List of Issues

The List of Issues has been prepared to help guide the Inquiry's investigative work.

The intention is to provide a more detailed approach to the investigation of issues raised by the Inquiry's Terms of Reference. Please refer to the Inquiry's Explanatory Note in relation to Scope for further information.

The List may evolve while the Inquiry receives evidence and undertakes its investigation; issues may be added, removed or amended, as appropriate.

It will be a matter for the Chair to determine the nature and extent to which any of the issues should be investigated in order to meet the Inquiry's Terms of Reference. Further, there may be issues which, due to the passage of time and / or lack of available evidence, cannot be addressed, fully or in part.

During the course of the 24-year period being considered, standards, practices, policies and procedures, as well as the legislative and regulatory framework under which mental health care and treatment was provided, changed. This will be taken into account during the Inquiry's investigation.

For the avoidance of doubt, the List is not intended to, nor would the Inquiry be permitted to, expand or capture issues outside the Terms of Reference.

Nothing in the drafting of the List should be taken to indicate any decision or conclusion by the Chair (or the wider Inquiry team) on the possible outcome of the Inquiry's investigation.

A. Background to NHS Funded Mental Health Inpatient Care and Treatment in Essex

1. Who was responsible for providing NHS funded mental health inpatient care and treatment in Essex[1] between 1 January 2000 and 31 December 2023 (hereafter referred to as "providers" and "the relevant period")?

2. How did these providers operate? How were they structured (including any reconfiguration of services), funded and regulated during the relevant period? How did they function and fit within the wider NHS?

3. How did placements with independent providers, or inpatient units out of area (i.e. outside of Essex), work in practice? What were the reasons for these placements?

4. Where placements occurred, what was the nature and extent of the relationship(s) with relevant NHS Trusts and / or commissioners? And to what extent were the following sufficient:
    a. monitoring of care and treatment at these providers; and
    b. systems and mechanisms relating to quality control and oversight.

5. Were there any limitations or exclusionary criteria which affected a provider's ability to offer and / or deliver mental health inpatient services in Essex? If so, what were the limitations or exclusionary criteria and how and why were they applied?

6. Against what background were providers expected to offer and / or deliver mental health inpatient services in Essex?
    a. What key policy changes were made during the relevant period?
    b. How, and to what extent, was mental health care and treatment prioritised by politicians and those in national leadership positions?
    c. How were mental health services funded?
    d. Were adjustments made to support service growth and mental health initiatives?
    e. Was there "parity of esteem" between mental and physical health care and treatment in Essex? Was this broadly the same across the nation?

B. The Pathway – Care and Treatment of Those Who Died

Assessment

7. How were individuals assessed for mental health inpatient admission, and what clinical processes and procedures applied during the relevant period? Specifically:
    a. Who could request or refer patients for such assessments?
    b. How, and to whom, could a referral be made? What criteria applied, and did these change over time?

[1] Note: The Inquiry considers "Essex" to be defined by the local government areas of Essex, Southend-On-Sea and Thurrock. This does not include areas of Greater London which were historically within the county of Essex. See Schedule 1 to the Lieutenancies Act 1997.

c. How easily could an assessment be arranged?
d. What factors affected when an assessment could take place?
e. Who carried out assessments for admission, and where were they undertaken?
f. Who was consulted during the course of any assessment, and who was notified as to the outcome?

8. Where an assessment for detention under the Mental Health Act 1983 took place, was it carried out in accordance with legislation and the Code of Practice? What factors were considered?

9. Where an assessment for detention under the Mental Health Act 1983 took place and a person was deemed to not meet the threshold for needing inpatient care or treatment, what action was taken? What factors were considered?

10. Where a capacity assessment took place, was it carried out in accordance with the Mental Capacity Act 2005 and related Code of Practice or (if prior to the 2005 Act and Code coming into force) was it carried out in accordance with requisite guidance? What factors were considered?

11. To what extent were assessments for detention under the Mental Health Act 1983 and / or capacity assessments carried out in a timely way? What were the reasons for any delay? How did this affect the person being assessed?

12. How were decisions not to assess a person under the Mental Health Act 1983 or the Mental Capacity Act 2005 (or requisite guidance) made? What factors were considered?

13. What other forms of assessment (in relation to mental health admission and inpatient care and treatment) were undertaken? How frequently were other forms of assessment used, and in what circumstances?

14. Were other forms of assessment carried out in accordance with relevant guidance or expected practice? What factors were considered?

15. To what extent were other forms of assessment carried out in a timely way? What were the reasons for any delay? How did this affect the person being assessed?

16. Where the decision was taken to admit a person following a mental health assessment, how much time elapsed between that decision and admission? What care or treatment was provided in the interim?

17. Where the decision was taken not to admit a person following a mental health assessment, what reviews, follow up or other action was taken?

18. Where a mental health assessment was requested but not carried out, what were the reasons for this?

19. Where the decision was taken not to refer a person for a mental health assessment, what reviews, follow up or other action was taken?

20. To what extent were the following decisions appropriate:
    a. not to admit a person following a mental health assessment;
    b. not to carry out a mental health assessment; and
    c. not to refer a person for a mental health assessment.

21. Were decisions relating to any mental health assessment (including a decision to refer for an assessment or not to assess) documented? If so, by whom and where? To what extent were sufficient details recorded and accessible to other healthcare professionals?

Admission

22. How were decisions about admission made?

23. What factors influenced whether, when and where a patient was admitted? Were the following relevant to any decision: bed capacity, the location of a ward, types of services offered, and / or a patient's needs.

24. Where admission was indicated, but did not take place, what were the reasons for this?

25. What policies and procedures applied when patients were admitted onto wards? Were the policies and procedures appropriate in the circumstances?

26. To what extent were the policies and procedures adhered to? Where they were not adhered to, what were the reasons for this?

Ward Environment

27. To what extent was consideration given to the ward environment?
    a. What standards and expectations applied? Were these met?
    b. How were factors relating to individual patients, such as sex, age, neurodiversity, learning disabilities, dementia, co-existing physical health issues, drug and alcohol addiction, patient history (including any known sensitivities) and other social and economic factors addressed and managed?
    c. What other factors (for example noise or disturbance) were taken into account?

28. Were wards clean, in a sufficient state of repair and safe?

29. Were wards therapeutic? How did they assist recovery?

30. How, and to what extent, was a patient's dignity retained?

31. What effect did the ward environment (including, but not limited to, ward layout and / or the use of technologies on a ward) have on patients?

32. Overall, were wards fit for purpose?

Treatment

33. How were decisions about treatment made?
    a. Who was involved in making such decisions?
    b. To what extent was a patient's preference or the views of others (such as family members or professionals who had been looking after the patient in the community) taken into account?
    c. How were disputes as to treatment resolved?

34. How were comorbid issues[2] addressed? Were they appropriately considered and adjusted for? What treatment options were available to patients beyond those relating to their mental health, for example, in respect of their physical health or neurodiversity?

35. How was risk assessed and managed and how was this balanced with other care philosophies and principles (such as least-restrictive practice and the need for care to be therapeutic and recovery-focused)? What approaches and interventions were considered?

36. How was medication prescribed, administered and controlled?
    a. To what extent were relevant factors, including contraindications to medication and any known side-effects, considered?
    b. How did providers approach treating those who did not agree to taking their medication or who lacked capacity?
    c. Were second opinions appropriately sought?
    d. Was there a practice or culture of over-medication?

37. Overall, was the treatment provided to mental health inpatients appropriate and adequate?

Transfer

38. How were decisions in relation to transfer between wards (including from acute to psychiatric intensive care, child to adult, and adult to older adult wards) made?

39. What factors influenced whether, when and where a patient was transferred? Were the following relevant to any decision: bed capacity, the location of a ward, types of services offered, and / or a patient's needs.

40. Where transfer was indicated, but then not actioned, why was this? To what extent was a decision not to transfer appropriate?

41. What policies and procedures applied when patients were transferred between wards? Were the policies and procedures appropriate in the circumstances?

42. To what extent were the policies and procedures adhered to? Where they were not adhered to, what were the reasons for this?

[2] Comorbid issues are one or more illnesses or diseases existing in a person at the same time. They may be issues relating to a person's physical or mental health and can exist independently of one another.

43. How did providers seek to ensure continuity of care and treatment when a patient was transferred? To what extent was this achieved?

44. To what extent were changes to a patient's environment anticipated and managed?

45. How did transfers, or decisions not to transfer, affect patients?

Leave, Absconsion and AWOL patients

46. How did providers deal with requests for leave (supervised and unsupervised)? What processes were in place? What information was considered? How was risk assessed?

47. Who did providers liaise with and subsequently inform about decisions relating to leave?

48. What community-based mental health support was made available to patients on unsupervised leave (as well as their families, carers, and wider support network)?

49. Overall, did providers deal with granting or refusing leave adequately and appropriately?

50. In relevant cases, how did patients abscond from inpatient wards? Were safety precautions / preventative measures sufficient? If they were not sufficient, what were the reasons for this?

51. Where a patient absconded from a ward or was absent without leave (AWOL – for example, by failing to return following a period of leave), what policies and procedures applied? Were these policies and procedures appropriate in the circumstances?

52. To what extent were the policies and procedures adhered to? Where they were not adhered to, what were the reasons for this?

53. Where a patient absconded from a ward or was AWOL, when and how were decisions made to involve the police? When the police were involved, what was their role?

Care Management

54. How were records created, kept and updated during a patient's stay on a ward? What systems were used?

55. Were sufficient and accurate details documented in patient records (including any care plans)? Where they were not sufficient and / or accurate, what were the reasons for this?

56. Were patient records appropriately updated with new information? Where they were not appropriately updated, what were the reasons for this?

57. How, and to what extent, was patient information shared between staff (including during any handover periods) and / or across teams?

58. What was the role of a care plan? Specifically:
    a. How was a care plan formulated and used?
    b. Who was involved in its preparation?
    c. Who was informed about its contents?
    d. How were comorbid issues addressed?
    e. How often were care plans reviewed?

59. How were decisions in relation to risk and observation levels (including when Therapeutic Engagement and Supportive Observation should be used) made? What information was considered, and by whom?

60. To what extent were decisions in relation to risk and observations adhered to? Where they were not adhered to, what were the reasons for this? What prompted a decision to be re-visited?

61. How did decisions in relation to risk and observation levels affect patients?

62. How, and to whom, could concerns about a patient's care and treatment be raised? What mechanisms existed for doing so, including (but not limited to) Patient Advice and Liaison Services and independent advocates? How effective were these mechanisms?

63. Overall, was the care provided to mental health inpatients appropriate and adequate?

C. Discharge, Continuity of Care and Treatment in the Community

64. When and how did providers start discharge planning?

65. What discharge procedures were in place and were they followed?
    a. Who was involved in the decision-making process?
    b. How was relevant and necessary information obtained?
    c. What assessments were undertaken?
    d. How was risk assessed?
    e. To what extent was statutory guidance abided by?

66. What was the role of a care co-ordinator (and related community teams) and what were their associated responsibilities?

67. How were care plans prepared for discharge? What information was included? Who were they then shared with?

68. What community-based support was organised and / or set up by providers? Where necessary, how soon after discharge would patients be visited, and by whom?

69. To what extent were changes to a patient's environment anticipated and managed?

70. What factors, beyond the control of providers, affected discharge?

71. To what extent were decisions around discharge appropriate? Was the care provided to those on discharge adequate?

D. Engagement

72. From the point of assessment through to discharge, what level of information was communicated to and / or obtained from patients during their time on an inpatient mental health ward?

73. From the point of assessment through to discharge, what level of information was communicated to and / or obtained from a patient's family, carer and / or other members of their support network?

74. What provisions or measures were in place to ensure that information had been properly received and understood? Were necessary adjustments made to accommodate those who had known difficulties with communication?

75. How, and to what extent, was the delivery of information to patients, their families, carers and / or other members of their support network documented?

76. How, and to what extent, were patients, their families, carers and / or other members of their support network involved in decisions relating to their care and treatment? Was NHS guidance adhered to?

77. How, and to what extent, did providers co-operate with others (i.e. community mental health teams and those acting for relevant support services) to plan, commission and deliver safe discharge plans and aftercare?

78. How, and to what extent, were patients who suffered serious harm or a near miss supported by providers following an incident?

79. How, and to what extent, were families, carers and / or other members of a patient's support network:
    a. informed of incidents of serious harm and / or near misses (including attempted suicides);
    b. informed of a patient's death;
    c. informed of and communicated with, during and after, any internal or external investigations; and
    d. supported through any of the above.

80. Overall, was provider engagement with patients, their families, carers and / or other members of their support network appropriate and adequate?

E. Safety

81. What preventative measures were put in place to safeguard patients from harming themselves or others on mental health inpatient wards?

82. What crisis and emergency management systems (for example, if a patient ligatured) were in place? Were they adhered to? Where they were not adhered to, what were the reasons for this?

83. What restrictive practices (manual, mechanical, chemical or seclusion and long-term segregation) were employed by providers? How and why were they used?

84. When restrictive practices were used, how and where was their use documented? If their use was not documented, what were the reasons for this?

85. What consideration was given to the Deprivation of Liberty Safeguards (after coming into force in 2009) for those who lacked capacity?

86. How, and to what extent, were the risks of adverse therapeutic outcomes arising from treatment aimed at promoting physical safety (such as confinement, seclusion, high level observations or restriction to the ward rather than confinement) considered? What guidance applied and was it adhered to? Where it was not adhered to, what were the reasons for this?

87. How, and to what extent, was iatrogenic harm considered?

88. What work was done by providers to understand why patients absconded or went AWOL?

89. Did patients feel safe when they were on mental health wards? Did families, carers and / or other members of a patient's support network have any concerns about their safety?

90. Did staff feel safe while at work on mental health wards? To what extent did staff safety affect inpatient care and decision-making?

91. What information and / or guidance on safety and raising concerns was available to patients, their families, carers and / or other members of their support network and staff?

92. How did providers work with partner agencies (e.g. safeguarding boards / the police) to safeguard and protect patients and / or staff members at risk? What systems were in place for referrals to other agencies?

93. How were disclosures of serious harm and reported safety concerns (including any potential issues of mistreatment or abuse) acted on by providers? Were matters escalated properly, and in a timely way?

94. To what extent were the steps taken by providers to identify, assess, evaluate and mitigate safety risks (to patients and staff) appropriate and adequate? Where they were not appropriate and / or adequate, what were the reasons for this?

95. Were patients and staff working on mental health wards safe?

F. Data Collection and Use of Technology

Data

96. What data were collected (in patient records or otherwise) during a patient's stay on a mental health ward?

97. Were the data collected adequate, accurate and up to date?

98. Where data were not adequate, accurate or up to date, what was done by providers to rectify this upon discovery?

99. How were data recorded? What secure technology and / or systems were used?

100. How, and to what extent, were matters of opinion (as opposed to matters of fact) identified and documented?

101. How were data retained, and for how long?

102. How were data shared, and for what purpose? Was the sharing of data adequate, relevant and limited to what was necessary?

103. How did providers receive data from third parties?

104. What data (whether captured during a patient's stay, at another point in time or by another organisation) were available to a provider to help them understand a patient's history (including previous or likely diagnoses, and known sensitivities)?

105. How were data used to make informed decisions about treatments and interventions? When these data were not available, what steps did the provider take to obtain them?

106. What efforts were made to ensure that the data collected were interoperable with data from other organisations?

107. What analysis was undertaken, at a regional and national level, of data collected on mental health inpatient wards?

108. What changes were informed by the collection and analysis of data?

109. Overall, were data collection, maintenance, storage, analysis, sharing and retention appropriate and adequate?

Technology and Privacy

110. What technologies were used by providers during the relevant period, and were patients aware of their use? Specifically:
    a. When and how were mobile devices used?
    b. When and how were body worn cameras used?
    c. When and how was CCTV used?
    d. When and how were Oxevision and Oxeobs used?

111. What other available technologies ought to have been used by providers to improve mental health inpatient care and treatment? Where applicable, to what extent was the decision not to use them appropriate?

112. What was the impact of any technologies used?
    a. To what extent did they improve the provision of mental health inpatient care and treatment?
    b. To what extent did they hinder or negatively affect the provision of mental health inpatient care and treatment?
    c. What changes were informed by the use of technologies?

113. In respect of technology, how did providers ensure a patient's privacy was maintained?

G. Staffing Arrangements, Training and Support

Staffing

114. How did providers identify what staffing roles were required on mental health inpatient wards?

115. What processes were followed for staff recruitment?
    a. What criteria were applied by providers? Did the criteria change depending on whether staff were recruited on a permanent, temporary or agency basis?
    b. How did providers seek to ensure consistency in terms of standards?

116. How were staff assigned to duties and shifts? To what extent was consideration given to how many staff of a particular grade were on duty, and whether those staff were permanent, temporary or agency staff?

117. To what extent were permanent, temporary and agency staff expected to perform different roles and duties? What were the reasons for this?

118. Were there perceivable trends or correlations between the assignment of staff, their roles, their grades, their status (permanent, temporary or agency) and the level and

quality of care and treatment provided? How and to what extent was this monitored and evaluated by providers?

119. How, and to what extent, did staff assignments either to shifts or roles / duties affect the care and treatment of mental health inpatients?

120. What factors were taken into consideration when organising shift frameworks / timetables?

121. How did providers determine if wards were sufficiently staffed? Specifically:
    a. Were caps on the numbers of temporary or agency staff applied? If so, how were these determined? Were caps abided by? How were any caps monitored?
    b. Was a different approach taken to overnight and out-of-hours care? If so, what were the reasons for a different approach being adopted?

122. Were the numbers and types of staff (including role, grade and status) assigned to shifts sufficient and appropriate? How, and to what extent, was consideration given to the following:
    a. the number or percentage of new and / or irregular (temporary or agency) staff assigned to each shift;
    b. the number or percentage of qualified staff compared to the number of unqualified staff;
    c. individual patient vulnerabilities and needs;
    d. the need for single-sex care; and
    e. any other relevant factors.

123. How, and to what extent, did shift frameworks and staffing timetables affect the ability of staff to properly care for and treat mental health inpatients?

124. What was the staff turnover rate on mental health inpatient wards during the relevant period? What were the reasons for this?

125. Were mental health inpatient wards understaffed?

126. How, and to what extent, were absences, role vacancies and shortfalls in staffing dealt with? How often was low staffing reported as a clinical incident?

127. Were there perceivable trends or correlations between staff turnover, sickness and vacancy rates and the level and quality of care and treatment provided to mental health inpatients? How and to what extent was this monitored and evaluated by providers?

Training

128. What theory-based and / or practical training (on induction and during post) did staff working on mental health inpatient wards receive (whether provided on a national or regional scale)? To what extent was this useful and appropriate?

129. To what extent did the training provided to permanent, temporary and agency staff differ? Where there were differences, what were the reasons for this?

130. What other training could or should have been given to staff (whether permanent, temporary or agency staff)?

131. How was staff training certified and monitored by providers? What action was taken when a member of staff failed to complete mandatory or essential training?

132. Can any trends or correlation be seen between the type and / or adequacy of staff training and the level and quality of care and treatment provided to mental health inpatients?

Support

133. What support (including emotional support and counselling) was available to permanent, temporary and agency staff? If there was a difference in terms of the level of support, how was this justified?

134. How did providers recognise and respond to the traumatic nature of acute ward working?

135. To what extent were staff supported when raising concerns and / or complaints?

136. Was the support that was offered sufficient? If not, what else could have been done?

H. Management and Leadership (at all levels)

137. What was expected of those in managerial and / or leadership positions dealing with mental health inpatient care and treatment?

138. How was responsibility apportioned?

139. Did those in managerial and / or leadership positions have suitable qualifications and / or experience? How, and by whom, was this determined, monitored and kept under review?

140. How did those in managerial and / or leadership positions ensure that policies and procedures in relation to the provision of safe and therapeutic mental health inpatient care and treatment were properly understood and implemented at all levels of the organisation?

141. Were those in managerial and / or leadership positions visible on wards? How did they supervise staff? Were they involved in clinical decision-making?

142. How were reporting lines structured?

143. How was performance managed, and was it managed effectively?
    a. In what areas was good practice clearly demonstrated? How was this recognised?
    b. How was poor practice reported and dealt with? What effect did staff shortages have on retention?

144. How did those in managerial and / or leadership positions ensure complaints and safety incidents were properly documented, acted on and investigated?

145. What barriers did those in managerial and / or leadership positions face? Were these a result of governance and / or the provider's culture?

146. To what extent was management and leadership appropriate and adequate?

I. Governance

147. How did the providers manage and monitor the provision of mental health inpatient care and treatment?

148. What were the functions of any boards (executive and non-executive)?

149. How, and to what extent, were boards sighted on key issues affecting patients and staff on mental health inpatient wards?

150. What influenced providers' decision-making and actions? To what extent did commercial and financial considerations apply?

151. What national and local structures, systems, policies, procedures, processes and guidance documents were in place or available to support and encourage the delivery of safe and therapeutic mental health inpatient care and treatment? And, specifically:
    a. To what extent were they appropriate and effective?
    b. What quality assurances were there?
    c. How was their implementation monitored?
    d. How was feedback sought and collated?
    e. What prompted any significant changes during the relevant period?
    f. What effect did the availability of resources have?

152. How robust and effective were providers' governance, information-sharing and monitoring systems?

153. What opportunities were there for reflective practice?

154. How, and to what extent, did providers implement and monitor improvement processes?

155. Was learning at ward level appropriately captured? To what extent was it shared internally and used to bring about change?

156. Overall, how well were the mental health inpatient wards in Essex being run? To what extent was governance effective?

J. Culture

157. What was the intended verses actual culture at each provider? How did the two compare?

158. Was the actual culture conducive to good quality inpatient care and treatment?

159. Was learning and collaborative working encouraged?

160. Did staff feel supported, professionally and emotionally? How could staff raise concerns, and to what extent did they feel comfortable doing so?

161. Were behaviours and relationships, at all levels (including staff to staff and staff to patient), appropriate? To what extent were they in line with provider policies and values?

162. How were any instances of bullying, harassment and / or intimidation managed on wards and further up the managerial chain?

163. Did those in managerial and / or leadership positions display positive role-modelling behaviour?

164. How and to what extent did beliefs, assumptions or orthodoxies held by those working on mental health inpatient wards (for example, in relation to the preventability of suicide) affect the care and treatment given?

165. Did stereotyping or stigma, for example around addiction, affect the care and treatment a patient received?

166. To what extent were patients' protected characteristics associated with any differences in the treatment they received? Was structural racism and / or discrimination an issue? If so, was it identified as an issue by providers?

167. What effect did compassion fatigue have on the care and treatment provided to patients?

168. How, and to what extent, did a provider's actual culture affect the care and treatment provided to patients?

K. Quality of Investigations Undertaken or Commissioned by Providers

169. What types of investigations (including any audits or reviews) were undertaken or commissioned by providers in relation to the provision of mental health inpatient care and treatment?

170. How were these investigations undertaken? Including:
    a. Were they initiated promptly and in accordance with any associated guidance or framework? If not, why not?
    b. Who determined an investigation's remit?
    c. Who was responsible for setting terms of reference and / or scope?
    d. If internal, who was responsible for conducting investigations?
    e. What effect did the use of an internal investigator have?
    f. If external, how were decisions made as to who would undertake such investigations?
    g. Did investigators have suitable qualifications and / or experience?
    h. Were the right people spoken to?

171. Did providers allocate sufficient resource to investigations? If not, what effect did this have on an investigation?

172. Did investigative findings produce meaningful results, recommendations or actions for change?

173. Who was informed about investigative findings, and were they informed in an appropriate way?

L. Quality, Timeliness, Openness and Adequacy of Responses

174. How, and to what extent, did providers respond to the following in relation to the provision of mental health inpatient care and treatment:
    a. Concerns and complaints;
    b. Safeguarding issues;
    c. Serious Incident, Root-Cause Analysis, and/or Patient Safety Incident Response investigations (or similar);
    d. Internal and external audits, particularly when they found shortfalls in compliance and / or unmet targets;
    e. Any other investigations or programmes undertaken or commissioned by the provider relating to the delivery of relevant care and treatment or the death of a patient;
    f. Inspections and / or investigations by commissioners;
    g. Inspections and / or investigations by the Care Quality Commission;
    h. Investigations by the Health and Safety Executive;
    i. Police investigations; and
    j. Investigations by HM Coroners Service.

175. What protections were afforded to those who raised concerns or issues internally (also known as whistleblowers)? Were these protections effective? Were there any repercussions for those who raised concerns or issues?

176. How did providers respond when staff were found to be underperforming, failing to comply with their duties or acting inappropriately on mental health inpatient wards?

177. What disciplinary procedures were in place and were these adhered to?
    a. How were concerns documented, and who were they shared with?
    b. Were appropriate referrals made in respect of any fitness to practice and / or potentially criminal matters?
    c. What action was taken by providers in response to disciplinary or criminal findings? Was this appropriate?

178. To what extent were responses reasonable, open and in accordance with the overarching duty of candour? In circumstances where they were not, how did this affect the relevant processes, or the ability to learn lessons or take appropriate action (including disciplinary action)?

179. To what extent was appropriate action taken?

M. Oversight by, and Interactions With, External Bodies

180. How did providers in Essex interact with external bodies, including (but not limited to):
    a. NHS England;
    b. Special Health Authorities;
    c. Other NHS Trusts;
    d. Provider Collaboratives;
    e. Department of Health and Social Care;
    f. Commissioners;
    g. Integrated Care Boards;
    h. Local Authorities;
    i. Safeguarding Boards;
    j. The Voluntary Sector;
    k. The Health and Safety Executive;
    l. The Care Quality Commission;
    m. Other professional regulators;
    n. The Disclosure and Barring Service;
    o. Complaints bodies;
    p. The police and other emergency services;
    q. Railway authorities and industry representative bodies;
    r. HM Prison and Probation Service; and
    s. HM Coroners Service.

181. To what extent was the level of interaction appropriate and effective? What more could have been done by (a) the provider; or (b) the external body?

182. Where referrals to independent regulators were required, were these made promptly and in accordance with any applicable guidance?

183. What recommendations, including from inquests, investigations, experts and any others within the professional or regulatory sphere were made to improve mental health inpatient care and treatment? Were appropriate steps taken by providers to act on such recommendations? What assistance was given to providers to support implementation?

184. To the extent that any recommendations were not implemented by providers, what were the reasons for not implementing them? Were these appropriate in the circumstances?

185. To what extent did any failure to implement recommendations cause or contribute to a poor standard of mental health care or treatment?

186. How was provider compliance with recommendations monitored? Did any mechanisms exist to ensure that recommendations were implemented?

187. Was there any mechanism by which the public could follow provider actions in response to recommendations and track progress?

188. What information has been collected and made available to the Inquiry to be able to compare Essex to other mental health inpatient care and treatment providers across the nation? To what extent was Essex an outlier?

18 February 2025