologies has a serious and adverse impact.

80. In a review entitled "*The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: A systematic review*", conducted by the National Institute for Health and Care Research (NIHR) Policy Research Unit in Mental Health (MHPRU) based at King's College London and

[43] Strudwick, P. (2023). *NHS chiefs investigate controversial video monitoring in mental health wards*. [online] inews.co.uk. Available at: https://inews.co.uk/news/nhs-chiefs-mental-health-services-not-use-video-monitoring-sytem-2646672

University College London, which reviewed 27 studies on the use of surveillance technologies in inpatient mental health settings (including 6 studies on 'Vision-Based Patient Monitoring and Management' (VBPMM), all of which were on the use of Oxevision in inpatient settings in the UK) found: "*There is currently insufficient evidence to suggest that surveillance technologies in inpatient mental health settings are achieving the outcomes they are employed to achieve, such as improving safety and reducing costs*".[44]

81. Amongst the study's key findings on staff, patient and carer perceptions and experiences, the review found that:

> "*Concerns were … expressed by staff and patients that surveillance technology use could have wide-ranging negative effects, including* ***negatively impacting patients' recovery, privacy and dignity, decreasing feelings of safety, exacerbating distress and paranoia, reducing quality of care, damaging therapeutic relationships with staff and exacerbating power imbalances between patients and staff****. Indeed, patient and service user groups, along with advocates and disability activists, have consistently voiced concerns about the potential iatrogenic harms associated with the use of surveillance technology in inpatient mental health settings...*" (emphasis added)

82. The review noted that: *"…our understanding of the impact of surveillance technologies in inpatient mental health settings, including their full range of potential harms and risks, remains incomplete*".[45]

83. A study of patient and staff perspectives on using Oxehealth noted a range of concerns including that:

    a. "*Some patients were not happy with "being watched" all the time, describing it as "big brother syndrome" ... This invoked paranoia and anxiety from the patients, particularly when they first came into the hospital. Staff also agreed*";[46]

    b. "*All participants described patients having a lack of privacy and dignity since Oxehealth technology was installed. Most patients were more bothered by the camera than Oxehealth itself (*checking they are breathing), and felt it was an invasion of privacy and violation of dignity";[47] and

    c. "*Most patients knew that Oxehealth monitored patient's vital signs, but they all described inaccuracies about how Oxehealth works and misunderstandings about the reason for the camera and how it is used*"[48]

84. In *Surveillance Practices and Mental Health: The Impact of CCTV Inside Mental Health Wards* (2022) the academic Suki Desai, who conducted research in several mental health wards in the UK regarding patient and staff experiences of CCTV, found that:

    a. The presence of the cameras inside the ward perpetuates the belief that PICU patients are violent and aggressive;

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[44] Griffiths, J.L., Katherine, Foye, U., Greenburgh, A., Regan, C., Cooper, R.E., Powell, R., Thomas, E., Brennan, G., Rojas-Garcia, A., Brynmor Lloyd-Evans, Johnson, S. and Simpson, A. (2024). *The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: A systematic review*. medRxiv (Cold Spring Harbor Laboratory). doi:https://doi.org/10.1101/2024.04.04.24305329 At [2]

[45] Ibid [78-79]

[46] Dewa, L.H., Broyd, J., Hira, R., Dudley, A., Hafferty, J.D., Bates, R.H. and Aylin, P. (2023). A service evaluation of passive remote monitoring technology for patients in a high-secure forensic psychiatric hospital: a qualitative study. *BMC Psychiatry*, 23(1). doi:https://doi.org/10.1186/s12888-023-05437-w at [7]

[47] ibid

[48] Ibid at [8]

b. Camera placement inside patient bedrooms raises a safeguarding concern, especially for women patients;

c. Camera placement in communal areas of the ward and inside their bedrooms restricted spaces where patients could go to get away from being under observation, which could affect patients' mental health and cause them to feel stressed; and

d. The presence of real cameras led some patients to believe that the ward also had hidden cameras, which also created stress and was not conducive to a therapeutic ward environment. [49]

85. Accounts collected by the Stop Oxevision campaign, have also identified adverse patient experiences with the system which would appear to parallel those experienced by Sophie:

> *"We've heard harrowing stories from people up and down the country who've described Oxevision as intrusive, dehumanising, retraumatising and having increased their distress. We have spoken to people who spent entire admissions sleeping on the bathroom floor, in communal areas, even in the garden, to avoid the camera, despite begging staff to turn this off"*[50]

Efficacy of Oxevision

86. Surveillance, including the use of the Oxevision system, is a restrictive practice. It carries associated infringements of individuals' rights to privacy, and, as demonstrated above, potential adverse consequences. The justification for the imposition of the restriction, and the efficacy of the system in achieving its stated aims, must therefore be closely scrutinised.

87. A joint report produced by the Restraint Reduction Network and the British Institute of 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"*[51]

88. The question therefore arises: what is the purpose of Oxevision's installation on wards? Promotional material published by Oxehealth describe the system as *"a tool that helps staff care for patients more safely"*.[52] While tools to complement the work of staff in caring for patients and keeping them safe are to be cautiously welcomed, the CP families query the extent to which Oxevision is achieving that stated purpose. Indeed, they have reason to be concerned that the installation of Oxevision had a detrimental impact on the well-being of their loved one.

89. In the first instance, the CP families are concerned that there is a risk that the role of staff in observing and thereby ensuring a patient is safe is delegated to Oxevision. Put bluntly, if Oxevision can keep a digital eye on inpatients, monitor their vital signs and sound an alarm if vital signs cannot

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[49] Desai, S. (2022*) Surveillance practices and mental health: the impact of CCTV inside mental health wards* Milton Park, Abingdon, Oxon: Routledge

[50] Stop Oxevision. (2024). *Actions are stronger than words: We raised our concerns – now it's time for decision makers to take action.* [online] Available at: https://stopoxevision.wordpress.com/2024/02/27/actions-are-stronger-than-words-we-raised-our-concerns-now-its-time-for-decision-makers-to-take-action/

[51] Restraint Reduction Network and the British Institute of Human Rights (2020) *Surveillance: A restrictive practice and human rights issue* | Available at: https://www.bihr.org.uk/media/rgdpn0ip/guide-surveillance-a-restrictive-practice-and-human-rights-issue.pdf p.9

[52] *Oxevision* [online] Available at: https://www.oxehealth.com/oxevision

be verified, what is the need for staff to carry out their own observations? The Inquiry is invited to explore the extent to which Oxevision might be used as a substitute for human observation, rather than a tool to complement the work of mental health staff.

90. For Oxevision's protective alerts to be effective, they must be responded to appropriately. In Sophie's inquest, EPUT was unable to provide evidence of staff having been trained in the use of the system. No staff member 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. It is trite to state that if staff were not appropriately trained, and were not even aware of where the tablet was, they would be unlikely to respond to emergency alerts as necessary.

91. The likelihood of effective response to emergency alerts is further compromised by the impact of potential alarm fatigue. Alarm fatigue occurs *"when clinicians experience high exposure to medical device alarms, causing alarm desensitization and leading to missed alarms or delayed response. As the frequency of alarms used in healthcare rises, alarm fatigue has been increasingly recognized as an important patient safety issue"*.[53] The potential adverse impact of alarm fatigue is acute:

> *"Research has demonstrated that 72% to 99% of clinical alarms are false. The high number of false alarms has led to alarm fatigue. Alarm fatigue is sensory overload when clinicians are exposed to an excessive number of alarms, which can result in desensitization to alarms and missed alarms. Patient deaths have been attributed to alarm fatigue"*[54]

92. With Oxevision alerts on EPUT wards sounding every time that a patient is in the bathroom for more than 3 minutes and, it is understood, repeating every 3 minutes after being reset until the patient leaves the bathroom, and with the myriad other alarms which sound on mental health wards including pinpoint alarms, the risk of alarm fatigue developing would appear to be high, as is the risk of alerts going unanswered as a result.

93. Both Oxehealth promotional materials, and EPUT's own policy and procedures state that Oxevision is an adjunct to patient care, and should not be used as a substitute for physical observations. It is notable, however that Oxehealth advertise the benefits of Oxevision as including savings in terms of reduced staff spending.[55]

94. The Stop Oxevision Campaign has raised concerns that:

> *"it is not possible to use this technology safely in the context of wards as they are – high acuity, overstretched staff and often high staff turnover, and agency staff use.* ***There have been recent, tragic deaths of patients, where in each case staff had not followed procedures to view the CCTV or respond to the Oxevision alerts properly***"[56] (emphasis added)

95. Tragically, in Sophie's case, the VBMS that caused her such anxiety in life, failed to offer her any meaningful protection from death. The purported basic purpose of the Oxevision system – providing an alarm which could be rapidly answered as needed – was not even fulfilled. While an alarm sounded to alert staff that Sophie was in a risk area at 17:29, this was not responded to until

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[53] Woo, M. and Bacon, O. (2020). *Alarm Fatigue*. [online] *www.ncbi.nlm.nih.gov*. Agency for Healthcare Research and Quality (US). Available at: https://www.ncbi.nlm.nih.gov/books/NBK555522/

[54] Sendelbach, S. and Funk, M. (2013). Alarm Fatigue. *AACN Advanced Critical Care*, [online] 24(4), pp.378–386. doi:https://doi.org/10.1097/nci.0b013e3182a903f9

[55] *Oxevision Evidence* [online] Available at: https://www.oxehealth.com/evidence

[56] Stop Oxevision. (2024). *Actions are stronger than words: We raised our concerns – now it's time for decision makers to take action.* [online] Available at: https://stopoxevision.wordpress.com/2024/02/27/actions-are-stronger-than-words-we-raised-our-concerns-now-its-time-for-decision-makers-to-take-action/

17:35. By that time Sophie was found lifeless and unresponsive. Mrs Smith finds it difficult to comprehend how such an intrusive system, which might have worsened Sophie's paranoia and mistrust, can be justified in circumstances where its efficacy is in serious doubt.

96. It is submitted that this Inquiry can now make a vital contribution to the understanding of the risks of technology such as Oxevision in mental healthcare.

Family engagement and post-death investigations

97. The engagement of families and carers, both in patient care, and in post-death investigations, is emphasised in guidance issued by NHS England.[57]

98. During Edwige's time as an inpatient, the Nsilu family, as detailed above, had a very limited understanding of Edwige's situation or vulnerabilities, and although contact with Edwige was facilitated by St Andrew's Healthcare, interpreters (who were required in order to enable effective communication between the hospital and the family) were not always provided. This led to gaps in the families' understanding of Edwige's treatment and progress.

99. A lack of family engagement, and of sensitivity to the needs of the family, is a thread which continues to run through post-death investigations for both CP families.

100. In Edwige's case, a serious incident investigation conducted by external investigators highlighted a number of failures (including causative failures) in her care. Although St Andrews claimed to have accepted those findings, their conduct at Edwige's inquest, which was combative and opportunistic, was extremely distressing for her family. This included refusing to make any meaningful admissions despite being directed to consider doing so on several occasions by the Coroner, seeking to object to aspects of the family's pen portrait, and seeking to rely upon witness evidence from a psychiatrist who had never treated Edwige but sough nonetheless to justify the actions of staff during Edwige's admission.

101. In Sophie's case, without any prior warning as to its existence or the sensitivity of its content, Mrs Smith was disclosed an internal EPUT investigation report which included a detailed chronology of highly distressing CCTV footage which described her daughter's fatal ligaturing in graphic detail. It is inconceivable that the impact on a grieving parent of being exposed to such distressing material had not been considered or appreciated. As will undoubtedly be explored in her evidence to this Inquiry at an appropriate stage, Mrs Smith also has serious misgivings in respect of the substantive adequacy of the report and investigation.

Structural Racism and Discrimination

102. The CP families endorse INQUEST's submissions on structural discrimination as outlined in their Opening Statement dated 21 August 2024.[58]

103. In 2022 the Black Equity Organisation reported that almost two thirds of black people who responded to a survey had experienced prejudice from doctors and other staff in healthcare settings. [59] This rose to three quarters among black people aged 18 to 34. Concerningly, given those

[57] See e.g. "*Involving people in their own health and care: Statutory guidance for clinical commissioning groups and NHS England*" and *"Engaging and involving patients, families and staff following a patient safety incident"* (Available at: https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/engaging-and-involving-patients-families-and-staff-following-a-patient-safety-incident/)

[58] Available at: https://lampardinquiry.org.uk/wp-content/uploads/2024/09/INQUEST-Opening-Statement.pdf at [15 -28]

[59] BEO. (2024). *Black Voices Reports*. [online] Available at: https://blackequityorg.com/black-voices-reports/?#gf_9

findings, according to recent figures on detention in 2023 black people were 3.5 times more likely than white people to be detained under the MHA[60].

104. More recently, in its June 2024 report entitled "*Public Harms: Racism, Misogyny in Policing, Education and Mental Health Services*"[61] which scrutinised the institutional harms caused to women and girls, and in particular black women and 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;
- A 'one size fits all' approach to public services.

105. The report found evidence that ethnic minority patients were more likely to be restrained or secluded, in punitive rather than therapeutic ways, with women being secluded at unexpectedly high rates, and poor conditions in seclusion rooms. It was also observed that the 'strong black woman' stereotype can serve to silence and minimise black women's distress, pain, and victimhood – leading to poorer care and increased vulnerability to depression. This trope, alongside stereotypes of aggression and dangerousness can mean black women experiencing mental distress are more likely to be perceived as a threat to others compared with their white counterparts, resulting in greater use of restraint and higher rates of diagnoses of psychosis among Black women.

106. These findings are of acute concern to the Nsilu's family. On the day that Edwige died, nurses tasked with caring and protecting Edwige, on finding her collapsed and unresponsive, determined that she was "*feigning unconsciousness*" as an apparent trick to lull them in so she could attack them. There was simply no basis for this conclusion. By contrast, there is clear evidence that it caused a delay in providing an emergency medical response.

107. The Nsilu family are acutely aware of racist attitudes and stereotyping of black people by healthcare professionals and others responsible for their care. They are aware of the several cases of black or other racialised people who have died while detained by the state after having been accused of feigning illness or unconsciousness, such as Olaseni Lewis,[62] Sean Rigg,[63] Habib Ullah,[64] and Leon Patterson.[65] These examples exemplify the culture of disbelief and mistrust of black people which

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[60] GOV.UK (2023). *Detentions under the Mental Health Act.* [online] www.ethnicity-facts-figures.service.gov.uk. Available at: https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/

[61] BEO. (2024). *Public Harms Facing Black Women*. [online] Available at: https://blackequityorg.com/public-harms-facing-black-women/

[62] Olaseni Lewis died in 2020 after being left unresponsive and unconscious without medical treatment due to a belief that he was "faking it" following prolonged restraint by police officers at Bethlem Royal Hospital. See for example: https://www.inquest.org.uk/seni-lewis-conclusion

[63] Sean Rigg, died in 2008 after a prolonged period of restraint by police officers. He was assumed by officers to have been "feigning" unconsciousness when he was taken to custody and as a result immediate medical assistance was not sought. See for example: https://www.policeconduct.gov.uk/sites/default/files/documents/Background-statement-Sean-Rigg-September-2023.pdf p. 2

[64] Habib Ullah died in 2008 after restraint by police officers. No resuscitation was attempted, and he was not placed in the recovery position before the ambulance arrived, despite officers recognizing his abnormal breathing *"due to the fact that the officers believed him to be feigning unconsciousness"*. See for example: https://irr.org.uk/article/second-inquest-returns-critical-verdict-on-death-of-habib-ullah/

[65] Leon Patterson died in 1992 while in police custody. During his several days in various police stations, although he presented as increasingly unwell, police officers, and at least one police doctor suspected that he was feigning illness in order to escape custody. See for example: https://www.4frontproject.org/leon-patterson

the Nsilu family are concerned played a role in the treatment Edwige received. Vitally, they illustrate the potentially fatal outcomes with which this racist culture can be associated, and tragically, they are poignant reminders that this is a long-standing concern in the black community. Scrutiny of the role of structural racism and the treatment of black service users and their families is a matter of particular importance them. It should also be a matter of concern to this Inquiry.

108. Questions of whether racism did or may have impacted Edwige's mental health treatment in life as well as the care she received at the point of death, as with the care and treatment experienced by other black and other racialised patients, should be answered by this Inquiry. That question cannot be adequately answered by an examination of the circumstances of Edwige's death alone. To assist it in understanding how structural and institutional racism and discrimination, including intersectional discrimination, might have impacted Edwige's death and the death of other patients, the Inquiry should obtain expert evidence.

109. The CP families also reiterate their request that the Inquiry give particular consideration to the treatment, protection and care of women and young girls, particularly those who, like Edwige and Sophie, have experienced sexual violence and abuse.

Leadership and culture

110. The CP families wish to emphasise at this stage that they do not consider that any one of their concerns described above can be siloed from another. Instead, it is submitted, they must be viewed through the prism of the culture and the enduring failures in leadership which not only allow them to occur, but subsisted and continue to subsist 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 co-operate, when errors and omissions that occurred behind closed doors or on locked wards were placed under public scrutiny.

111. The scale of deaths in the care of Essex mental health services is and cannot fail to be galling. What is more galling, is the repetition of themes which recur throughout cases of deaths which, the CP families are deeply concerned, could and should have been prevented if lessons had been learnt earlier.

112. The CP families note that the two Trusts who have made opening statements to this Inquiry to date, EPUT and the North East London NHS Foundation Trust ("NELFT") have both expressed their commitment to co-operating with this Inquiry, and to facilitating the Chair's investigations. For the CP families these statements are platitudes that must be put to the test by this Inquiry. The CP families have to date seen no evidence of Essex mental health services' commitment to those words, nor the spirit of that commitment. And, of course, their experience gives no reason to be confident. They call on this Inquiry to rigorously hold the Trusts to their words and commitments, and to compel their co-operation and expose non-cooperation where they fall short.

113. We set out in the following section, practical steps which we invite the Chair to adopt in order to facilitate this, and to ensure that this Inquiry is fully able to deliver upon its Terms of Reference.

D: Practical steps

Position Statements

114. On 17 July 2024, the new Government confirmed in the King's Speech its proposal for a 'Hillsborough Law' – introducing a legal duty of candour on public officials and public bodies, and making misleading or obstructing investigations a criminal offence. The aim was said to be to

"*introduce a duty of candour for public servants [and authorities]*" to "*address the unacceptable defensive culture prevalent across too much of the public sector*", improve "*transparency and accountability where failure in the provision and delivery of public services is the subject of public investigation and scrutiny*".[66]

115. The Prime Minister confirmed in his keynote speech on 24 September 2024 at the Labour Party annual conference that legislation will be introduced in Parliament before the next anniversary of the Hillsborough disaster (on 15 April 2025). The mischief at which the Hillsborough Law is aimed was vividly highlighted by that tragedy and by the experience of the families of its victims, but also by a series of other disasters and injustices including Orgreave, Windrush, the infected blood scandal and Grenfell. This Inquiry, examining as it will over 2,000 deaths of some of the most vulnerable people in our society – should consider itself alongside those investigations and require its participants to act with absolute candour throughout.

116. To that end, the Inquiry is invited to issue to the Trusts and other organisational CPs and material providers requests for the provision of position statements.

117. Concern over a lack of candour from State and other organisational participants has been present in numerous previous inquiries, including:

a. the Francis Report into failures by the North Staffs NHS Trust (2013);

b. the Equality and Human Rights Commission inquiry report into Deaths in Adult Mental Health Detention (2015);

c. the Harris Review into self-inflicted deaths of young people in custody (2015; the Kirkup Report into maternity facilities at Morecambe Bay NHS Trust (2015);

d. the Angiolini Review of Deaths in Police Custody (2017);

e. Bishop James Jones' report into the experiences of the families bereaved by the Hillsborough disaster, entitled 'The Patronising Disposition of Unaccountable Power' (2017)),

118. In various ways these are examples of Inquiries where criticisms have been made of organisations who have tried to cover up their mistakes, adopt an obstructive approach or, on occasion, to seek to mislead the inquiry.

119. The 2020 JUSTICE Working Party report, 'When Things Go Wrong: the response of the justice system', chaired by Sir Robert Owen, stated [p.2]:

> "*Institutional defensiveness can impede the effectiveness of an inquiry or inquest, with a detrimental impact on participation and public confidence. We consider that a statutory duty of candour, which includes a rebuttable requirement for position statements, would help to foster a "cards on the table" approach. Directing the inquiry to the most important matters early on in the process could result in earlier findings and reduced costs.*"

120. Sir Robert Owen endorsed the use of position statements as Chair of the Litvinenko Inquiry, as have, amongst others, Sir John Goldring (Assistant Coroner in the Hillsborough Inquests), Sir Peter Thornton QC (the former Chief Coroner), Sir Martin Moore-Bick as Chair of the Grenfell Tower Inquiry and Sir John Saunders as Chair of the Manchester Arena Inquiry. When used

[66] Background Briefing Note to the King's Speech 2024

effectively, position statements have enhanced the collaborative, transparent and public nature of inquiries, and increased their efficiency.

121. The advantages of this approach include the early (in Inquiry terms) provision of a comprehensive account, to which witnesses can later refer and be referred; and avoiding any corporate inertia, where organisations remain silent on particular matters until being specifically asked, causing distress, delay and the appearance of evasiveness to bereaved families in particular.

122. The legal basis for adopting this course is straightforward: Section 17(1) of the Inquiries Act 2005 provides that "*subject to any provision of this Act or of or of rules under section 41, the procedure and conduct of an inquiry are to be such as the chairman of the inquiry may direct.*" This is subject only to s.17(3), which provides: "*In making any decision as to the procedure or conduct of an inquiry, the chairman must act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or to witnesses or others)*". The flexibility inherent in s.17 therefore means that the Chair has the power to request that position statements are produced – a process which can be used independently of opening and closing statements, both of which are provided for in the legislation. Such requests could be made via Rule 9 of the Inquiry Rules 2006, although it is not necessary to do so).

123. It is submitted that these position statements should identify, with respect to each relevant issue (as identified by the Inquiry):

a. That organisation's narrative version of events, including:

i. Its responsibilities, processes, policies and resources;

ii. Any relevant legal or regulatory framework(s) which applied;

iii. What did, did not and should have happen(ed) within the knowledge of that organisation, and;

iv. Lessons learned, good and bad practice;

b. The performance of any of other CP or organisation, insofar as it affected the CP and was within their knowledge;

c. Any potentially relevant material that organisation holds with respect to the matters in (a) above; and

d. The relevant aspect of each scope issue to which such material relates.

124. Position statements should be signed off by the Chief Executive (or a person with similar authority) within the organisation.

125. It is submitted that this course should be adopted here, given:

a. The number of CPs and material providers involved in this Inquiry;

b. The volume of potentially relevant material;

c. The breadth of the Inquiry's Terms of Reference (as evident in the Provisional List of Issues), albeit within a defined time period; and

d. The need to progress this Inquiry as speedily as possible;

e. The benefit to the Inquiry, and to the bereaved, in the early stage identification areas of agreement or disagreement.

126. In some areas of this Inquiry the issues and material may be more obvious. At the outset, however, the NHS Trusts and other organisational CPs are likely to be in the best position to identify the facts within their knowledge and the material they hold, rather than leaving the Inquiry to search for unknown facts. This will, it is hoped, encourage candour on behalf of the CPs, and assist in the Inquiry's search for the truth and in making appropriate recommendations. It should also assist the bereaved families to know that if particular CPs recognise that mistakes have been made by their organisation or their employees, that will be made clear to the Inquiry so that remedial action can be taken. This approach would help to identify where there was agreement among CPs, and assist the Inquiry to identify the contentious issues that require to be explored. With appropriate deadlines, position statements should also expedite and enhance the production and disclosure processes.

Evidential procedure

127. Flowing from this, the Inquiry is invited to adopt an approach whereby **all** potentially relevant material should be obtained by the Inquiry, adopting a broad approach to what is potentially relevant – which should assist in achieving the confidence of the bereaved families and the wider public, demonstrating that the Inquiry is casting its net sufficiently broadly, then conducting its own independent assessment of relevance when determining what material needs to be considered in evidence (including in oral evidence). That confidence is vital given the context of this Inquiry and the experiences of far too many bereaved families in Essex.

128. Were the Inquiry instead to permit material providers to determine relevance prior to disclosure that would give rise to significant suspicion and concern among the bereaved families, other CPs and the wider public. The Inquiry should also closely scrutinise any attempt by material providers to seek to withhold material from the Inquiry. Efforts by material providers to withhold material from the Inquiry should be rejected: they will undermine the independence of the Inquiry, call into question its efficacy, and hinder the confidence that the Inquiry must build.

129. In identifying and providing material to this Inquiry, CPs and material providers should be reminded that they have a duty of candour; and, such are the experiences of the bereaved families, CPs should be required to confirm that **all** potentially disclosure has been provided to the Inquiry.

130. To that end, at an advanced stage, when the disclosure process is complete or nearing completion, the Inquiry is invited to obtain a statement from an individual with appropriate seniority and responsibility within each Trust or agency, confirming that the disclosure obligations to the Inquiry have been discharged in full and with candour.

Interim and Monitored Recommendations

131. We adopt and endorse the submissions in the written opening statement submitted on behalf of those patients and families represented by Hodge Jones and Allen solicitors that the Chair should keep an open mind as to the need to publish interim recommendations. The evidence that this Inquiry will hear dates back some 20 years but will include, we anticipate, concerning evidence about recent and ongoing failures. Where interim recommendations might address ongoing failures to protect current patients, urgent interim recommendations might well be appropriate.

132. Moreover, given the history of EPUT's failure to implement changes, even in the face of CQC recommendations, Inquest jury findings or Coroner's Prevention of Future Death Reports, the Chair should ensure that interim or final recommendations are appropriately monitored to ensure substantial progress is made in relation to their meaningful implementation within a set period after publication of the Inquiry's report – a matter to which we are likely to return in closing submissions.

Independent Assessors

133. On behalf of the CP families, brief observations have been made in correspondence in relation to the Inquiry's proposed Independent Assessors. We repeat the previously expressed concerns that it does not appear that any Independent Assessors have been identified who have experience either as a patient or carer or family member. Additionally, it is unclear what steps the Inquiry has taken to ensure an ethnically diverse panel. In relation to the latter, we reinforce our submission that the Inquiry would be assisted by expertise and/or expert evidence in relation to structural racism and discrimination.

E: Conclusion

134. This Inquiry is the product of sustained efforts by dedicated campaigners calling for scrutiny of the deaths not only of their own loved ones, but of hundreds more vulnerable people. The CP families are grateful for the opportunity to participate in this Inquiry, though doing so comes at great personal cost, because they are keen to ensure that the failings that led to their loved ones' deaths are not repeated without end – because they want to break that cycle that destroys vulnerable lives, and churns through bereaved families without care or pause.

135. The CP families welcome the thorough and detailed Terms of Reference, and Provisional List of Issues this Inquiry has issued, and they hope that through the rigorous examination of those issues, and the ones they have raised herein, a cycle of destruction will be broken, and lasting change achieved.

4 November 2024

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