Monday, 12 May 2025

(10.08 am)

THE CHAIR: Good morning, Mr Griffin.

MR GRIFFIN: Good morning, Chair. Chair, this week is Mental Health Awareness Week. The theme this year is Community.

According to the Mental Health Foundation, being part of a safe, positive community is vital for our well-being. Communities can provide a sense of belonging, safety, support in hard times and give us a sense of purpose. The Inquiry would like to acknowledge Mental Health Awareness Week.

Chair, today we will be hearing from Deborah Coles of the organisation INQUEST. There are broad themes to her evidence which include the inadequacies of post-death investigatory processes, particularly from a family point of view -- INQUEST are calling for an independent investigatory body -- and, allied to this is, INQUEST's call for a National Oversight Mechanism to consider recommendations and the like arising from inquests and other forms of investigation.

Another theme in the evidence will be the absence of a coherent and complete set of statistics in relation to those who die in mental health detention and INQUEST's relevant case work and what it reveals about the

national picture and the Essex picture, and the serious and concerning themes arising, including of a suggested closed culture at EPUT.

Ms Coles' evidence will highlight serious concerns from the perspective of her organisation and her own personal experience.

In the afternoon, Chair, we will hear evidence from EPUT's Dr Milind Karale, who will be asked about the assessments process. His evidence will not touch on individual cases.

That does mean, though, that today's evidence and information may be distressing in certain respects and difficult to listen to, including Ms Coles and what she is going to tell us about INQUEST's case work.

For some, it may not be possible to sit through this session, and anyone in the hearing room is welcome to leave at any point. Again, I would like to remind people that emotional support is available for all of those who require it. The well-being of those participating in the Inquiry is extremely important to the Inquiry, and we have support staff from Hestia, an experienced provider of emotional support, here today and, as I have said previously for each day of the hearing, there is a private room downstairs where you can talk to Hestia support staff if you require

emotional support. The Hestia staff are wearing orange scarves -- would you mind just raising your hand -- and orange lanyards. You can speak to them directly or, if you want to, come up to a member of the Inquiry team and we can put you in touch with them. We are wearing purple lanyards.

If you are watching online, information about available emotional support can be found on the Lampard Inquiry website, that's lampardinquiry.org.uk, and under the "Support" tab, which is near the top right-hand corner.

We want, Chair, all of those engaging with the Inquiry to feel safe and supported.

Chair, with that, I am going to ask that we call Deborah Coles and ask that she comes to the table, please.

DEBORAH COLES (affirmed)

Questioned by MR GRIFFIN

MR GRIFFIN: Thank you. Would you provide your full name, please?

A. Deborah Jane Coles.

Q. Ms Coles, you provided the Inquiry with a 47-page statement, dated 1 April. Can you confirm that its contents are true and accurate?

A. Yes, I can.

Q. Do you have that statement in front of you?
A. I do.
Q. Please feel free to refer to it as you wish.
Your statement and the exhibits that you have provided stand as part of your evidence and so I won't be asking you about every aspect of your witness statement today. This is an introductory phase of the Inquiry's hearings and the focus in your evidence today will be on important general and systemic issues.
May I ask you about names.
In your statement, you refer to people who died as "mental health inpatients in Essex" -- we will come on to this later but it is from your paragraph 58 -- and this is to illustrate and provide an evidence base for some of the points that you go on to make. Is it correct that INQUEST has not, at this stage, provided to the Inquiry the names of the individual deceased to whom you refer there?
A. Correct.
Q. Does INQUEST agree to work carefully and responsibly with the Inquiry in order to make further disclosure to the Inquiry of the names and further details in the cases on which you have relied in your statement?
A. Of course, yes.
Q. Before I go any further, I am going to pause because

I understand there is something you would like to say.

A. Yes, I just wanted to say something to the families involved in this Inquiry and, in particular, I want to acknowledge the incredible strength, courage and determination of families who have been relentless in advocating for their loved ones, in both life and in death, and in having to fight for truth, justice and accountability.

And we know the trauma of your bereavement but also the trauma in your dealings with the Trust, and the lack of candour and denial and false promises of learning and action, and how retraumatising that has been, and this Inquiry, I think, is an absolute testament to your perseverance. When someone you love is taken into mental health care you expect them to be looked after and kept safe.

The team at INQUEST stand both in solidarity and in support for what you have achieved but also recognise the emotional and physical impact of what you have been and are still going through. You have ensured that a light is being shone behind the closed doors of these mental health settings and focusing a light on the candour of the Trust, and the truth must come out. And it's vital that your questions are asked and answered and that, through this Inquiry, we see the

transformative systemic change that is so needed.

Thank you.

Q. I would like to ask you about yourself first. Have you worked for the charity INQUEST since 1989 --

A. Yes.

Q. -- becoming its Co-Director in 1994 and Executive Director in 2017?

A. I have.

Q. Let's just check in what capacity you are giving your evidence today. Are you speaking as CEO of INQUEST, ie on behalf of the organisation, in a personal capacity or both?

A. Both.

Q. Do you hold and have you held a range of other positions outside INQUEST, including membership of the Independent Advisory Panel on Deaths in Custody or IAPDC?

A. Yes.

Q. Could you just explain in brief what does the panel do?

A. The panel is a cross-Government sponsored panel, both by the Ministry of Justice, Home Office and Department of Health, and it provides independent advice to the Ministerial Board on Deaths in Custody. Its key aim is to prevent deaths in custody, including those detained under the Mental Health Act. It conducts research and I think has been a very helpful addition in terms of

exposing some of the issues around deaths but particularly the deaths that this Inquiry are concerned with, and I can talk about that a little bit more.

Q. Well, as part of its role, does the IAPDC publish reports covering aspects of its work?

A. Aspects of its work and, I think, importantly, a statistical bulletin, looking at the number of deaths across State institutions.

Q. Chair, I understand that you wish it to be made known that you were interim Chair of the IAPDC for a period from 2015 to 2016?

THE CHAIR: Thank you, that's correct.

MR GRIFFIN: Can we now move on to talk about INQUEST, the organisation.

So INQUEST is a charity, is it, that was founded in 1981?

A. Correct.

Q. What's the focus of its work?

A. Our -- I suppose our key work is working alongside families bereaved after what we would call State-related deaths, so that includes deaths in custody and detention, including mental health detention.

Q. Can we cover those so that people are aware. Clearly, we are going to be interested in your mental health related work --

A. Yes.
Q. -- but does INQUEST, also as part of its remit, consider deaths in police custody, in prisons and young offenders institutions, and also in immigration detention?
A. Yes.
Q. Have I missed anything?
A. No.
Q. Okay.
A. Then we also work on deaths that raise questions about other multi-agency failings, so we have done some work on learning disability settings -- deaths in learning disability settings or where State and corporate accountability are in question. So that's included work around the Hillsborough football disaster and the Grenfell Tower fire.
Q. Thank you. Is an important part of your work inquest work, and does that relate to post-death investigations?
A. Yes.
Q. Can you just explain what that term encompasses, please?
A. So our work is -- and our case work team that work directly with families help families navigate the post-death processes and I think what people don't always realise is not only is a family dealing with a traumatic death but then there are legal processes that follow.

So there are post-death investigations and, for the purposes of this Inquiry, that will be the investigations conducted by the Trusts or private providers or an independent investigation, if one is instructed.

And then you have the inquest system, and so the role of, of our organisation is to help families navigate those processes to make sure that families are informed about what their legal rights are because what we too often find is that there is an information deficit after a death happens, and it's very difficult to understand exactly what is going to happen, not least when you are dealing with the trauma and the grief of having a loved one die in a place that you thought they would be safe.

Q. Thank you very much. In fact, we will come on to talk about post-death investigations a little bit more later on.

A. Yes.

Q. Does INQUEST work across England and Wales principally but occasionally further afield?

A. Yes, our primary area is England and Wales. But we have also been doing some work -- well, I have been doing some work in Scotland, particularly around how deaths in Scotland are investigated and I can talk about that,

particularly in the context of the National Oversight Mechanism.

Q. Thank you. You have touched on this already but could you provide a little bit more of an explanation of the role that bereaved people play in an inquest?

A. I mean, I think at the heart of our organisation are the experiences and voices of bereaved people and our work with families informs all of our policy and campaigning page work for systemic change. We have a family reference group made up of families who have been through inquests, a number of whom have had loved ones die whilst receiving mental health care. We also hold regular family forums, family listening days, where families can come together and talk about their experiences.

Q. We will actually come on to think a limit bit more about the family listening days later on. Carry on.

A. Okay. So I mean, I think what's probably important about the work that we do is that the work is directly informed by the day-to-day work that we do with bereaved people and not only is that important in terms of our policy work but also in trying to make organisations aware of what families need after a death and, obviously, that's been work going over kind of nearly four -- well, it is four decades before I joined. But

our work is to try and not only prevent future deaths but also try and improve the treatment of bereaved families more generally and try and minimise the trauma of those post-death processes.

Q. Thank you very much. You say in your statement, this is paragraph 6, that families are experts by experience. Can you explain a little bit more what you mean by that?

A. Well, nobody knows better what it's like to have the death of a loved one in an institution that is ordinarily a closed institution and where a family is reliant on that closed institution for every aspect of their loved one's treatment and care, and then, when things go wrong, you know, they best know what it's like to go through the system of trying to find out truth. And I think it's important to understand that the processes that follow deaths are protracted. They can take a long time for an investigation or an inquest to take place.

And what we will no doubt talk about is the experiences of many families who feel very -- you know, very shut out from those processes that are there and should be there to answer those families' questions about how and why their loved one died in a place where they should have been safe.

So when we talk about experts by experiences, that

is a recognition that nobody knows better than bereaved people themselves about what it's like to go through those processes. But, importantly, they best know what needs to change.

Q. Thank you very much. Just now onto how INQUEST is organised, is it organised around case work, media and policy, family engagement, specific projects, operations, those general areas?

A. Yes, that's correct.

Q. Does INQUEST undertake its work with a relatively small number of staff, an executive and governance by a board?

A. That's correct. I mean, I think sometimes people overestimate the size of the organisation because we are the only organisation that is doing this work and that comes with it many challenges. I think the other important thing to say is that we are completely independent of Government and we don't take Government funding because we recognise the importance to families of our independence and our ability to speak truth to power, to be able to use our evidence in a kind of campaigning and policy way and to try and inform change.

And I think one of the things I perhaps should have said around families, I mean the other important role that INQUEST plays alongside families plays is to try and ensure that the voices and experiences of families

are heard by Parliamentarians and policy makers because I think -- you know, the team can go off and talk to people but, actually, the people you will remember, and I am sure the Inquiry will -- this will resonate with the Inquiry, that actually it is the voices of bereaved people who you will remember, their stories, those human stories about what has happened.

Q. Thank you. I want to now ask you about the increase over the years that INQUEST has experienced in its casework in mental health settings. You describe in your witness statement, this is from paragraph 8, INQUEST's involvement in the early 1990s and up until recent times in a range of inquiries and commissions and the like, concerning deaths in mental health settings. Was INQUEST's early casework, in relation to deaths where the deceased had been experiencing mental health conditions, initially in the police and prison context?

A. Yes.

Q. Did mental health inpatient deaths become an increasing part of your casework?

A. It did and, in fact, in preparing for this statement, I was then reminded of my first experience, quite early on in my career, of giving evidence to the Louis Blom-Cooper Inquiry into the situation within Ashworth Hospital, and that was in 1992, which interestingly

followed a Channel 4 documentary that had exposed ill treatment at the hospital, uncovering abuse and was particularly concerned with the kind of brutalising and oppressive nature of what was going on. And that Inquiry, I think, was probably the first inquiry, I think, in my experience that gave a kind of insight into what was going on in mental health detention.

Q. Just to pause there, that's 1992?

A. That was in 1992, yes. And I think we -- I think because we had been aware of the impact of mental ill health on people's experience of prison and policing, particularly around excessive and disproportionate use of force, by way of example, we were then becoming more aware of deaths of mental health inpatients.

Q. Thank you. You describe in your statement that there were important legal developments, including in a case where SEPT was a defendant. This is paragraph 16. In essence, were those legal developments decisions from the House of Lords and then the Supreme Court, in two legal cases in 2008 and 2012, concerning Article 2 of the European Convention on Human Rights and people detained, or de facto detained, in psychiatric hospitals?

A. Yes, that's right.

Q. What effect did those decisions have on INQUEST's case

work?

A. I mean, I think by that time we had done further work -- I don't know if you are going to take me to the earlier paragraphs -- but we had started -- we had started doing more work on mental health deaths but, obviously, these were two significant judgments and particularly around the recognition that the Article 2 duty applied to people in detention and de facto detention, which was significant in the sense of, I suppose, an acknowledgement that these were deaths that warranted proper, you know, public scrutiny.

And we had seen a corresponding increase in the number of families that were turning to INQUEST for help, in the absence of any other organisation. I mean, I think it's just important to note, you know, for context, that none of the mental health organisations work with bereaved families. So there is nowhere else for families to go.

At one point in my early years at INQUEST, the mental health charity Mind had a legal department that did take on some of these cases but nobody does this work. And so, in a way, we were -- I suppose, we were filling a gap and we recognised just how important it was that, you know, deaths in another closed institution should be, you know, properly investigated but those

families needed to be supported. In the same way as other families, they needed to be aware of what their legal rights were in terms of accessing, you know, help and support.

Q. By 2014, had mental health inpatient deaths come to make up a significant proportion of INQUEST's casework?

A. Yes, yes.

Q. I think you may have described how it came about generally. Are there any other explanations for this increase that you haven't yet given?

A. I mean, I suppose, because of the nature of our work and the fact that we had been involved in -- I mean, I don't know whether you want to take me to the death of Rocky Bennett.

Q. We will come on to that in a moment.

A. We will come on to that, okay.

Q. Yes.

A. But I think what happened was there was kind of corresponding -- you know, people became more aware of our organisation and the work we were doing and we were also -- by 2014, not only did the deaths make up a significant proportion of our casework but it became clear that we were seeing the kind of recurring nature of failings in mental health care that we were concerned about and we were becoming more and more concerned about

the system of investigation.

Q. We will come on to all of that.

A. Okay.

Q. But you have mentioned in your statement, this is paragraph 18, that, even at this stage, key themes were emerging --

A. Yes.

Q. -- from your work in this area. Were these national themes, rather than focused on one part of the country?

A. Oh, definitely national.

Q. Can you provide us with an indication of what those themes were, please?

A. Yes, I mean, I would say the first one was the lack of advice and support for families after deaths occur; but then failures to involve families in the care of their loved one whilst in mental health settings; lack of support in the community and that -- the significance of that being that many people were becoming in serious crisis and trauma and distress, resulting in detention because there was a lack of support in the community; familiar issues around observations, poor quality of care, you know, poor assessments.

I mean, I think what's quite depressing really, for me, in, you know, thinking about the work that INQUEST has done over such a long period is that, sadly, these

are all too familiar themes today. I think the other thing I would say is that, you know, it was quite difficult when we first started working in this area because some of our workaround police and prison deaths was making us aware about how prisons and policing were an inappropriate response to people in mental health crisis, and so we were advocating that there should be better mental health services and better support.

At the same time, we were seeing mental health settings where you, at the very least, expected somebody to be safe because, by the very nature, you expect a mental health setting to be therapeutic, to have care at its heart and, yet, we were seeing many of these really concerning -- you know, concerning features.

The other one I should mention is around the overuse of restraint -- concerning use of restraint and also isolation and, you know, and segregation, seclusion.

Q. What approximate proportion of INQUEST's current case work comprises inquests into deaths arising within mental health settings?

A. I think probably it would be fair to say about a third. I mean, we have, you know, the real challenge that I need to kind of just, you know, be candid about is that, you know, we have far more families coming to INQUEST than we can offer support to.

So we are currently kind of rolling out, you know, a new way of working to try and make sure that, whether or not we can give somebody full casework support, at the very least we want to make sure that our resources are made available, we are going to be running -- holding workshops because there is a real gap here and what families need when the worst thing has happened is they do need access to proper advice and support.

Q. Some of that will be available online?

A. Absolutely, we have online resources a handbook, et cetera.

Q. You have spoken about the different things that INQUEST does. I want to look at a couple of them briefly please. First of all, your monitoring role and then we will come on to look at casework?

A. Okay.

Q. What does INQUEST's monitoring and evaluation work involve?

A. Are you talking --

Q. So this is --

A. Do you want to take me --

Q. Well, we can look at paragraph 41, if you like, but you talk about carrying out comprehensive monitoring and collating of statistics in relation to deaths in police custody.

A. Okay, sorry, yes, yes.
Q. But not the equivalent in relation to deaths in mental health detention.
A. Yes, yes.
Q. Do you want to talk about that a little bit and then also about your monitoring, as opposed to your casework role --
A. Yes.
Q. -- generally?
A. I mean, one of the things that we think is important is trying to make publicly available comprehensive data on who is dying and where they are dying in places of detention or in and following, for example, police contact.

So we monitor and collate statistics and we are able to do that because we draw on the official sources available, as well as, you know, Freedom of Information Requests.
Q. We will come on to talk a little bit more about those official sources.
A. Okay, okay. So -- but, unfortunately, we are not able to carry out that formal monitoring in relation to mental health deaths because there has never existed a central comprehensive source of authoritative data of either mental health inpatient deaths or the deaths of

those who have died in the community following contact with or under the care of mental health services. And this has been an issue that INQUEST have raised for decades.

Q. Well, we will look at a little bit of that in a moment.

A. Okay.

Q. So there is no formal monitoring but is there, in fact, informal monitoring, for example through Prevention of Future Deaths reports?

A. Yes, I mean, our -- all of our work is informed by our monitoring and collating of statistics where available, our monitoring of investigations and inquests into State-related deaths and, of course, that will include the outcomes of inquests, both in terms of jury narrative conclusions and Prevention of Future Deaths reports. And it's important just to make the point about jury conclusions because those are -- there is no central collation of jury conclusions, which can be extremely important in understanding whether or not any system failings have been identified during the course of the inquest.

So where we can and where we have been working with a family, we will collate those, and then we use that evidence to inform our policy work and particularly our work to try and effect change, be that in the post-death

processes or in regard to the issues that have been raised by the particular case and the subsequent evidence that's come out of an inquest.

Q. Thank you. We will look at both what INQUEST has been doing in relation to post-death issues and also statistics in a moment. Can we move though now first on to casework.

In general terms what does INQUEST's casework consist of? You cover this at paragraph 22.

A. Yes. So, I mean, I suppose our key motivation is to make sure that families are supported to navigate the processes that follow a death and know how -- well, I suppose to enable and empower them to play a meaningful part for investigation processes, and I think it is important to just kind of bear in mind that, as we will all know from experiencing the death of a loved one, you know, your initial -- your initial kind of response is one of grief and dealing with those kind of post-death processes, like the funeral and, you know, being with family and friends and loved ones.

But where you have a death that has taken place in an institution, your ability to grieve and your bereavement is impacted by the very experience of having an investigation. You have had a death of a loved one in an institution, they hold all the resources, they

hold all the knowledge, and you are having to try and find out what has happened at a time, as I say, when you are grieving and you are trying to hold, you know, your life together and support other family members.

And so our role really is to try and make sure that you have access to information, you have access to a lawyer, if that's what you want, and we would advise families to seek legal representation because it can be extremely important whilst you are navigating the post-death processes, the funerals, to know that there is somebody who can be beginning to start to get the information together to begin to help you to understand why a death and -- how and why a death has happened.

So --

Q. If a lawyer is instructed, does the caseworker continue and work alongside the lawyer?

A. Irrespective of whether a lawyer is instructed or not a caseworker will. And, as I say, I mean, the other way of supporting is by trying to give families access to other forums where they can meet other families, where they can have kind of that informal support because one thing that families, you know, tell us time and time again is, you know, you are thrown into a really alien process. There's very often an information kind of deficit.

It can be a very isolating and lonely place and, as I said earlier, it can take a very long time before you begin to get answers, and many families will tell us that they can't begin to grieve until they know the truth about what has happened.

Q. So they put their grief on hold during this difficult time?

A. Absolutely.

Q. Does the casework that you are talking about also form part of your information base. So you are talking about monitoring, and so on --

A. Yes.

Q. -- but is INQUEST, as an organisation, also learning a lot about what is happening on the ground through its involvement in its casework?

A. Absolutely, and I mean all of our work is informed by that evidence base.

Q. What is that? I mean, what kind of information -- where you are working on a case with a caseworker, what kind of information is INQUEST, as an organisation, gathering and recording?

A. Well, as much as possible, with a relatively difficult database. You know, as an NGO, I think -- I am sure people will understand that we don't have those great, sophisticated systems, we would love them. But we

don't.

But we will --

THE CHAIR: Can you remind me how big an organisation it is?

A. At the moment we are a team of 16. Yes. But only four -- four caseworkers and one part-time casework assistant.

So, sorry, the question was ...?

MR GRIFFIN: Well, I was asking about the information that INQUEST as an organisation gathers through its casework. You also address this at paragraph 31 of your statement.

A. Thank you. We will document as much information as possible and that will be everything from how was a family -- how was a family informed about a death, what information were they given about where to go for advice and support, how candid was the information that was given to them by Trusts and private providers, and then, obviously, you know, as the case develops, as much information that we can glean from the different processes.

So, you know, I would say that, you know, we have a huge amount of information about families' experiences of these processes going back decades.

Q. As you said, does the information that you are gathering through your casework go into your database?

A. Yes, prior to the database, obviously it was handwritten

in folders and files, which we still have.

Q. The information in the database -- you cover this in paragraph 31 -- is used for various purposes. Could you indicate what they are?

A. Well, I think, you know, it enables us, as an organisation, to draw out trends and patterns, both in terms of, you know, families' experiences of the post-death processes, through to the issues that play out, you know, through the investigations and through the inquests.

And, you know, in a sense, I think what we are trying to do is -- you know, all of our work is about prevention, all of our work is to try and stop the deaths happening and kind of shining a light behind, you know, the closed doors of institutions. But also, I think rightly, it's about ensuring that these, you know -- that these institutions that owe individuals a duty of care, and you have already talked about Article 2 -- but you know it's important to say that, you know, people who go into detention are completely dependent on others for their treatment and care and, in a sense, that's an extremely vulnerable position to be in.

So it's also about ensuring that their human rights are respected and that they are treated with dignity and

respect and, where there are human rights abuses and, in particular, you know, inhumane and degrading treatment that those are brought to light in the hope that we can inform the change because every family that we work with will say that, "We want the truth about what has happened and we want people to be honest and open about what has happened". But nothing can bring your loved one back, but they hope that, by going through these protracted, distressing processes, they hope that something positive can come out.

And that can give meaning to people's loss, that can be quite cathartic, it can be healing but only if they see the corresponding change happen and I think what is sometimes forgotten is that these processes, by their very nature, are retraumatising. You will hear time and time again organisations say, "Oh, you know, we will -- lessons will be learned", the most overused --

Q. We will come on to some of this a little later on. But, as I understand what you are saying, is that there can be a very important element in your casework where a loved one has died, with the possibility that that death is not in vain because the hope is that meaningful change will be effected from the learning that comes outside of it --

A. Yes.

Q. -- and, if the processes aren't in place for that learning, then there are problems in grieving, and so on?

A. Yes, and I would say even if the processes are not in place and you have a situation where you have had, you know, a very poor investigation, the inquest can then play an important role and that can help to expose the truth and, you know, can help identify system failings.

But I think what, again, is not recognised is what it's like to be a family who have gone through all those processes, have been told that there will be action and then they learn of another death in similar circumstances, and that can be extremely traumatic and, I have to say, that's something that, you know, speaking about my work within INQUEST, it is the thing that makes me the most angry and frustrated and upset, is that, you know, we are still seeing those familiar issues.

Q. Just staying with the subject of the data and the information that you as an organisation are able to gather. You say this at paragraph 42 of your witness statement, and this is something you have touched on:

"However, we do not carry out formal monitoring in relation to mental health deaths."

A. Yes.

Q. "This is because there is no central comprehensive

source of authoritative data of either mental health inpatient deaths or the deaths of those who have died in the community following contact with or under the care of mental health services."

You then have a footnote which says this:

"Although we analyse data from our casework to inform the direction of strategic and policy work, to set casework priorities, make remit decisions and for the purpose of specific reports, we do not therefore routinely collate and analyse our data as part of a formal monitoring role. The lack of a central dataset ..."

We are going to come on to talk about all of that.

A. Okay.

Q. "... also means that, although we review case files to ensure any information published or shared is accurate data arising from our casework is not statistically representative of the national picture."

I just wanted to ask you about the last part of that, "data arising from our casework is not statistically representative of the national picture"; could you just explain what that means?

A. I mean, I -- I think what it means is the fact that you know, we -- there is no corresponding data that we can go to, to say how many deaths there have been in

a particular -- under particular trusts or private providers. It is a really disparate picture.

So our casework is only as representative as the families that we can work with or the families that come to us. But I would say that, you know, we work with families across the country and I am confident that the trends and patterns that we draw out reflect many of the -- you know, many of the issues that this Inquiry is looking at.

Q. Thank you. I am going to ask that a document is put up, a part of your statement, on the screen. Could you put up core bundle, page 185, and expand paragraph 54, please. We can see here that you say, "By way of overview" -- sorry, this is dealing with data held by INQUEST:

"By way of overview, during the period under review by the Inquiry, INQUEST has worked on a total of 7,460 cases across all types of deaths across England and Wales. This includes cases where we provided ongoing casework, but also where we provided initial advice. Of those, 1,843 are marked within our casework system as having been mental health related. This will include the deaths of people who were detained under the [Mental Health Act], receiving mental health care in hospital but not detained under the [Mental Health Act] and

deaths in the community. These deaths may also involve other agencies, for example the police or the local authority."

First point: does that give us an idea of the extent of your casework?

A. Yes.

Q. There is reference here to deaths in the community and involving other agencies, which may not come within the Inquiry's Terms of Reference, depending on the particular circumstances. But I would like to, at this stage, consider any other caveats the Inquiry should have in mind when we are looking at or considering your data.

I am staying with paragraph 54 and 55. In fact, can we look actually at the footnote 2 at the bottom of the same page:

"The Inquiry will note that these figures have been extracted using information recorded by our casework system and that they should be used as estimates only. For example, the dates used to identify cases within the relevant period refer to dates on which the case was opened on our system, not the date of death. Further factors to be taken into account are then set out in the following paragraph."

So that's something else we just need to bear in

mind when we are looking at or considering the information that you are providing to us. Could you take that down please. At paragraph 55, you list further limitations we need to bear in mind when considering INQUEST's data.

A. Yes.

Q. To summarise, are they that: the purpose for which INQUEST collects data is primarily to deliver its casework, rather than to conduct a formal monitoring role, at least in relation to mental health, and the way it collects data is structured accordingly?

A. Yes.

Q. Also, the breadth of your remit, as an organisation, including in relation to mental health, reflects -- it is a point you have just made -- your casework capacity --

A. Yes.

Q. -- and operational reality, so the amount of people, the amount of cases you can actually take on?

A. And particularly in mental health, such was the demand we have had to make some very difficult decisions about those deaths that we can work in detail on and -- you know, and, sadly, you know, that's the reality of our funding situation, and that's particularly impacted on deaths in the community, you know, which we started working on because we were so concerned about the number

of people who were dying, either for want of support from mental health services or who, in our view, had been discharged prematurely from mental health services to no proper support in the community.

And also we were -- I mean, we -- our work situates deaths in their broader kind of social and political context and one of the concerns we had around mental health was that we were seeing cuts to frontline services, which, in our view, were impacting on people's ability to get proper, good mental health support in the community.

And I think that alongside, you know, increasing austerity and inequality, meant that we were seeing a real need for scrutiny of those deaths but we, as I say, have had to make some difficult decisions purely because of our resources, not because we didn't recognise that those deaths needed -- those families, importantly, needed that support.

Q. Thank you very much. Just staying with other matters we just need to bear in mind when considering INQUEST's data and information, again, it is a matter of you have touched upon, but INQUEST's recordkeeping has changed over time, starting with those manuscript records you were telling us about --

A. Yes.

Q. -- transitioning to digital databases, with recordkeeping improving over time?
A. I would hope so, yes, yes.
Q. I think, just staying on that theme, there was limited functionality of your first digital database but that's a situation, as I understand it, from your statement --
A. Yes.
Q. -- which improved with a later version or versions?
A. Yes, and I think you should also bear in mind that, in the early years of doing this work, there was very limited disclosure to families. You know, when I first started at the organisation, I mean, you know, you were lucky if you turned up to an inquest with anything, you know, other than maybe a postmortem report or, you know, a kind of front sheet with information on it.

So of course that, you know, as, you know, families importantly have been given more rights and also as, you know, the Article 2 of the Human Rights Act has impacted on the way in which inquests are held, there has been more corresponding information. So, of course, you know that's --

Q. Well, that is an important point. So earlier in the period of interest to this Inquiry -- we go back to 2000 --
A. Yes.

Q. -- one of the reasons you as an organisation may have less information is that families themselves were receiving less information?

A. Yes.

Q. Thank you. I want to now ask you broadly about cases falling in the Inquiry's Terms of Reference, as you have assessed them to be.

Have you, in fact, gone to individual case files held by INQUEST for the information -- we will look at that information a little later on -- about cases you have determined fall within the Inquiry's Terms of Reference?

A. Yes.

Q. Were you able to review cases that were held -- I mean, do you have any files that are still in paper form or has everything been transitioned onto a database?

A. No, we have many files in paper form.

Q. Have you been able to review those for the purpose of the information that you provided to the Inquiry?

A. I don't think we have. I think the -- I think because of the fact you were looking at 2000 onwards, I think those were all -- from memory, those were all within the database.

Q. So the paper files relate to an earlier period?

A. They do, yes. I mean, I reviewed -- for example, in

preparation for the statement, I reviewed the Louis Blom-Cooper Inquiry because that was -- obviously pre-dated digitalisation and I looked at kind of my statement for that, by way of example.

Q. To what extent do you think that limitations, inevitably, in the digital database mean you may not have identified all potentially relevant Essex cases that you hold?

A. I mean, I feel confident with the information we have provided in the statement. So I hope it's -- I mean I am confident it is representative of the deaths that that this Inquiry is concerned with.

Q. Thank you. So the casework service that INQUEST provides, when normally would that come to an end in any particular case?

A. It would usually come to an end at the conclusion of the inquest, the formal relationship. But, of course, many families are interested in the process of policy change, so it may be that families will remain involved in the organisation and maybe come to some of the online connection cafés that we organise; they may play a role in some of our policy and campaigning work.

Q. That's what I was going to ask you about next. In fact, on the basis of all of the information you gathered, from whatever source --

A. Yes.
Q. -- does INQUEST also produce reports and provide evidence of matters within its knowledge and experience for a range of different organisations, including Parliamentary and health bodies?
A. Yes, and we have been -- I mean, you may come on to the --
Q. We are going to look at David "Rocky" Bennett in a second.
A. Okay, but I am also thinking of our family listening days.
Q. We are going to come on to those as well.
A. Okay.
Q. Can we come on then to the David Bennett Inquiry, which reported in 2003, so towards the beginning of the period within the Inquiry's Terms of Reference.
A. Yes.
Q. Who was David Bennett? You touch on all of this from paragraph 11.
A. Yes. So David, known as Rocky, Bennett was a patient at an NHS-run clinic in Norfolk and he died as a direct result of the restraint that was used against him. He, he died of asphyxia. He was restrained over a long period and I think that, for INQUEST, this was a death that was a reminder of the violence and racism that we

had seen in police and prison context, and it was the first -- probably the first death that we had worked on in detail with his family.

Q. Was there an inquest in 2001?

A. There was.

Q. Did the jury return a verdict of accidental death aggravated by neglect --

A. Neglect, yes.

Q. -- and say that the cause of death was due to prolonged restraint as well as long-term anti-psychotic drug therapy?

A. Yes. I think we were fortunate at the time that there was a coroner who, from recollection, I believe, had got some mental health -- had got a background in mental health and there was an inquest in which the family were represented and were able to play a proper part in that process, and it was a full -- I think a full and -- actually focused, importantly, on the use of restraint in --

Q. Well, we will look at aspects of that in a moment.

The Independent Inquiry into the death of David Bennett reported in December 2003. You speak in paragraph 12 of your statement about INQUEST's evidence to that Inquiry and what it highlighted?

A. Yes. I mean, I think what's important here is that, I think similar to this Inquiry, it was the family's

determination that something positive could come out of his death, that informed the decision to set up that independent Inquiry, to which we gave evidence and we raised a number of issues and I think importantly, to address your earlier point, we highlighted the lack of data to enable monitoring of deaths in mental health detention, so that it was difficult to understand not only, you know, who was dying but why they were dying. And that, for us, was particularly important in the context of race and ethnicity.

Q. Did you also highlight issues in post-death investigations?

A. We did.

Q. We are going to look at the report and pick up on those.

A. Okay.

Q. So the Inquiry went on to make various recommendations itself, didn't it?

A. It did, yes.

Q. Could you put up please exhibits bundle, page 14339 and expand the right-hand column. Thank you. Can you actually read that? I will read the relevant --

A. I can.

Q. -- bits.

A. Thank you.

Q. So we can see at the top there, "Sudden Deaths in

Psychiatric Hospitals":

"The Inquiry found the evidence relating to sudden deaths in psychiatrist hospitals to be unclear. The statistics were unsatisfactory so it was difficult to draw clear conclusions from them. We recommend that more detailed statistics are kept so that it can be known how many patients in mental health institutions die when being restrained or within a short time thereafter with details of their ethnic grouping."

If we drop down a little bit, we can see:

"INQUEST told us that since 1996 there had been monitoring of the ethnic origin of people who die in custody but this did not include deaths of detained patients."

Is that going back to the point about different collection of data for those in police or prison detention?

A. Yes, I mean, it followed -- it followed some lobbying, from recollection, of the United Nations in highlighting the lack of data and the lack of any kind of monitoring of race and ethnicity, and that then prompted this to be looked at in the context of police and prison but not in the context of deaths of detained patients. I mean, what is -- what is --

Q. Yes. May I just finish the paragraph --

A. You may, yes.
Q. -- because it says:
"There was a gap in information, not only about who was dying but why they were dying."
A. Yes, I mean --
Q. Yes.
A. -- what I was going to say is what is really quite depressing about this is that this is the situation that remains today and you will note from the Independent Advisory Panel's most recent statistical bulletin that they make the very same point.
Q. We are going to be tracking this point through a couple of different reports over time in a moment?
A. Yes.
Q. Does the Inquiry report go on to say that:
"The Inquiry notes that coroners make recommendations from time to time and proposes that those recommendations should be monitored and collated centrally.
"INQUEST told us that the failure by the NHS to provide information and support to families after a death had a highly detrimental effect on families' mental health."
Again, picking up on points you have already made --
A. Yes.

Q. -- to us.

Can we, therefore, see recommendations there covering, as you have just said, unsatisfactory statistics into an important aspect of mental health care. In fact, the report does go on -- and this is recommendation number 11 in the report -- to make this recommendation, that the Department of Health should collate and publish annual statistics on deaths of all psychiatric inpatients which should include ethnicity.

We can see in the highlighted or expanded part there, also the recommendation in relation to the coroners' recommendations, and that they should be centrally collected and monitored.

Would you go to the next page and expand the left-hand column just, at the top. So the next page, thank you very much.

This is continuing on from what we have just been looking at and we can see here the paragraph starting:

"Families should have access to information about where to go for help after a death of a family member who was in a mental health institution."

A. Yes.

Q. Again, picking up on points you have already made to us.

A. Yes.

Q. Can we see about halfway down:

"If there was an investigation after the death, families should have an effective access to that investigation process from the beginning to the end. The investigative body should be an independent body. One was left with a feeling that some people's lives did not have equal worth with others."

So here we see, do we, a recommendation for an independent investigative body?

A. Indeed.

Q. Could you take that down, please. You refer in your statement to concerns -- this is paragraph 47 but we don't need to go to it -- over deep inequalities in access to mental health care and outcomes, particularly in respect of black people.

A. Mm-hm.

Q. So we saw it here in relation to a report over 20 years ago.

A. Yes.

Q. To what extent have those issues improved over time?

A. They haven't, and I think I provided examples of more recent literature. I mean, I think it's -- I think there's an acknowledgement by some, at least, that racism is embedded into those structures of healthcare and we know that black people are more likely to enter the mental health system via the criminal justice

system; they are more likely to be detained under the Mental Health Act; more likely to be placed under community treatment orders; and then, when they are actually in detention, that they are more likely to be subject to violence, the use of restraint and isolation, particularly prone restraint. And I think you know, this has been the subject of research, it's been --

Q. Well, is one of the relevant reports, which you have provided to the Inquiry, a rapid review from February 2022 the NHS Race and Health Observatory report --

A. Yes.

Q. -- Ethnic Inequalities in Healthcare, and does that pick up on some of the points you have just been telling us about?

A. It does.

MR GRIFFIN: Thank you.

Chair, I am about to move on to a new topic, we have been going for about 1 hour and 10 minutes. Would this be a good time for a 15-minute break?

THE CHAIR: Of course.

MR GRIFFIN: Thank you very much.

THE CHAIR: Thank you, see you in 15 minutes.

(11.10 am)

(A short break)

(11.30 am)

MR GRIFFIN: So I want to come on now to the topic of investigations, please. You have mentioned family listening days and information that you can give to this Inquiry about themes arising from those.

You set out in your statement -- this is paragraph 38 -- what, as you put it, families have been telling INQUEST since you started holding those family listening days in 2010, and your statement refers to the reports of three family listening days, in support of various points that you then go on to make. Can we just deal, first of all, with what those family listening day reports were.

First of all, the report of the IAPDC, Independent Advisory Panel on Deaths in Custody, family listening day, which was held in 2011?

A. Yes.

Q. That involved families who have, as it says, direct experience of the investigation and inquest system following the death of a relative whilst in mental health detention?

A. Correct.

Q. Was that organised by INQUEST on behalf of the IAPDC?

A. Yes, we were commissioned to run it on behalf of the IAP.

Q. The next is INQUEST's report on the CQC family listening

day, in 2016, and the stated purpose there is to gather evidence to inform the CQC's review of how NHS Trusts investigate and learn from deaths, so that's not limited to mental health settings but deaths across the spectrum, as I understand it. So this is your report on the CQC listening day --

A. That was within NHS.

Q. Across the NHS?

A. Yes.

Q. Thank you. Then the third is the INQUEST family consultation day report on deaths of people with mental ill health, a learning disability or autism --

A. Yes.

Q. -- more recently in 2023?

A. Yes, and in a way, the reason that -- the thing that distinguishes the two and then the consultation one was it was an opportunity for us to bring families together to see whether or not, in the passage of time, things had improved.

Q. As we have said, all three of those listening days were looking at matters on a national basis, rather than focusing on any particular part of the country?

A. Correct.

Q. In two of the three reports, the number of families involved is given as 11. We couldn't find a number in

the third report but is it likely to have been around the same number?

A. Yes, possibly a few more, actually, in that one.

Q. Why, in your view, do family listening days of this sort and size provide a firm basis for conclusions or themes that you say come out of them; is there a sufficient evidence base when you are talking to 11 or more families?

A. I think a very strong evidence base and, importantly, these are hearing directly from families about their experiences but also about their recommendations for change because one of the important things -- and it goes back to my earlier point -- is that many of the families who come to these days want to try and improve the situation for other families. So they have been days that involve also the organisations that commission them having to come and actually actively listen and that can be a very powerful experience for those who are listening. And the reason why we have been commissioned to run them -- we have run another one most recently in February, commissioned by the Ministry of Justice, on why we need a Hillsborough law and we can touch on that one.

That's not in my -- in this current statement. I can follow that up with you.

Q. So these family listening days are being provided to the CQC and to Government --

A. Yes.

Q. -- Departments, and so on, and they are asking INQUEST for its assistance in running them?

A. Yes.

Q. Thank you very much.

A. And I suppose, importantly, that families get involved because they trust the organisation but also in the hope that they will be listened to and that that listening results in change.

Q. Understood. You say you set out at paragraph 38 a number of the themes that you say have emerged from these family listening days. In fact, you have already told us about some of them but can we look at them and I will ask you to expand on one or two where you haven't already provided information to us.

You start by saying in paragraph 38 that the biggest challenge for families is that they face investigatory processes which are, as you put it, exclusionary, delayed and defective and I think you have started to tell us about that already.

A. Yes.

Q. Then the themes that have come out of the family listening days include, first of all, that notifications

of the death of their loved one are inconsistent and often insensitive. Can you briefly explain what you mean by that?

A. Yes. I mean, that refers to the very early information that is provided, and I think the key take away from that is the fact that there is very little information given and information that is sometimes given is then found to be untrue or it's not consistent with the first version of events that was given.

I think the other point to make there at those very early stages is just the information, what families describe as an information deficit, not only about how the person died but about the processes that will follow.

Q. Well, in fact, that's the next theme that you have given us arising out of this and, in fact, you have touched on it already as well. But not knowing, particularly if you don't have legal representation or the assistance of an organisation such as INQUEST, not knowing what to expect?

A. No, and you are dealing -- I mean, you are also dealing with, in many cases, that kind of shocking reality that your loved one is going to be the subject of a post-mortem and dealings with the coroner and, you know, none of us will know what that means until, you

know, we are first confronted with it. So it is that -- it is not only that information deficit but it is also the fact that, you know, that the body of your loved one is held by a coroner until it can be released to the family to arrange a burial.

And, I mean, these are very distressing processes and if you aren't told about why, you know -- and, you know, to be fair some coroners' courts, you know, do that well but I am particularly talking about, I suppose, the responsibility of the organisation in whose care somebody has died to be the -- to provide information in an accessible and sensitive way, and that is certainly quite different to what most families experience, in our view.

Q. You go on to mention that contact with representatives of the relevant NHS Trust is defensive. I want to come on separately to ask you about that specifically in relation to Essex, if I may --

A. Okay.

Q. -- and that the investigations are not independent, which is a point that you have already made, and we are going to come on to look at again in a moment --

A. Yes.

Q. -- and that the quality of investigations can be poor, and investigations -- and this is what you say at

38.6 -- often fail to include evidence of concerns or complaints raised by families during their loved one's life.

Could you expand on that, please?

A. Yes. I mean, I think what we found too often -- I mean, I would include "during their loved one's life and death"; in other words, you know families of people who die in mental health settings have very often had lots and lots of engagement with mental health services, either on the journey into detention or whilst the individual is in detention, and will have raised concerns about their treatment and care. And, yet, they have either not been given an opportunity to raise those with investigators or those concerns have not been addressed within the investigation.

Q. Quite apart from complaints, there may be other relevant information that the family members may have that could be passed on that would be of relevance?

A. Absolutely.

Q. You talk about the process being gruelling, for the families, no doubt. Is that for all of the reasons that you have already been explaining to us?

A. Yes, because I think you will see within my statement there are lots of direct quotes but the familiar story that we hear is that, from the beginning, everything

feels like a fight to try and get information and to try and play a meaningful part.

And you know, that -- I think one of the things that I think our work has identified thematically is that default response of many NHS Trusts and private providers to kind of denial and defensiveness, and a lack of candour and a concern more about reputation management than being concerned about learning and seeking improvements.

Q. Can I ask you this -- I mean, you mention candour but all of the points that you have just made -- to what extent are those issues to this day?

A. Oh, they are issues that we are experiencing within our casework service today.

Q. The last of the themes that you have explained in your statement, arising from your family listening days, is reference to a lack of accountability and a failure to implement change?

A. Yes. Yes.

Q. I would like to move now to consider one of your reports. It's called "Deaths in mental health detention: An investigation framework fit for purpose?" Now, this is a report from 2015, I think, so around 10 years ago. It addresses mental health detention. Does that mean, for the purposes of this report, either those detained

under the Mental Health Act and those de facto detained whilst being treated voluntarily as informal patients, so both categories, both formal detention and de facto detention?

A. Yes.

Q. Was it looking at the national situation again, rather than looking at any particular part of the country?

A. It was looking at the national picture, yes.

Q. Does that mean England and Wales or just England?

A. No, England and Wales.

Q. Can we look at an aspect of the report, please.

Amanda would you put up exhibits bundle, page 14522. Thank you.

So this is an aspect of that report.

A. Mm-hm.

Q. Its heading is, "The lack of independent investigation into deaths", and the report says this:

"There is a glaring disparity between the manner in which deaths in mental health detention are investigated pre-inquest compared to those in other forms of state custody. Unlike deaths in police, prison or immigration detention or following contact with State agents -- where the coroner's inquest is based on the independent investigation of the Independent Police Complaints Commission (IPCC) [as it was then] ..."

Is that now the Independent Office for Police Conduct?

A. Yes.

Q. "... or the Prisons and Probation Ombudsman (PPO) -- no such equivalent investigative mechanism exists to scrutinise deaths in mental health settings. Instead, the inquest is reliant pre-inquest on the internal reviews and investigations conducted by the same Trust responsible for the patient's care."

A. Yes.

Q. So, again, drawing attention to the differing approaches to deaths in mental health detention and those in prison, et cetera?

A. Yes, and, I mean, I think there it's a question of, you know, however good an investigator might be, you know, you are effectively looking at potential failings in systems or in conduct of individuals working within the same Trust and I think it's difficult to reconcile how there was acknowledgement of the importance of independent scrutiny for deaths in other settings but that that equivalence wasn't recognised as being important to deaths in mental health settings.

And, of course, the significance of that cannot be understated in terms of how it's those investigations that inform the subsequent inquest and it's -- you know,

if that is flawed, it is like, you know, the fruit from the poisoned tree point; it is very much the quality of the investigation that's carried out that can inform the way in which the coroner will then conduct the inquest into the death.

Q. So this is a report from 10 years ago but does that same point remain true to this day?

A. Yes, I mean, in preparation for today, I revisited that report, which was a significant piece of research and it was -- you know, it was probably -- well, it was the first report to actually look at these issues in any detail, and we did work with members of our INQUEST lawyers' group, obviously from the team, but also reviewed other literature and the reality today is no different, I would strongly suggest.

Q. So the report includes recommendations --

A. Yes.

Q. -- for a single body conducting independent pre-inquest investigations, with meaningful involvement of families in investigations?

A. Yes.

Q. Does INQUEST still call for such a body, an independent investigative body?

A. Yes, I think we would -- I think we are even more convinced of its need, as we have not seen the kind of

corresponding culture change within trusts and providers in terms of investigations, and also in the learning that flows from those investigations. And I think that, you know, whilst we may well still have criticisms of the investigation bodies in deaths in prison and police custody, there is definitely an advantage about having a single body that has oversight of those investigations and can also produce bulletins around learning and draw out thematic issues.

And I think, you know, that's not also important for families and the public interest but, of course, it's really important for those who have to work within settings because I think there's often a very -- there is often a disconnect between the information that comes out of investigations and inquests, and the sharing dissemination of learning to people working within mental health settings.

Q. Can I ask just some further questions about what this body might look like?

A. Yes.

Q. So you have talked about potential equivalent bodies being the IOPC or the Prisons and Probation Ombudsman. Are you looking or suggesting something along those lines?

A. Yes. Yes, you know, a completely independent body to,

to do that, to do those investigations. And, within that, of course, there should be a function on, on behalf of those who are working within those organisations to ensure that families are informed from the outset of their rights, of what the processes are and how to play a meaningful part within those investigations.

Q. Understood. I am just trying to -- has INQUEST articulated anywhere in further detail what this body might look like?

A. Yes, within the 2015 report, there are some kinds of suggestions as to how it might look and I should say we are not alone in identifying this kind of disparity. The Joint Committee on Human Rights, I think back in -- I think, even, in fact, prior to the publication of this report, recommended an investigation body and I know this is something that, when I was on the Independent Advisory Panel on Deaths in Custody that we looked at in some detail and I know they are currently doing some work around that.

Q. If we, as an Inquiry, go back to the 2015 reports and other reports, will we find further and more details of what kind of body you have in mind?

A. Yes, yes.

Q. Thank you very much.

Could you take that down please, Amanda.

Could we move on to look at a submission by INQUEST to the Care Quality Commission, please. In October 2016, did INQUEST provide a submission to the CQC review of investigations into deaths in NHS Trusts?

A. We did. And I was also on a working group to that review, along with a number of members of our INQUEST lawyers' group.

Q. Thank you. So you provided a submission. Was it addressing issues on a national basis and was it health-wide, not confined to a mental health setting?

A. Yes, it was -- our expertise, in terms of that one, was largely around our work on deaths in mental health settings.

Q. Understood and, in fact, the submission includes reference to the deaths from 2004 to 2015 of six inpatients by hanging at the Linden Centre in Chelmsford?

A. Yes.

Q. It also refers to the repeated failure of NEPT, the North Essex Partnership University NHS Foundation Trust, there. But could we put up exhibits bundle page 14582, please.

So this is part of the submission, and we can see here "Structures for Learning and Oversight". Does it

say this, is there a quote first of all:

"A lack of any national system for monitoring and oversight is allowing dangerous systems and institutions to go unnoticed and unchecked."

A. Yes.

Q. Does it then say:

"It should not be the continuing responsibility of families and organisations like INQUEST to piece together and identify concerning patterns."

Then you make five points within this, including at the first point:

"An independent national learning mechanism is needed to oversee and monitor, including for visibility and tracking around learning and recommendations arising out of deaths, both regionally and nationally. Also to help inform national training programmes."

A. Yes, I think we have, we have -- since then we have developed a more --

Q. Well, we will come on to look at that --

A. Yes.

Q. But can I ask you this. Was this submission in part a response to what had happened in the Linden Centre and the deaths that you had seen there?

A. Yes. And, in fact, a number of those -- excuse me -- a number of those families attended the family listening

day that we were commissioned to run for the CQC to directly inform their review.

Q. Thank you very much.

Would you take that down, please.

We can see later in your statement, and this is paragraph 80, that INQUEST is currently calling for what's termed a National Oversight Mechanism?

A. Yes.

Q. Is that the same or a development of the National Learning Mechanism, that we have just been looking at there?

A. Yes, that's, that's I think a slightly more sophisticated version of what we were recommending there. I mean, this recommendation for an independent public body is borne out of our frustration of seeing the same issues being repeated, the same avoidable deaths continuing, and a failure on the part of private NHS bodies, and others, to enact change and, in particular, the accountability gap that we saw that, although now, for example coroners' Prevention of Future Deaths reports are published on the judiciary website, there is nowhere where you can track and monitor what action has actually been taken.

Too often and I think this is, this is an important point to make, too often it's families who have to drive

that culture and policy change. They will be the ones who will be trying to follow up with trusts, "What have you actually done in response to the failings that have been highlighted?"

Q. Is that the point that you actually made in the document that we were looking at previously --

A. Yes.

Q. -- about it should not be the continuing responsibility of families and INQUEST to piece together and identify these patterns?

A. Yes, and I'm afraid to say that that is the reality and, I think, one of the things that doesn't help is the point I alluded to around the protracted nature of these processes. So I think what tends to happen is that the -- you have an inquest that can be a year/several years after death, where I think the tendency on the part of the Trust is to suggest, "Well, that was a couple of years ago, since then everything's changed". And yet we as an organisation see deaths occurring in almost identical circumstances. And there is that lack of scrutiny of what is actually happening on the ground.

And, of course, the National Oversight Mechanism is about collating, analysing and following up and its ability to be able to do pieces of research, to have that kind of thematic -- those thematic research

publications to help everybody's learning, to help inform the change that we know is -- is needed. So that is the mechanism. That's what we have been kind of proposing. Now --

Q. Can I ask you just about you have used the word "mechanism"?

A. Yes.

Q. Is this actually an organisation or a body?

A. Yes, it's an independent public body. But I think it's important to note that it wouldn't be a regulatory or enforcement body because those already exist. Rather, it's an oversight body with the ability to follow up with those regulatory or enforcement bodies to encourage the action and transparency on recommendations.

Q. I understand. May I just pick up on that --

A. Yes.

Q. -- because we heard evidence last week from the former Parliamentary and Health Service Ombudsman, Sir Rob Behrens?

A. Yes.

Q. One of the things he spoke about was the complexity of the regulatory and complaints landscape, he talked about there being over 12 bodies or organisations that one had to contend with.

Whilst what you are suggesting here may not be

a regulatory body, wouldn't this, and indeed the independent investigatory body that you are calling for separately, potentially just add to the complexity of an already difficult landscape, rather than have the opposite effect?

A. I mean, the first -- my first response to that would be: we have got to acknowledge that people are still dying avoidable deaths in places where they should be safe now -- and that's the reality and that should really, I think, shape everything that this Inquiry is looking at and ends up recommending.

I think the first point I would make is the NOM would be performing a role that no -- that doesn't exist, it doesn't exist anywhere. There is nobody who is bringing all that -- sorry -- bringing all that information into one place. So that would be my, my first point.

The second point would be that regulators such as the CQC or the Health Service Investigation Branch, which I do want to come to in a minute --

Q. We are going to look at an HSIB report, so maybe that's the time to do it?

A. They do not have the specific function or role of monitoring recommendations made following deaths in their stated core duties, and the only time you may well

look at recommendations made in one death is if another death were to occur and, you know, hopefully the represented family would then have a lawyer who would be able to identify the fact that these similar themes and patterns had emerged.

So I think that that's really important. The other thing is there is no body which sits across those different sectors to provide oversight of all of those deaths and I think there is a lot to be -- you know, there's a lot -- a lot of those cases involve multiple agencies or departments and we need much better joined up Government and we need much better thinking across the different agencies and we feel that that new body is capable of providing that oversight as its main responsibility.

Q. Thank you.

A. And I do think that I would say that -- I mean, we have been engaging at kind of high Government level policy levels on this and there is, I think -- we have certainly won the moral argument. I think people find it quite remarkable that inquiry and inquest recommendations can just disappear into the ether, without anybody having central oversight and monitoring of them.

And, you know, I also think it's worth considering

the public cost, you know, the cost to the public purse of these very complex inquest and inquiry processes, when you think that the objective of a National Oversight Mechanism would be about learning accountability but, absolutely importantly, system change and prevention.

We need to try and do more to stop these deaths happening and I think our proposal is informed by a lot of people coming together to think about you know what that lacuna of accountability looks like and how could we have a -- how could we have a better system and --

THE CHAIR: Do you envisage the investigatory body you have talked about being the same as/part of this oversight mechanism; could they be the same body?

A. No, because I think the -- I think the National Oversight Mechanism would be concerned with all State-related deaths. I think there is still a very compelling need for an independent body to investigate deaths in mental health settings.

THE CHAIR: Thank you.

A. I think, you know, I just think that glaring disparity between other places of detention. You know, why -- why is it that mental health patients do not have that same independent body? And I think some of the issues that I have drawn on in my statement about the lack of

candour and openness and transparency could well be addressed by such a body.

MR GRIFFIN: Thank you. I would like to next move on, still within the topic of investigations, to the Patient Safety Incident Response Framework. I don't want to spend much time on this, but is the PSIRF, for short, is its stated aim -- you cover this in paragraph 39.

A. Thank you.

Q. Is the stated aim the NHS's approach is to develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety, and was it published in 2022, replacing the 2015 Serious Incident Framework?

A. Mm-hm.

Q. The Inquiry understands that EPUT, the Essex Trust that we are looking at, was an early adopter of PSIRF and you say in your statement at paragraph 39 that:

"Whilst there have been some changes to the post-death investigation processes since INQUEST started holding family listening days in 2010, such as the PSIRF, our experience as an organisation is that families are continuing to raise similar concerns and we have not seen fundamental improvements in families' experiences as a result of those changes."

Could you briefly expand on that, please?

A. I mean, I think I will only just repeat what I have said before, that we haven't seen any noticeable improvements and one could say, in some sense, there are examples of worsening practice: I mean, families still reporting remaining excluded from the process.

And I think a number -- I mean, I think it's interesting to see how a number of coroners are raising concerns about poor quality investigations in their Prevention of Future Deaths reports.

The other, the other thing just to mention is that the difference between the PSIRF, if that's the right acronym, is that the Serious Incident Framework required full investigations into every death but this is no longer mandatory. So there is a concern that perhaps this new framework could dilute accountability and, you know, it just -- I would just restate the fact that, in our experience, it's still down to families and their legal representatives, if they have them, who have to really fight to play a meaningful role in the investigations that follow.

And we know, in regard to Essex, that, of course, there have been inquests that have been going on since the review and subsequent Inquiry started, where those familiar concerns have been repeated.

Q. Thank you. Thank you very much. I want to move now to a new topic and that's statistics, and we have already trailed this in your earlier evidence but I want to look at one aspect of this first.

Please put up exhibits bundle page 14522, and this is a paragraph in your report from 2015 that we have been looking at, and the title there is "Statistical background", and it says this:

"Our findings draw on statistical data from the National Confidential Inquiry into Suicide and Homicide by People with Mental Health Illness (NCISH), based at the University of Manchester, which publishes figures on both deaths of individuals detained under the Mental Health Act and those receiving inpatient treatment as informal patients. This is supported by information on detained patients' deaths from the [IAPDC]."

Then the report comes on to say this:

"The number of deaths in mental health detention is high in comparison with other forms of custody. The most recent IAP figures show that out of 7,630 custody deaths recorded between 2000-2013, 4,573 deaths were of detained patients -- making up 60% of the total numbers of all deaths in custody."

So that's over a 14-year period?

A. Yes.

Q. We see a 60 per cent proportion in relation to detained patients. May I ask you this: has that high proportion, relatively speaking, of detained patients continued to this day?

A. Yes, I mean, I think -- I think with statistics, obviously, they kind of -- you know, they fluctuate. But I think I would suggest that you look at the most recent -- and apologies, I should have put this in the statement -- the most recent report by the Independent Advisory Panel still shows the concerning number of deaths of mental health inpatients within their statistical bulletin.

Q. In fact, there is a 2024 report which I think you have provided to us, although it covers the period between 2017 and 2021.

A. Yes.

Q. That includes this, and I quote:

"The mortality rate of individuals detained under the Mental Health Act remains disproportionately higher than other places of detention."

A. Yes, yes, I mean, I think the frustrating thing, as well is, just to, you know, make the point, that it's always hard with deaths of mental health inpatients, unlike, say, the deaths of people in prison and in police custody and following police contact, is that the

figures are always behind.

I mean, we have -- we have data shared with us, for example -- and I would suggest this is good practice -- the Ministry of Justice share data with us on who's dying in prisons on a fortnightly basis and, you know, the Independent Office of Police Conduct they bring out an annual report each year and, obviously, we monitor the deaths that we are working on. But we have a much excuse me clearer understanding of who's dying in other State detention than we do for mental health.

Q. Can we come on to consider that now, please. Could you take this down. So we saw in the David Bennett Inquiry report a recommendation about the need for better statistics --

A. Yes.

Q. -- which I think is what you are about to talk about.

A. Yes.

Q. Did INQUEST continue to argue for better statistics over the years that followed that Inquiry report?

A. Oh, yes, and also I did when I was a panel member and it's an issue that has been raised at so many of the Ministerial Board of Deaths in Custody meetings.

Q. For example, the submission of evidence to the Joint Committee on Human Rights from 2003 --

A. Yes.

Q. -- does that include a recommendation to collate and publish annual statistical information about deaths of detained patients?
A. Yes.
Q. So that's 2003. The Joint Committee's report on Deaths in Custody 2004, so this is, as I understand it, the report that followed on from the submission of your evidence --
A. Yes.
Q. -- did that 2004 report recommend that annual statistics should be published by Department of Health?
A. Yes.
Q. You refer in your statement to something you call the data problem and, at paragraph 45, you set out six different sources of data about mental health deaths that currently exist, and you provide in relation to each --
A. Yes.
Q. -- limitations?
A. Yes.
Q. Can I ask you, first of all, are those six sources the following: the Care Quality Commission?
A. Mm-hm.
Q. NCISH, which we have just seen, the National Confidential Inquiry into Suicide and Safety in Mental

Health? How do you pronounce the acronym: is it NCISH or NCISH, or does it not matter?

A. I don't think it matters.

Q. The Office for National Statistics?

A. Yes.

Q. The National Reporting and Learning System, which was replaced by Learn from Patient Safety Events?

A. Mm-hm.

Q. The IAPDC and NHS England Digital?

A. Yes.

Q. So the Inquiry will look at all of those and what you say about them but I do want to ask you about two of them, if I may?

A. Yes.

Q. First of all, the CQC and its role with regard to data. You address this at 45.1 of your statement. What do you believe the limitations are with data held specifically by the CQC?

A. I mean, I have, I have referenced in the statement that the notification of patients who are subject to community treatment orders is not mandatory, so those figures are incomplete. But also they do not include patients who weren't detained under the Mental Health Act, including those who died in the community.

The other thing I would make make about CQC data, and as

I say this is well evidenced and has been brought up by INQUEST and others for decades, is that their data also includes a large number of what they call "undetermined". So, you know, I just find it incredulous that you have the CQC, who can provide data with such a gap in terms of the quality of that data, you know, in telling us who is dying and where they are dying.

The other thing, and apologies this wasn't in my statement, but there's also a discrepancy that we have seen between the deaths identified by the Care Quality Commission and those deaths reported to coroners, and I would like to perhaps provide a bit more evidence on that because --

Q. Would you follow up with that evidence?

A. Yes.

Q. Thank you very much. I also wanted to ask you about the Office for National Statistics. This is 45.3 of your statement?

A. Yes.

Q. What is the issue, in INQUEST's view, with the ONS mortality statistics in relation to mental health establishments?

A. I think it is the fact it is qualitative and not quantitative. So it's not disaggregated in respect of

particular trusts or providers, and there's no published information about causes of death or, importantly, protected characteristics and there, I think, you know it's a point I made earlier on, in terms of identifying trends and patterns, in terms of race, gender, you know ethnicity, disability, and also it's only data in relation to deaths within detention.

So, again, the insight into community -- into community deaths is not there.

Q. That does give rise to one question I did want to ask you. You talk, for example, about the ONS data not being disaggregated?

A. Yes.

Q. Clearly INQUEST will have access to information that's in the public domain.

A. Yes.

Q. But is it possible that organisations, such as the ONS, will actually have more data that is not disclosed and is, for example, disaggregated?

A. It may well be. But, I mean, I think there is something really concerning that we have identified all of these different datasets and, yet, we still do not have that comprehensive data set, so that we all know who is dying and where they are dying.

I just -- I find -- I think it's something that has

just not had, I guess it's the kind of political and organisational will to do something in response to the gaps.

Q. Can we pick up on that by going back to your 2015 report, could you put up, please, exhibits bundle page 14560. So this is --

A. Yes.

Q. -- a section of that report from 2015, looking into mental health deaths.

A. Yes.

Q. It is entitled "Collation and publication of statistics". Can we see it says here:

"The current system of publicly-available statistics concerning deaths in mental health settings has developed in an ad hoc way and fails to provide a coherent source of statistical data. The lack of uniform definitions and the difference in approach applied by each body collecting data make it extremely difficult to produce a clear analysis of the figures. The failure to collate key information concerning institution, age, gender, race or crucial features (for example, the use of force) hinders any comprehensive analytical narrative in relation to deaths in mental health settings."

Now, is that picking up on the points you were just

making?

A. Yes.

Q. Can we see then that in bold:

"INQUEST argues that an agreed, coherent set of published statistics is needed which includes all information necessary to provide an overview of the number and features of deaths of mental health inpatients."

A. Yes.

Q. So what did INQUEST have in mind, specifically in relation to the reference to a coherent set of statistics?

A. Well, exactly what we have been talking about, you know, comprehensive data on who is dying and where people are dying and how they are dying disaggregated. I mean, a very stark example of the challenge with this has been we did work on the deaths of children in inpatient settings back in 2016 and we had to -- you know, we had to resort to the use of Freedom of Information Requests because we were aware that the information we had been provided by both the CQC and in response to Parliamentary questions did not reflect the number of families with whom we were working whose children had died in mental health settings.

Now, you know, I do not, I don't think that's

acceptable. We need to we need to know, we need to have that data, and the same argument that we were making then applies today.

Q. You talk about the necessity of it being published, rather than withheld by particular Government Departments or health bodies?

A. Yes.

Q. Thank you. So the deaths in mental health detention report that this comes from is 10 years old. Can we look at more recent information to see to what extent all of this still remains a problem.

Could you take that down, please, and let's look at some more recent reports covering this issue.

Dr Geraldine Strathdee, who was the Chair of this Inquiry when it was in its non-statutory phase, conducted a rapid review into data on mental health inpatient settings and produced an updated final report and recommendations in March last year. You refer to this at paragraph 43.

A. Yes, thank you.

Q. I am going to ask that part of that is put up on your screen. Could you put up exhibits bundle page 14722, please.

Is that 14722? Thank you.

A. Yes.

Q. That's fine. Would you expand the top two paragraphs, please?

So can we see here a section in the Rapid Review Report entitled "Data on deaths in mental health inpatient settings"?

A. Yes.

Q. What I would like to do is look at the second of those two paragraphs, please. It says this:

"We found that there are several organisations that collect and report on deaths of people with mental health problems and on people with a learning disability but that these collections are fragmented, which presents significant challenges in providing an overview of how many people die while in contact with inpatient services and the cause of their deaths. There is no published national overview of the deaths of people in inpatient mental health settings nor of the total number of deaths of people in contact with mental health services at provider level."

Does that reflect the concerns that you have been raising?

A. Absolutely. I mean, we met with the -- we met with the review team and I think it perhaps helps you understand the frustration that INQUEST feels about having raised these issues for such a long time and still we have

a situation where, you know, as recently as last year, the same issues are being flagged up as being important.

I mean, I think the other important thing about the review was that it also said that it needed to improve timeliness, quality and availability of data as well --

Q. Well, it produced a recommendation, didn't it, that more work was needed --

A. Yes.

Q. -- to map the full range of data on death, including what is collected by which organisation and what can be done to improve it.

A. Yes.

Q. Is that a recommendation that you would agree with?

A. Absolutely.

Q. Could you take that down, please. You mentioned HSSIB before, and we are going to come on to look at an HSSIB report now, please. Would you put up, Amanda, exhibits bundle page 14768.

So this is the Health Services Safety Investigations Body report -- it is quite recent, isn't it, from January this year --

A. Yes, yes.

Q. -- called "Mental health inpatient settings: Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days

of discharge."

Could you go, please, that's the front cover, could you go please to page 14778, and could you expand the top two bullet points, the top of the page and the top two bullet points, please.

So we can see here that the report says this:

"Examining the mechanisms that capture data on deaths (and near misses) across the mental health provider landscape, including up to 30 days after discharge.

"There is inconsistency in data reporting. Mental health providers report deaths and near misses in varied ways, using different definitions and methods. This inconsistency makes it difficult to compare data across providers and understand overall trends in patient safety.

"There is not a standardised national system requiring providers to report deaths in the same way. This means that each provider's reports may look different ... "

Would you just expand the next three bullet points:

"... which reduces the reliability of data for understanding patient safety across the board."

Then:

"There is not a single, comprehensive database that

includes all deaths and near misses within mental health services, including those occurring within 30 days after ... discharge. This makes it hard to see the full picture of patient safety outcomes and identify patterns or risks."

A. Yes.

Q. "There is not a central or applied organisation or process effectively overseeing and coordinating data on deaths. This lack of oversight limits the ability to identify systemic issues, reduce duplicated efforts, and drive ... improvements across mental health services."

Are those all points with which you and INQUEST would agree?

A. Yes.

Q. In fact, the report goes on to make a recommendation that:

"The Department of Health and Social Care, working with NHS England and other relevant stakeholders should develop a comprehensive unified dataset, with agreed definitions for recording and reporting deaths in mental health services, to include deaths that occur within a specific time period after discharge."

So the suggestion there is that responsibility for collating and centralising the data should devolve to the Department of Health and Social Care, NHS England

and other key stakeholders. Do you have anything specifically in relation to that suggestion that you would like to say?

A. No. Only that, you know, the similar recommendations have been made before and, you know, I think it's deeply depressing that we are still talking about it.

I would like it say one more thing about HSSIB, in terms of this report and what they recommend just going back to your early question to me regarding the National Oversight Mechanism.

Q. Yes.

A. We have had a number of meetings with HSSIB because they have been doing a number of different investigations and they became the first Government agency to recommend INQUEST's proposal for a National Oversight Mechanism, citing our briefing on the proposal from June '23 in their report.

May I just read out briefly what they have recommended?

Q. Yes.

A. They wrote that:

"HSSIB recommends that the Department of Health and Social Care creates a National Oversight Mechanism that supports coordination, prioritisation and oversight of safety recommendations to implementation across the

system. This is to ensure that recommendations from public inquiries, independent patient safety investigations and other patient safety investigation reports, as well as Prevention of Future Deaths reports from inquests are analysed, monitored and reviewed until their implementation, using a continuous quality improvement approach to learning."

And I think that's just I think that's quite interesting, given that they are the Health Service's safety investigation branch.

Q. Thank you that goes back to your point on the NOM, or the National Oversight Mechanism?

A. Absolutely, so data is, of course, extremely important but then so is the findings from investigations and inquests.

Q. Thank you. I would like to now come on to the last of the topics I want to deal with with you, and it is data that's held by INQUEST in relation to your Essex casework and also learning a little bit more about the national picture?

A. Mm-hm.

Q. You referred before we saw this, it was at paragraph 54, to there being 1,843 cases marked in your system as having been mental health related, and that was across England and Wales over the period that this Inquiry is

covering?
A. Yes.
Q. Have you been able to identify cases having involved the Essex Trusts? This is paragraph 58?
A. Yes.
Q. How many in total have you found?
A. 39.
Q. Can we just break that down a little bit: did you analyse those 39 cases in order to determine which, in your view, came within the Inquiry's Terms of Reference?
A. Yes.
Q. Did you do that by reference to the case files themselves?
A. Mm-hm.
Q. Of those 39, did you conclude that 26 came within the Terms of Reference, the 26 that you have termed Group 1?
A. Yes.
Q. Did you also determine that three further cases were likely to fall within the Terms of Reference and five further cases may do so?
A. Yes.
Q. Those are your Groups 2 and 3?
A. Yes.
Q. In fact, if we add those all up, they come to 34 individuals, and you have referred to 39 Essex cases.

Is it right that, in fact, you and INQUEST determined that those further five didn't fall within the Terms of Reference either for reasons of geography or other reasons?

A. That's correct.

Q. Could we move then to consider the 26 cases that you have determined fall within the Inquiry's Terms of Reference.

Could I ask, Amanda, please, for you to put up core bundle page 188. Would you expand paragraphs 59 and 60. Thank you very much.

So can we see what you have said here, please, Ms Coles, that, in relation to Group 1, so those you have determined do fall within the Terms of Reference:

"In terms of time span, people in Group 1 died between 2008 and 2023. 12 are identified as female ... and 14 as male. 12 people were aged 18-30 when they died, 9 were aged 31-60, and 5 were 61 or older. The youngest was 18 and the eldest was 76. Ethnicity is recorded for 21 of the 26 people, of whom 1 is identified as mixed white and African heritage, and the remainder as white."

Can we see then in your next paragraph, paragraph 60:

"In terms of location, 17 of the 26 people died

during admissions to mental health wards."

A. Yes.

Q. "This includes people who died whilst physically on mental health wards, those who died elsewhere but where the incident leading to their death occurred on the relevant mental health ward, and people who died whilst on leave or after having absconded from the relevant ward. All but 2 of these 17 cases contain information confirming the relevant location ..."

Do you then list the locations as: the Linden Centre for five people; Basildon Hospital for three; Rochford Hospital for two; Broomfield Hospital for one; The Lakes for one; Brockfield House for one; Derwent Centre for one; and St Margaret's Hospital for one.

You refer there in the second or third sentence in paragraph 60 to those who died elsewhere but where the incident leading to their death occurred on the relevant mental health ward. Could you just explain what you meant by that?

A. In terms of that paragraph, just what it says, so there would be some -- there would be some people who will have been on -- given leave from the setting or have absconded from the ward.

Q. I see. So an example would be an absconsion?

A. Yes.

Q. Thank you very much. Could you take that down, please.

I think you go on to say at paragraph 61 that nine of the 26 in this Group 1 died in the community; is that right?

A. Yes, yes.

Q. Similarly, did the further eight people who came within your Groups 2 and 3 also die in the community?

A. Yes.

Q. I just want to acknowledge a part of your statement, please, I don't intend to ask you questions about it.

You refer in your statement, this is paragraphs 70 to 78, to people who died in HMP or Young Offender Institution Chelmsford shortly following release, and also people following contact with Essex Police and, in fact, another police force?

A. Yes.

Q. As I say, I want to just acknowledge that you have provided that information to the Inquiry and I want to say that the Inquiry wants to consider that information in further detail and will be asking you for some further information to allow us to consider to what extent these people fall within our Terms of Reference.

A. Yes, I mean, I think the significance there is in terms of the Trust and the provision of mental health services at the time.

Q. Yes. So can we look now at your paragraph 64.

Would you please put up core bundle page 189, please.

Do we see here:

"INQUEST's involvement in Essex cases demonstrates that most of the common features identified in INQUEST's report in February 2015 ..."

Is that the report we have just been looking at several times, the Deaths in mental health detention report?

A. Yes.

Q. "... and which INQUEST has witnessed nationally, are also apparent in Essex cases ..."

We will come on in a moment to look at those points that you go on to make.

A. Mm-hm.

Q. Could you take that down, please. Are all of the trends that you go on in your statement to outline evident in INQUEST's Essex's casework, specifically Essex?

A. Yes, but they are also familiar to us in terms of the national picture.

Q. National, thank you.

A. Yes.

Q. Would you help us with the trends that you have identified. First of all, can we see at 64.1, "Poor

systems for information sharing and communication", and would you just very briefly explain what you mean by that?

A. I mean, this is such a familiar one. I mean the significance around staff sharing important information about patients, lack of information between different teams involved in an individual's care and poor risk assessments --

Q. That takes us on, doesn't it, actually to your next point --

A. Yes, observations.

Q. -- which is failures in understanding of and compliance with basic policies and procedures including, as you have just said, around risk assessments and observations.

I want to ask you a little bit about the next point, poor recordkeeping including falsification.

A. Yes.

Q. Would you just explain particularly about falsification?

A. I mean, I think -- the situation I think is well known within the Essex context -- but with people just falsifying very significant safety records, so --

Q. You refer actually later in your statement in relation specifically to Essex --

A. Yes.

Q. -- to a high prevalence of falsified observation records?
A. Yes. I mean, if you think about the importance of observations to people who are particularly vulnerable and not least to self-harm and self-inflicted death then, you know, observations are absolutely critical. And of course, you know, it then -- to then see falsification does speak to a very worrying culture, I think.
Q. Well, we'll come on to that perhaps in a moment.
A. Yes.
Q. You also refer to inadequate staffing levels and inappropriate skill mixes --
A. Yes.
Q. -- inadequate levels of clinical oversight; inadequate treatment and response to dual-diagnosis needs --
A. Yes.
Q. -- poor treatment of physical health; high levels of absconsion and poor implementation of missing persons policies; poor communication with families, particularly around care and risk factors; unsafe environments, inadequate emergency medical responses; failures to provide any therapeutic input; Oxevision; lack of autism-specific provision; failures in early intervention; inappropriate follow-up or provision

following presentation at A&E; and inappropriate decisions to discharge patients; and lack of trauma-informed, gender-sensitive and culturally sensitive care, leading to care which is at odds with the person's needs and which can lead to further trauma and harm.

So a wide-ranging group of themes that you set out there?

A. Yes.

Q. There is one that I want to come on to particularly, which you then cover at paragraph 65 and you talk here about a closed culture. You say this, paragraph 65:

"Our organisational experience of the Essex cases has been particularly striking in evidencing the existence of a closed culture within EPUT and its predecessor Trusts."

What do you mean by a closed culture?

A. I mean we have used in here the definition that the CQC uses, which is, you know, around a poor culture that can lead to harm including human rights abuse -- breaches such as abuse, and I think, I think one of the most shocking aspects of our work is the disconnect between what one imagines therapeutic care and support of people who are in distress or experiencing trauma and the reality of their experiences.

Now, I know that the Inquiry has seen the Dispatches programme and I think clearly, you know, that was an extremely disturbing spotlight on a culture that was clearly very unhelpful, and when I say "unhelpful" I mean -- I should have said "unhealthy" in the context of what you would expect.

Q. Can I pick up on that --

A. Yes.

Q. Because you mention Dispatches --

A. Yes.

Q. -- specifically in your statement in connection with abuse.

A. Yes.

Q. But you also mention, and this is at 65.1, lack of compassion or empathy in the delivery of care. Could you expand on that, please?

A. I think the evidence that we have seen that has come out of so many inquests is about the lack of trauma-informed care and support for people who are highly distressed and the kind of cultures of disbelief or seeing behaviour as somehow manipulative or attention seeking. And some, you know, some extremes of that have -- you know, in terms of people believing that somebody's potential kind of dying moments are feigning unconsciousness or just not recognising people's

distress and the staff's desensitisation in having a compassionate response.

Q. Can I ask you about that?

A. Yes.

Q. To what extent does your casework reveal a compassion fatigue amongst staff?

A. I think -- I think it does reveal that. I think too many settings seem to be more concerned with containment and control rather than healing and therapeutic care and recovery and I think there are perhaps some important kind of questions to be asked about how have those cultures developed, you know.

That raises questions about leadership, it raises questions about staff's access to training, to therapeutic support themselves because we know that this is not, this is not easy work. But if their -- if the actual physical environment is not a healthy one then, you know, you then get the corresponding kind of behaviour, but some of the behaviour that we have seen, you know, manifests itself in unnecessary and frequent use of restraint.

Now, my view of that would be if you have a setting that has high levels of the use of restraint that, to me, suggests that's not a healthy therapeutic culture.

Q. Thank you. You have mentioned a number of different

things there.

A. Yes.

Q. First of all, I want to say this. Thank you for explaining the further areas that the Inquiry should be looking at. I can tell you that all of those are captured within our list of issues.

But, is one of the points that we need to be looking beyond the ward and up to the leadership of the Trust to be really getting a full picture of what's going?

A. Yes, absolutely.

Q. The other point I wanted to ask you about is this, I mean, you have mentioned closed culture specifically in the context of Essex or it being a particular issue in Essex. Were the points that you have been making specific to Essex or do they also resonate on a national basis?

A. I think the points I was making were specific to Essex, but I would suggest that many of those points apply nationally.

And I mean that, that -- I think it's important to say that, you know, we've got decades of experience of seeing traumatic experiences of families and their dealings with Trusts and private providers both when their loved one was alive, but then that extends to that closed culture in the conduct of staff and their legal

representatives post-death, and that is the culture I was talking about --

Q. Can I pick up on that, please.

A. Yes.

Q. Could you put up, please, core bundle, page 167 and I would like to end on this, please.

This is your paragraph 21. So can I just read that:

"Although there have been some changes to the availability of data, and to the frameworks governing post-death investigations, the grim reality is that the barriers to improving patient safety following deaths today remain fundamentally the same: there is lack of comprehensive data to allow us to see exactly who is dying and where, and the system for post-death investigation is ill equipped to tell us why ..."

So that is encapsulating two of the main points that you have been making today as I understand it?

A. Yes, and I don't want to kind of underestimate the point about the cultures of defensiveness.

Q. Well, can we come on to that, please --

A. Yes.

Q. -- because this paragraph continues:

"... particularly in circumstances where there is no appetite on the part of the NHS Trust or independent provider to examine deficiencies in their care. And

nowhere has the effect of institutional defensiveness on patient safety been more clearly illustrated than in Essex."

A. Yes.

Q. Can I ask you one technical question. Well, first of all, to what extent does INQUEST's experience extend to private providers?

A. It does. We work -- yes.

Q. Thank you. This picks up on what you have just been saying, I think. But, what is the basis for saying that the effect of institutional defensiveness on patient safety has been most clearly illustrated in Essex?

A. I think through our experience of working with families and viewing the conduct of the Trust and lawyers representing the Trust at inquests, and just seeing how the main focus of those trusts seems -- well, seems to be -- is about protecting their reputation, defending their policies and practices even when they are indefensible.

And rather than being open -- and I think there is something about, you know, in a way, it's about -- you know, a commitment to truth and to social justice requires public institutions to behave honestly and openly and to accept where they have failed, where they have failed in their duties to protect somebody's life

and where they have not provided the therapeutic care that I referred to earlier. And that has been seen in -- I think with Essex's, particularly, lack of issues around -- and I illustrate some of this in my statement -- you know, the lack of disclosure, or late disclosure.

Q. As you have already said about fabrication of evidence?

A. Yes, and, you know, coroners and juries making findings that evidence given by EPUT staff was not, in fact, true. And, I mean, I think, you know, being realistic here, the very fact we are sitting in a statutory public inquiry is because of the lack of candour on the part of, you know, Essex at a senior management level and staff level to cooperate with the previous independent review.

And it's difficult to kind of -- it is difficult to say, you know, how traumatising that is for families, when they are sitting at an inquest which has been given as their opportunity to find out the truth, to hear directly from those in whose care their loved one died and then see legal representatives try and effectively stop a coroner from making a Prevention of Future Deaths report, which is ultimately about trying to safeguard lives in the future.

Q. Thank you.

A. And I find that reprehensible, actually. I think, you know, we are talking here about trying to protect lives and also remember those who have died, where those deaths were preventable and we owe that, really, not only to those who have died but also to their families, and that's not just in the family's interest but it is in the public interest. All of us are impacted by learning and accountability. You know, it is in all of our interests to have that openness and transparency.

MR GRIFFIN: Thank you very much.

Chair, I have no more questions at this point for Ms Coles. Unless you do, may I suggest that we break for 10 minutes and reconvene to see if there is any further questions.

THE CHAIR: Yes.

MR GRIFFIN: Thank you.

(12.45 pm)

(A short break)

(12.58 pm)

MR GRIFFIN: Chair, just a couple more questions for Ms Coles.

THE CHAIR: Yes.

MR GRIFFIN: Ms Coles, we spoke briefly about the duty of candour before the break?

A. Yes.

Q. In your view, and in the view of INQUEST, is that properly being discharged within Essex?
A. No.
Q. Is that for the reasons that you have explained before the break?
A. Yes.
Q. In your view, is the duty of candour properly being discharged on a national basis within mental health trusts?
A. No, and it's one of the reasons why a lot of my statement talks to the culture of defensiveness that we see across the country, the cover-ups that we have seen in some cases and the importance of Hillsborough law in bringing about an enforceable legal duty of candour on public authorities, public servants and corporations who hold responsibility for public safety and, of course, you know, mental health settings are absolutely fundamental to that.
Q. Thank you very much.
My last question is this, you are probably aware of this: there was a House of Lords Select Committee considering the statutory public inquiries, which reported last year and, in fact, there is a Government response from February this year?
A. Yes.

Q. Just coming back to monitoring. One of the issues that was raised before the Select Committee was for a formal implementation monitoring role to be undertaken by a new Joint Select Committee of Parliament, which they termed the Public Inquiries Committee. So you have referred to a National Oversight Mechanism?

A. Yes.

Q. Here we have a slightly different option, as I understand it.

A. Yes.

Q. Could you give us your take on what was being recommended there, please?

A. I mean, I gave evidence alongside somebody from the Institute for Government on that and we listened -- I mean, we considered carefully that recommendation and we would suggest that the independent body would be accountable to a Parliamentary committee but don't believe that the function should be solely aligned to Parliament because of the capacity and changing nature of Select Committee memberships.

So I think we are also talking about -- I mean, the benefit, I think, of a National Oversight Mechanism is that it is concerned with state related deaths, it is concerned with deaths in custody and detention, as well as other deaths that raise questions about state and

corporate accountability, and that that body can better analyse, follow up, produce thematic reports and inform Parliamentary committees.

Q. So you mentioned that it would be answerable to a Select Committee; do you have one in mind?

A. Well, the -- the challenge in that is, of course, that these issues cut across so many different departments. I think we have thought of perhaps the Joint Committee on Human Rights, you may remember that Dame Elish Angiolini conducted a review looking at deaths in and following police custody and she recommended, at the time, an office of Article 2 compliance because she recognised that these were deaths that engaged Article 2 of the Human Rights Act, and I think we were thinking that possibly that committee, if -- and, you know, that's notwithstanding a committee being set up that could have this as part of its function but I don't think that a Select Committee or, you know, Liaison Committee, which they are recommending, is enough.

MR GRIFFIN: Thank you very much.

Chair, do you have any further questions?

THE CHAIR: No. Thank you.

MR GRIFFIN: Those are all the questions for you, Ms Coles. Thank you very much.

THE CHAIR: Thank you so much.

A. Thank you.

MR GRIFFIN: We will rise now until 2.00, please.

(1.03 pm)

(The short adjournment)

(2.02 pm)

THE CHAIR: Mr Griffin.

Statement re Oxevision evidence by MR GRIFFIN

MR GRIFFIN: Chair, before we begin this afternoon's evidence, there is an important matter to be addressed in relation to the evidence the Inquiry was due to hear this Wednesday, 14 May. That evidence relates to the use of Oxevision technology on wards and units operated by EPUT, as well as to the technology more generally, and concerns that have been raised about its use.

The Inquiry was due to hear from three witnesses: Hat Porter, on behalf of the campaign group Stop Oxevision; Laura Cozens, Head of Patient Safety and Quality at Oxehealth Limited; and Zephan Trent, Executive Director of Strategy, Transformation and Digital and Senior Information Risk Officer at EPUT.

The Inquiry had sent to the Trust on 14 March 2025, a request under Rule 9 for a witness statement in relation to various aspects of the Trust's use of Oxevision technology.

That was Rule 9(3)(c). The Trust's response was

a witness statement from Mr Trent, dated 21 March 2025. That statement was disclosed to all Core Participants on 28 March as part of the Inquiry's core bundle of statements for these hearings, and it can be found at pages 1285 to 1313 of that bundle. A number of relevant exhibits were also disclosed to Core Participants.

On 26 March, the Trust was notified that Zephan Trent would be required to attend to give oral evidence during the course of this week. In the witness statement, at paragraph 42, brief reference was made to a review that was then being undertaken, and I quote, "to ensure that the Trust has considered the matters raised in the NHS England document that was published in 2025, 'Principles for using digital technologies in mental health inpatient treatment and care'". That document has also been disclosed to Core Participants and can be found at pages 13660 to 13671 of the exhibits bundle.

While the statement indicated that the Inquiry would be updated about the outcome of the Trust's review, no further information was given. On Wednesday, 6 May (sic), after working hours, the Inquiry's legal team received an email from the Trust's representatives informing us that the Trust would be serving an additional witness statement from Mr Trent that would

provide details of actions taken since the review that he had referred to in his original witness statement. The additional witness statement was not received until mid-morning last Friday, 9 May leaving less than three working days for the Inquiry's legal team to review, process and disclose it to Core Participants and still less time for Core Participants and their legal representatives to review, consider and formulate questions on it under Rule 10 of the Inquiry Rules, and I'll come back to that.

Even a preliminary analysis of the additional statement, which was accompanied by eight exhibits running to over 100 pages, revealed that, far from a review that simply considered the matters raised in the NHS England document I have referred to, the Trust appears to have been in the process of effecting very substantial changes, both operationally and in terms of policy and approach, to the use of Oxevision technology.

The position appears to be a very different one than was set out in the Trust's initial statement just six weeks earlier and that is not just in relation to the question of consent. While the Inquiry's legal team did communicate to both the witnesses and legal representatives for Oxehealth Limited and Stop Oxevision in meetings on the morning of last Friday, that a new

statement from the Trust was to be received, that was of little assistance to those witnesses and their legal teams until the statement was actually received and could be disclosed to them, which was done later in the day.

The new witness statement tells us that the changes set out in relation to the Trust's use of Oxevision were only authorised at board level last Wednesday, on 7 May. The exhibits to the new witness statement demonstrated that, by 10 April, it was clear within EPUT that major policy and procedural change was needed and would occur. Equally, those exhibits make clear that, during the month of April, in relation to those major changes, new training plans were being written, new staff and inpatient briefings were being drafted, new information posters were being prepared and that a new standard operating procedure was to be finalised before the end of April.

The situation is, to say the least, highly unsatisfactory. Whilst that will be a matter for careful examination at a later stage, it's nonetheless difficult to see why, during the month of April, while not only were the Trust's very significant changes to its policies and operating procedures plainly afoot but substantial preparatory and implementation work for

those changes had begun, the Inquiry was not afforded any indication of them.

Chair, having considered the matter with great care, you have decided that, in fairness to all Core Participants, as well as those engaging with the Inquiry, including those to whom the use of Oxevision technology is of importance and concern, it would no longer be appropriate to hear evidence relating to Oxevision this Wednesday, the 14th and that the evidence of all three witnesses from whom the Inquiry had planned to hear will be moved to a later hearing.

That decision has not been taken lightly and, in taking it, you have borne in mind the fact that witnesses, in particular for Stop Oxevision and Oxehealth Limited, were prepared and ready to give their evidence in just two days' time, and that the postponement of this evidence inevitably causes significant disruption and potentially causes distress; the fact that Hat Porter, the witness for Stop Oxevision, wishes to proceed with their evidence this Wednesday, despite the material changes to the Trust's positions.

Chair, you have considered with care submissions provided to you about this. However, in line with your duty under Section 17.3 of the Inquiry's Act 2005, to

act with fairness, you have carefully considered, amongst other things, the extremely late disclosure of these matters and the very limited time therefore afforded to Core Participants, legal representatives and the Inquiry to review and consider them.

In your view, the time is unacceptably short, particularly given the importance and potential impact of the changes revealed by the information in the new witness statement and exhibits, which may give rise to additional questions of fundamental importance, both to the Inquiry and to Core Participants, as well as to Stop Oxevision. May I just expand on that, please?

Chair, in your view, there is insufficient time for the process that would need to follow the receipt of this new evidence: consideration by Core Participants with their clients, formulation of further questions under the Rule 10 procedure to provide to the Counsel to the Inquiry team and for the CTI team then to review them and incorporate them as appropriate in questions for the witness or witnesses on Wednesday. Furthermore, the new information is likely for example to lead to a further request for evidence from EPUT, for example about the extent to which the changed approach and the reasons for it are a commentary on the processes previously adopted, including during the period within

this Inquiry's scope.

Chair, you will also recall that the Trust, in its opening in September last year, expressed a commitment to candid engagement with this Inquiry, approaching the Inquiry in an open, collaborative and supportive way, assisting the Inquiry in its investigations, responding to all requests as fully as it can, doing all that it can to ensure that full and frank evidence is given by its staff, supporting you and your team to give to families, carers and those with lived experience the answers they have been waiting for.

The Trust must now seek to honour those commitments through its actions, not through words or further broad assurances. It will be held to those commitments by this Inquiry, by all those who suffered and by and in full view of the wider public. Thank you.

THE CHAIR: Thank you very much, Mr Griffin.

I want to add that I have considered all the written submissions made to me on this matter with great care and I have also considered the wider circumstances. I am profoundly conscious that some Core Participants may be disappointed with the decision I have made to postpone hearing evidence in relation to Oxevision.

I wish to reassure Core Participants to this Inquiry and the public that the use of Oxevision is and will

remain a matter of significant interest for the Inquiry. My decision to postpone evidence into this area should not be viewed in any way as enabling EPUT to avoid answering questions about its use of Oxevision or to evade responsibility: quite the reverse.

I wish to make it clear that I am extremely dissatisfied with EPUT's late submission of evidence. I have said previously, and I repeat, that I will not hesitate to use my statutory powers to compel evidence should this be required.

Thank you, Mr Griffin.

MR GRIFFIN: Thank you, Chair. I now hand over to my colleague, Ms Harris, and this afternoon's witness.

MS HARRIS: Thank you, Chair.

We now move to a slightly different area of evidence and that is evidence that is going to provide an overview of how mental health services were being provided by EPUT during the relevant period, and to some extent now, and we will begin by looking at a topic of pre-admission assessments and so, that having been said, I think we have got ready and waiting Dr Karale, who will, I think, be sworn to start off with. Thank you very much.

DR MILIND KARALE (affirmed)

Questioned by MS HARRIS

MS HARRIS: Please can you state your full name for the record.

A. It is Milind Ramkrishna Karale.

Q. Dr Karale, you are the Executive Medical Director at Essex Partnership University NHS Foundation Trust, that we also know as EPUT?

A. That's correct. Can I -- Chair, before I give my evidence, I would like to offer my personal condolences to the families for the loss and apology for the poor quality of care they have received. Thank you.

Q. Going back to your position then, Dr Karale, you have held that position within the Trust and its predecessor, SEPT, since 2012?

A. That's correct.

Q. Your portfolio includes medical leadership, managing medical directorate, Caldicott Guardian responsibilities and research?

A. That's right.

Q. You are also what is known as the Responsible Officer for the purposes of revalidation of doctors. In short, you ensure that doctors working within the Trust are fit to practise from EPUT's perspective --

A. That's correct.

Q. -- and you provide information to the General Medical Council, if required?

A. That's correct.
Q. You report directly to Paul Scott, EPUT's Chief Executive Officer?
A. That's correct.
Q. You are also a consultant psychiatrist?
A. That's correct.
Q. By way of background, as part of its work, and you will be familiar with this, the Inquiry sent a Rule 9 request to EPUT for evidence about pre-admission mental health assessments and, when EPUT received that request for evidence, it was you that made a witness statement to the Inquiry on behalf of EPUT to provide the information?
A. That's correct.
Q. For anyone following by way of documentation, that statement begins at page 1032 of the core bundle, which was disclosed for the purposes of this hearing, and that statement will be published in due course.

Do you have a copy of that witness statement in front of you?
A. I do. Chair, I would -- sorry, I would also like to say that I have relied on other colleagues for gathering this information and I may not have in-depth knowledge of all aspects of the evidence that's been provided.
THE CHAIR: You can point that out to Ms Harris as we go

along.

MS HARRIS: Thank you, Chair, and if, for some reason, I haven't made that clear or it's not clear please do make clear when you have relied on the information of others.

Your statement, I think, is 64 pages long, it is dated 25 March this year and, at page 60 of that statement, or page 1091 of the core bundle, you make a statement of truth and you have signed it?

A. That's correct.

Q. I understand that there are two minor corrections you would like to make to the statement and I will ask you to identify those when we get to the relevant part they both, in fact, relate to your evidence about mixed-sex wards?

A. That's correct.

Q. Do you ask that this statement be taken as your evidence to the Inquiry at this stage?

A. Yes.

Q. Let me make this clear. Although I am going to ask you questions about it, I am not going to take you through it line by line and we may jump around, and we will pick up on issues and matters of interest and concern to the participants but your statement and the exhibits with it -- and there were 42, is that right --

A. That's correct.
Q. -- will all form part of the evidence for this Inquiry to be considered by the Chair in due course. So, in short, I am acknowledging that you have covered in your statement more than we will necessarily deal with in oral evidence.

Also, by way of background, are you aware that last Thursday the Inquiry heard evidence from two experts, a consultant psychiatrist and a senior nurse?
A. Yes, I'm aware of that.
Q. They gave evidence at high level of what constitutes good care for mental health inpatients and they gave evidence of the key principles and standards for the delivery of that care. But the request made to EPUT was a different one. Can you confirm it was a request for a broad explanation of the forms of mental health assessment that EPUT's patients received over the relevant period --
A. That's right.
Q. -- and it was a request for an understanding of the guidance, policies and other documents that apply to those assessments?
A. That's right.
Q. Your evidence this afternoon will therefore focus on pre-admission assessments undertaken by EPUT during the

relevant period, the arrangements in place and, where you have provided it, the relevant documentation.

Can I ask you, or begin by asking you a preliminary question about your statement and this is a general to step back, please, and just consider your statement in its form. Would you agree that at some points your statement might be considered or read as aspirational; do you know what I mean by that?

A. I understand what you are saying.

It would be helpful if while going through the statement, if there are certain areas you feel are aspirational, I am happy to comment on those.

Q. Perhaps I should make it more clear, please forgive me: I mean certain areas, and we will look at them, where you set out what processes should be -- apologies -- sometimes setting out what processes should be and what should happen, as opposed to what might actually have happened; do you understand what I mean?

A. Yes, yes.

Q. All right. At paragraph 10 of your statement, you start your evidence, in effect, with the following two statements: the first, that an assessment of a patient is a dynamic process and occurs at every contact with a healthcare professional, including planned, unplanned, formal or informal contact; do you see that?

A. That's correct.
Q. Also, that mental health assessments are, therefore, a skilled and often very complex process?
A. That's my opinion.
Q. So do we take -- you have answered my next question -- that, in your view and experience, some form of assessment takes place whenever a healthcare professional engages with a patient?
A. That's correct. We heard from Dr Davidson as well last week that every interaction is some form of assessment, may not be a formal assessment, but a clinician who sees a patient undertakes some assessment -- some form of assessment.
Q. Those assessments can be complex?
A. That's true.
Q. You also state that it involves identifying social and psychological factors contributing or leading to the presentation as the professional tries to understand how each of these elements influences the person's mental well-being?
A. Yes.
Q. These factors would include, for example, neurodevelopmental conditions, such as autism, for example?
A. That's correct.

Q. For the record, from paragraph 10 to paragraph 14 of your statement, you go on to set out further issues to be taken into account when undertaking an assessment of an individual's mental health and you acknowledge in your paragraph 14, do you agree, that the process of an assessment becomes more formal at the point of a referral being made to a service?

A. That's correct.

Q. The purpose of your first witness statement, as we have outlined to this Inquiry, was to provide an overview of how assessments were undertaken in practise at EPUT and, to some extent, the position now. Can we begin, please, by putting up paragraph 15 of Dr Karale's statement, you can have a look at it, it is at page 1036 of the core bundle.

There you say, at paragraph 15:

"Assessment documents are used to seek and document the clinical understanding of a patient's presenting problem, clinical history and trigger(s), family history, personal history, past psychiatric, medical history, substance misuse history, medication, social situation, forensic history, mental state examination and risk assessment. As part of the assessment process, the clinician will consider the patient's mental capacity to make informed decisions of the outcome and

pathways to follow the assessment. To inform the assessment, additional tools may be used which are dependent upon the patient's presenting concern and needs. These are utilised in addition to the Trust's requirement of a risk assessment document approved for use within the Trust records systems. Regarding risk assessment, a comprehensive history, eliciting various risk and mitigating factors, along with a detailed mental state examination, is key in understanding the risks and formulating a risk management plan."

Can I ask you some questions about that paragraph, please --

A. Please.

Q. -- which sets out, in one go, the position.

When you say or refer to assessment documents at the beginning, what are you talking about there?

A. So in order to undertake to gather the information in a structured manner, the Trust has certain forms to undertake a core assessment. So we have two major record systems, the Mobius and Paris, and the two core psychiatric assessment forms, 2.1 on Mobius and V6 on Paris, capture all the headings which you read out just now, so that the information is gathered in a structured manner.

Q. When you refer to "additional tools" what are you

referring to?

A. So this is the core psychiatric assessment to understand patient's psychiatric presentation. There are additional tools, which are used by certain specialities, for example, in old age services, in order to decide where a patient gets admitted frailty is an important component, and to understand the level of frailty, a frailty tool might be used.

So there are other tools which add to the core assessment but the core assessment is the main psychiatric assessment that's undertaken.

Q. In relation to your reference to risk assessment documents, can you explain what those are, please?

A. So my personal view is a comprehensive psychiatric assessment is a risk assessment. There are brief risk assessment tools but, in EPUT, what we have done on our -- the two main assessment forms is we have included the risk assessment at the bottom of the assessment forms, so they are not separated, we expect the clinicians to undertake a comprehensive assessment and then provide a formulation at the end.

If I can -- because it can't -- it is -- risk assessment, as we heard last week, can't be a form-filling exercise. I am happy to illustrate that with an example.

Q. Perhaps we will come back to that but it may be that you can help us with this. Are there specific documents that are required, then, for use within the Trust's record systems?

A. So, longitudinally, the forms have also evolved as I have shown in my statement. Currently, the risk assessment is part of the comprehensive assessment. There are other brief risk assessment tools, which are undertaken when someone is leaving the ward, where -- on a leave because the assessment's already been undertaken, and that assessment of risk is for a specific purpose. There are other risks -- could be -- it is a huge term. In forensic services, if they are assessing a risk of arson, there would be specific risk assessment tools for assessing the risk of arson; likewise there would be specific risk assessment tools for assessing the risk of aggression and violence are mentioned, HCR-20. So there are various risk assessment tools for various purposes but when you talk about a core psychiatric assessment leading to an understanding of a person's risk in context of the mental illness, we rely on that initial assessment form.

Q. So again, just to be clear, is there a specific, then, risk assessment document formulated by the Trust which is approved for use within your system?

A. There is. It is -- and it covers broad headings: risk to self; risk of self-harm; risk of suicide; risk of aggression and violence; risk of neglect. So there are various headings. What we have done is we have not made it a tick-box exercise. These are areas -- indicators of which areas a person needs to be mindful of, depending on the presentation.

Risk assessment forms, as we heard last week, can never be tick-box exercises. They are just a way of guiding a clinician as to what areas they need to cover when -- in gathering information.

Q. Is an audit carried out then? I am not asking for any results or outcomes, but does the Trust then audit the use of this risk assessment document?

A. Risk assessment documents are audited.

Q. We will come --

A. However, can I add, as we heard last week, that it is the quality of the assessment that's important, rather than risk assessment forms and, as Dr Davidson mentioned, health services have been far pre-occupied with the risk assessment tools.

We try to make it more as an area where an assessment can be documented. For example, if a person attends or comes -- is seen following an overdose, it is important to understand -- it's

understanding the person and the circumstances. How long has the person been contemplating about it; what led to; did the person took an overdose inside the house or drove five miles away into the bush to take an overdose; did he seek help afterwards; did he make any final acts? This is a conversation. You cannot get that information by filling a form.

How does the person feel now; is he relieved that someone has listened and help is available; or the person still feels actively suicidal? So that forms the risk assessment.

Q. We will come back a little bit to risk assessment and assessment, in due course, but, just dealing with this paragraph further. There's reference within it to mental capacity and assessment of mental capacity is vital because it dictates the path a patient's treatment might take?

A. It is more relevant in certain specialities, as we know capacity as a person is taken to have capacity and is capacity specific but in elderly care services, where dementia -- where capacity is an issue, this becomes more relevant.

Q. Do you agree then, using that, perhaps, the last example as an example, that the involvement in family and carers at that point, in the assessment of mental capacity, is

of fundamental importance, if that information is available?

A. Absolutely. Family involvement is essential in -- wherever possible, in every assessment.

Q. Put shortly, how is capacity assessed?

A. Capacity is topic specific, it is matter specific and should be undertaken by a person who is either undertaking the procedural assessment: so whether the person understands the question; is he able to weigh the pros and cons of that particular decision, whether to stay on the ward or get admitted or not get admitted; whether he can retain the information that's provided; and he can convey that information.

So there are several steps, formal steps, that are undertaken. But we -- capacity, it is assumed that a person has a capacity. One should never assume that a person lacks capacity, unless there are indicators and then you need to undertake a formal assessment.

Q. It is obviously a very difficult area. How important are consultant leadership, for example, or peer review, talking to colleagues, in assessing a patient's capacity?

A. As I mentioned, capacity is for a specific condition, treatment, purpose. If the capacity is for a procedure the person who is undertaking that procedure, who knows

that procedure, is best placed to explain that procedure and see whether the person understands that procedure, can -- against the steps where they will weigh and pros and cons of not agreeing to that procedure.

So the person who is undertaking the capacity for a specific purpose needs to have a knowledge of the particular task that's -- or the point in the matter in question.

Q. Is that person encouraged or are professionals encouraged to discuss those sorts of matters with colleagues?

A. Certainly, yes.

Q. We will return to the question of documents and recordkeeping in a while but, in relation to pre-admission assessments and undertaking those assessments, or EPUT undertaking those assessments over the relevant period, you explain in your statement that the requirements for an assessment have "evolved", I think is the word you would use.

You explain that there have been changes that are apparent from the policies that you have provided, and we will look at one or two of them in a moment, and you have set those changes out in your statement. You do note, however, for the record, at your paragraph 17, that a generic assessment, you say, undertaken by

psychiatrists has followed the same structure for a number of years, as guided by the Royal College of Psychiatrists?

A. That's correct.

Q. Can we consider then the policy and procedure that you refer to in your statement, that you indicate was governing and guiding EPUT's delivery of mental health care, including pre-admission assessment, which is what we are dealing with this afternoon, over the relevant period.

I think you would agree that your statement focuses very closely on the Care Programme Approach?

A. That was the national document guiding the assessments and the care planning at ...

Q. I think it's also known in shorthand as the CPA -- is that right -- so we can perhaps call it the CPA? Dr Davidson gave evidence about the CPA last week, you will be aware, and it's also set out in broad terms in many of the documents you have provided.

But can we have a look, please, at what you say about it and can we put up paragraph 45 of Dr Karale's statement, which is at 1050.

Just to set the scene, although most will know about it:

"The Care Programme Approach (CPA) was introduced by

the Department of Health in 1991 to provide a framework for effective mental health care. As an overview, it provides a process which describes the approach used in mental health services to assess, develop a personalised care plan, manage risk, review and coordinate care and support in order to address the needs of people requiring the expertise of a secondary mental health services."

So pausing for a moment, and hopefully I don't summarise this inaccurately, but if the Inquiry understands your witness statement and what you have just said and the documents you have provided, the CPA was or is -- we will come back to that in a moment -- the approach taken by EPUT throughout an individual's contact and engagement with mental health services and, by that, I mean right from first contact, referral or assessment, through any care provided in the community to the services provided to an individual as an inpatient through to discharge and beyond, that approach applies throughout?

A. That's right.

Q. The Inquiry understands from the evidence that there are criteria to be met before care is provided to a patient in accordance with the CPA?

A. That's correct.

Q. We will come to that in a moment. I think the slide can go down now, thank you, Amanda. There are two levels of CPA: standard and enhanced?

A. There used to be two levels of CPA. CPA underwent a change, they realised that standard and enhanced created a two-tier system. What it meant was that people or patients who were on enhanced CPA had a care coordinator, and they had defined which patients were eligible for enhanced CPA were more complex presentations, more than one agency requiring input, and so forth; and standard CPA is where only one agency was involved. Most of the patients in the outpatient clinics were standard CPAs but CPA has moved away from either you are on a CPA or not on a CPA.

THE CHAIR: When did that happen?

A. That happened, exactly I don't remember. I think it is 2026 (sic), around that time.

THE CHAIR: 2016?

A. 2016.

THE CHAIR: Thank you.

MS HARRIS: Thank you, Chair. We will go back because obviously this Inquiry is concerned with how care was being provided over the relevant period, so back to 2000, but there were four or there are four main elements to the CPA, which are, I think, as follows:

systematic arrangements for assessing the health and social care needs of people accepted into specialist mental health services; and then, secondly, the formation of a care plan, and a care plan, we heard in evidence, should follow the patient; the appointment of a care coordinator, that is key, I think, we will come back to that in a moment --

A. Yes.

Q. -- and regular review and, where necessary, agreed changes to the care plan. Those were --

A. That's correct.

Q. -- the four principles. Now, dealing with the relevant period, it would appear -- and we will look at it in a moment -- from the evidence that you provided that EPUT and its predecessor trusts, I am going to call them SEPT and NEPT, if that's all right, have provided mental health care and services in accordance with the CPA throughout the relevant period, the period that this Inquiry is concerned with; is that right, 2000 to 2023?

A. Yes, as per the evidence. I have not had any involvement with NEPT, so I am relying on documents. But SEPT I've seen CPA being implemented since I have been in SEPT and EPUT.

Q. I think that's why I explained that part of that is from the documents that you have provided. We will look at

them in a moment.

The CPA applies to all adults of working age in contact with mental health services?

A. That's -- the patient may have a very brief interaction with the mental health services and may not be on a CPA. It doesn't -- in my understanding, it doesn't apply to everyone -- patients when they come into mental health services and they are with the Community Mental Health Team or have an inpatient, they then go on a CPA. A brief assessment does not mean that a patient will be on a CPA. Patients could be referred -- for example, neurodiversity assessments, they have their assessment and they get a diagnosis or not and they are discharged. That patient will not go on CPA, so there are certain --

Q. Perhaps it was my question: should I have said all adults who met the criteria?

A. Yes.

Q. Although I think it is right to say that its principles throughout the period have applied to younger people and older adults as well?

A. That's right.

Q. All right. Let's just look then, please, at what was provided or the approach that was provided. Can we start with SEPT and, again, I am not going to take you through all of this documentation, we would be here for

a long time if I did, but you set out that SEPT's -- or the first version you can locate of the CPA handbook is dated July 2003, so that's not the beginning but early on in the period with which the Inquiry is concerned.

Please can we put up MK-2, which is at page 7300, I believe. I think that's just the top of it, I am not sure if we can zoom out a little bit. If not, I think we can probably see that.

So that's the very first version that you have located, I think, that people can see that. It's dated July 2003. This is a handbook. I don't know if people can make it out but we see reference on the bottom of the page that the document has been produced by the CPA Steering Group; do you see that, Dr Karale?

A. Yes.

Q. Who are they, please, or what are they or what is that: the CPA Steering Group?

A. I will have to get back to you on that, I am not -- this is way before my time.

Q. Is there a CPA Steering Group in existence now or was there in the latter period?

A. Not that I am aware of.

Q. Okay. I think we can move very briefly through the slides. If we look at 7301, on the left-hand side I think we can see it actually it is the page

underneath. That's the background. I think if we look down to the next page, 7302, I'm not sure if that's possible. Thank you.

I am not going to go through it in detail but we see the "Purpose of this handbook" is on the left-hand side and we see there this is back in 2003, the criteria then for acceptance onto the CPA.

If we look down to 7304, please -- again, I appreciate this is early on in the period, this is in 2003 -- we see "Assessment" is dealt with at the left-hand side of the page, which you replicate at your paragraph 19, which:

"The purpose of undertaking an initial assessment/screening of a service user's circumstances is to determine whether intervention from the mental health services is considered appropriate.

"Where the criteria for the [CPA] is met, a full holistic health and social care assessment must be undertaken to determine the following:

"Areas of need/difficulties, including level of risk

"Strengths and abilities of the service user

"Identify the service user's CPA level of need [and of course this was when there was standard or enhanced]

"Identify the need for specialist assessments."

Then it goes on to deal with how:

"The assessment process must be thorough and comprehensive and that the practitioner undertaking the assessment must ensure that the service user and carer, where appropriate, are central to the process."

So right from the beginning of the period, we can see documents acknowledging the importance of families and carers and their input.

We see on the right-hand side, "Risk Assessment and the Management of Risk". Again, I am not going to read this all out but we can see that it says:

"Risk assessment is an essential and ongoing part of the CPA process. Risk must be clearly documented and reviewed regularly. Risk management is regarded as ongoing process."

There it lists examples of risk: self-harm; suicide; violence to others; and other types of risk are listed; self neglect; exploitation, are all outlined there.

On page 7305, I think, if we look at that briefly, please, there is reference there -- thank you -- to the "Risk Profile Tool", which was to be completed in the following circumstances:

"For those clients who meet the criteria for 'Enhanced' CPA status [and we see]

"On admission to hospital and/or prior to discharge ...

"At the practitioner's discretion; if doubt, complete the risk profile.

"The completion of the Risk Profile Tool will supplement the CPA Contingency Plan."

Now, I am not going to suggest we go through the handbook in detail. But it goes on to describe, I think, the processes and requirements for those admitted as inpatients through to discharge and, whilst we are dealing in this evidence session with pre-admission assessments, we know, as we have already identified, that the CPA approach would apply for the whole of the inpatient pathway.

So that was back in 2003 and that was the handbook. The corresponding CPA policy is your exhibit MK-16, which we have, if I am right, please, at page 7571.

Can I just ask you a question: so this is the policy, the CPA policy, we see at the top "CLP30", we will get used to that reference from 2003. Can I just ask you about paragraph 1.3, which says that:

"The CPA forms, guidance and audit tools introduced with this policy and procedure provide a more consistent framework for the delivery and monitoring of the [CPA]. But it is important to emphasise that CPA is a framework for good practice and a way of working, not just a new set of documents and forms. The ability of individual

practitioners to communicate clearly with each other, work in partnership with service users and carers and use sound professional judgement and skills are crucial to its success."

Now, appreciating that you weren't working in SEPT in 2003, are you able to tell us what the forms and guidance and audit forms consisted of back in 2003?

A. I'll have to get back to you on this one.

Q. It's not, I think, any of the documentation that you have been able to provide.

I think, if we can take that down, please, thank you, Amanda.

Your statement follows the development then of the CPA from EPUT's perspective through that period, so you have provided SEPT documents from 2006 and, again, I am not going to take us through all of them but please can we put up the SEPT CPA policy, dated September 2006, which is your MK-4, which is 7327, please.

Thank you very much.

Again, I just want to ask you about one or two aspects of this document, we can see it is an updated CLP30 and it sets out at the beginning a "Controls Assurance Statement" and an "Introduction" sets out that it applies to all service users with a mental illness or who are in a mental health crisis in contact with

secondary mental health services, both health and social care, and that it's not dependent on the setting in which care is provided and it is just as relevant to people with mental health problems in prisons, in residential care, supported housing, nursing homes, secure units or in hospitals, as it is those living independently.

A. Correct.

Q. So it is very broadly applied. It says at 1.2:

"The Trust will provide a set of standardised CPA processes and, where necessary, accompanying documentation, which will be used by Adult Mental Health Services. In order to ensure consistency, best practice and continuity, this documentation will be approved and managed by the CPA Steering Group."

But that's not a group with which you are familiar, you tell us?

A. No.

Q. Then looking at 1.3, please, it says:

"Services such as Older People, Children, Forensic, Drug and Alcohol, Learning Disabilities and Inpatients will require service-appropriate assessment, care planning and review documentation. All documentation will be approved centrally by the CPA Steering Group in order to ensure compatibility."

Are you aware, in this period, of any of that separate documentation that applies to those different groups or specialist assessments?

A. I am not aware but I can understand the reason why they would want to have a specialist CPA forms for different services.

Q. I am going to come back to that in a moment but, in terms of that documentation, that's, as I say, not something that you have been able to provide and, again, you are not sure what the CPA Steering Group was?

Can I just ask that we look at one or two features of the assessment section which is at 7328. In fact, can we look at paragraph 3.1, which is also set out in your paragraph 21.

It's been suggested, actually, because it is small, can we expand paragraph 3.1, Amanda. It might help with viewing, please.

Meanwhile, I will, I think, read it in any event:

"All persons assessed by the Clinical Assessment Service [I will come back to that in a moment] will receive a Core Assessment which will include Mental Health, Physical Health, Medication, Substance Misuse, Learning Disabilities, Forensic History, Cultural and Spiritual Needs, Relationships, Carers Needs, Housing Finance, Employment, Education and Networks.

"All persons referred for a medical opinion or psychology services will be assessed in accordance with their specialist practice.

"It is expected that all assessments will adhere to the principles of Social Inclusion."

Thank you and can we move on to 3.4, which is further down the page, please. It just underlines that:

"Risk assessment is integrated into the assessment processes at all stages. Therefore where risks are identified the management of these risks will be addressed in the care plan", at that time whether it was standard or enhanced?

A. Yes.

Q. CLP30 was to be read in conjunction with the corresponding policy regarding clinical risk assessment and management and, again, can we just look briefly please at your MK-3 which is page 7319. I just want -- there it is -- to identify it as 2006. This is the "Clinical Procedural Guidelines" and it indicates in the bottom of the first paragraph that:

"These guidelines should be read in conjunction with associated Trust policies: Serious Untoward Incidents, Accident & Incident Reporting, Care Programme Approach", which is what we have just looked at.

At 1.1, they identify the principles of

managing risk.

But can we have a look, please, over the page, at paragraph 4.4 on 7320:

"Risk assessment and the management of risk is a fundamental principle within the Care Programme Approach ... see policy CLP30. This includes the management of handing over and discontinuation of care between professionals."

Can I just ask you very briefly about that. We heard some evidence about it from Dr Davidson last week. That's an area of particular difficulty, isn't it, when you are transferring care; that's when information gets lost?

A. Yes, and that's one of the reasons why, if we look at the CPA document, it stipulates where a CPA review needs to take place, as a rule every six months, but if a person is being -- if a patient is being transferred from one service to another, or being discharged from inpatient unit into the community, or moving out-of-area, so there were certain transition points where it was identified that the risks of either a relapse or a discontinuation are higher, that a CPA review and a risk assessment as part of the CPA review should be undertaken. I think that was the purpose of that particular statement.

Q. Again, I won't read them out but, if we look at 7321, we see the section in relation to "Assessing Risk" and the elements of risk that are listed -- again, I won't read them out -- at 5.1 and 5.2.

I think that can come down, please, Amanda. Thank you.

Can I just ask you very briefly about those being treated in the relevant period for whom care was provided under the CPA, as opposed to those who were considered non-CPA. We have already heard and noted that there were criteria to be met for a patient to be treated under the CPA. But there would have been many patients who didn't meet that criteria, and I think you have identified a SEPT handbook from 2009 -- or two, one from May and one from September 2009 -- that deals with that.

It's right, I think, that non -- sorry, I should say could we look at page 7356, Amanda, maybe. This is your MK-7. I just want to look at 1.2.2. I think it's my fault I have given the reference 7360 as a later reference but it is 73 ...

THE CHAIR: Is that it?

MS HARRIS: It isn't but I can perhaps just read the relevant sentence. We will come onto that in a moment:

"Non-CPA applies to service users with a mental

illness or who are in a mental health crisis but do not have the higher risks and complex clinical symptoms or care management requiring multi agency intervention with care coordination."

A. And that was the distinction between an enhanced and a standard CPA.

Q. I think we can turn, sorry, to NEPT, please, and we note from paragraph 26 of your witness statement, that NEPT had similar provisions. You provided the Inquiry with a copy of a NEPT CPA policy, dated March 2007, and could we put up a copy of that policy. It's your MK-8 and it starts at our 7365. Thank you.

As we understand your evidence, that's the earliest document that it was possible to retrieve from NEPT; is that right?

A. Yes.

Q. Its approval date was March 2007, with a review date of 2008. But just in terms of what was going on at NEPT in the relevant period, if we look at page 7372, could we look at paragraphs 8.1 and 8.2, in relation to assessment?

A. Yes.

Q. It says that:

"All mental health service users will receive a comprehensive holistic assessment of their mental

health and social care needs. This should be carried out by a professionally qualified member of the mental health team and must always include an assessment of risk.

"The agreed Trust wide multi-disciplinary CPA assessment and CPA Assessment guidelines should be used."

I am asked to clarify this because this is replicated at paragraph 27 of your statement. When it says "All mental health service users will receive a comprehensive holistic assessment of their mental health and social care needs", that means they will undergo an assessment, not that they will receive a document or anything of that nature?

A. Yes, I think the core element of CPA was that, if a patient requires an assessment, assessment should be offered and most -- and there was a process of referral screening or initial screening to see whether the patient met the criteria. Things were slightly different at the time when services were defined as mental health services providing services for patients with severe and enduring mental illnesses, so there were certain criteria. Primary carers tried antidepressants for a duration of time before -- so the initial screening was to -- was undertaken to see whether the

person met the requirements for an assessment and, based on that assessment, that the patient qualified for subsequent treatment.

Q. If we look in terms of what again what NEPT were doing in the relevant period, can we just look at the top of the next page, please, 7373, 8.4 and 8.5, it says:

"Assessments must identify service users' strengths, skills and ability and must identify what is required to promote recovery. The assessment should take into account service users' own beliefs and opinions about their mental health issues."

It then goes on to say:

"Assessments of needs should identify all aspects where specific support and further assessments are required", and then it gives a list there of the aspects that should be considered.

At 8.6, there is an example of the types of specialist assessments that may be required; is that right?

Can I just ask that we go to 7374, please, which is the section on "Risk Assessment", and it says, "Please refer to the Trust's Clinical Risk Management Protocol"; do you see that? It says:

"Risk assessment is an essential and ongoing part of the CPA process and there must be a specific assessment

of the level of risk posed to self and/or others using the Trust's approved risk assessment tool.

"Risk assessments should take into account all of the available information from the service user and other sources, such as GP, carers, family members, other professionals and agencies who have knowledge of the individual."

Again, it lists at 9.4 that:

"Risk assessments should include an estimation of the degree of risk presented in respect of", and gives a list of indicators or things that should be considered.

Can I ask this: has it not been possible to identify or locate the Trust's Clinical Risk Management Protocol from that time?

A. I relied on people to gather information.

Q. All right.

A. I can -- I can take it back and see whether they can locate the required protocol.

Q. Just finishing the chronology, that was reviewed in April 2009, I am not going to ask us to look at it -- that can come down, thank you, Amanda -- and you set out the additions at paragraph 28 of your statement. It was reviewed again in July 2012 and you set out the additions at paragraph 29 of your statement. So that's

what SEPT and NEPT were doing.

EPUT, we know, was formed in 2017 and, at your paragraph 30, you explain how the CPA Policy documents from SEPT and NEPT, you say, were reviewed and harmonised. Can we look, please, quickly at MK-11, at page 7488 -- or 196, I think, Amanda, internally.

If we see the top of that document, we can see that which you have described, and I am looking at the top right-hand of the table:

"The Care Programme Approach Policy and Procedure has been harmonised and reviewed following the merger of SEPT and NEPT to ensure it is fit for purpose for the new organisation."

Can we please now look at 7491. We note there the introduction about the Care Programme Approach and, at 1.2 that it's the framework and what it's intended to do. Do we notice at 1.3 that:

"The patient/carer is put at the centre of care planning and delivery."

That was the point of it?

A. Yes, that is right.

Q. We see this is EPUT's first document following the merger and at 2.1 it explains how:

"Following the initial assessment, service users will be placed on either CPA or non-CPA", and that's

a clinical decision?

A. That's right.

Q. It sets out the differences there between CPA and non-CPA, which we have touched on.

Can we go over the page, please, to 7492, and confirm at 2.2 that:

"CPA or non-CPA is applicable to all individuals (adults, older adults and younger people) receiving secondary mental health services in whatever setting that care is delivered."

And that at 2.3:

"The following key groups will automatically be considered to require the support of CPA ..."

The top bullet point is those "Who are admitted to a mental health hospital as an inpatient"?

A. That's correct.

Q. If we --

THE CHAIR: What is the date of this, again?

MS HARRIS: This is 2017, this is the first EPUT CPA policy after the merger, Chair.

If we look at the bottom of the page, 7492, "CPA Process" deals with the referrals and acknowledges -- and we will come to this in a moment -- that they are received from a range of sources, and all sorts of sources are listed there. It sets out the components at

3.2 and, for the purposes of this afternoon, we can see that it applies to assessing and risk assessing.

Over the page at 7493, we see some of the language now being merged from the previous policies we have looked at, SEPT and NEPT, as you have said. At 3.3, at the top:

"Those accepted for assessment will receive a comprehensive holistic assessment of their mental and physical health and social care needs (in line with the Care Act) and this must always include an assessment of risk."

At 3.4:

"Risk assessment is an essential ongoing part of the CPA process and there must be a specific assessment of the level of risk posed to self and/or others using the Trust's approved risk assessment tool."

In the corresponding procedure, which is your MK-12, which is at page 7498 -- sorry, it starts at 7495 but could we look please at 7498 -- perhaps important to note at the bottom of 7498 "What is an assessment?":

"The assessment is the starting point for all patient care."

No doubt you share that sentiment?

A. That is right.

Q. It's a very important aspect. 7500, please. Is there

a table which you have set out in your statement --

A. Yes.

Q. -- there we go -- of everything that should be taken into account as part of the assessment? Again, I won't go through that.

So, again, understanding the position correctly, CPA carried on applying to all mental health assessments in the relevant period after the merger of EPUT?

A. (The witness nodded)

Q. You complete the picture -- and then I promise we will leave the documents alone for a while -- by providing MK-13, which I think is the most recent EPUT CPA policy and procedure. That's page 7517, please.

We see that's the EPUT CPA policy. If we look at the "Policy Summary", it says:

"[It] outlines the implementation of the Care Programme Approach and Non-CPA for Essex Partnership University NHS Foundation Trust. The policy must be applied together with other relevant legislation, and should be read in conjunction with the CPA Procedure which provides detailed reference for staff and advice regarding care under CPA and non-CPA."

It goes on to explain again what the CPA is but do we see that this document is next due for review in March 2026?

A. That's right, yes.
Q. So this is still of application?
A. Still of application.
Q. That's the policy and, if we look very briefly at page 7524, do we see the corresponding procedure, which again has a review date, this time of May 2026?
A. That's correct. Yes.
Q. So that's where we are now, is it, as far as EPUT is concerned?
A. That's right.
Q. Before I move on -- sorry, that can come down, thank you, Amanda, and that's the majority of that documentation -- what role has the CPA played in other assessments during the relevant period and, by that, I mean gatekeeping assessments or Mental Health Act assessments or specialist assessments?
A. I think CPA has been the cornerstone for the assessments. It is a national document, which is domestic which has dictated, the care, the treatment and the initial assessments.

So the other services have developed their own specialist assessments but based on the CPA principles.
Q. In providing your statement to the Inquiry, and in providing the documentation, you have only provided CPA or non-CPA documentation. In answer to one of my

questions a while ago, you explained that you would understand why the other specialist assessments or different assessments would have their own documentation. Is there some reason why we haven't got that documentation? Is there other documentation for the other assessments?

A. So, the -- I have included some specialist assessments -- some information on specialist assessments in my statement.

Q. You have?

A. So assessment for -- an autism assessment would be a completely different assessment, and assessment for ADHD would be a different assessment, eating disorder services would have their own different assessments. So these are not overall psychiatric sort of assessments. They are specialist assessments for specialist purposes.

Q. What about gatekeeping assessments?

A. Gatekeeping assessment is more or less the core psychiatric assessment.

Q. Is there documentation relating to gatekeeping assessments?

A. We use the same V6 and the 2.1 form. The teams -- the crisis response teams and the gatekeeping teams might have their own headings or slightly different versions but the approach is and the layout is pretty much based on

the CPA.

Q. What status does the CPA have now then? We have looked at this documentation in EPUT's delivery of mental health care. Is it still the main approach?

A. It is still the main approach.

Q. Your statement makes no reference to the community mental health framework. That's right, isn't it?

A. Yes. We are -- we have a community framework implementation and transformation programme. We have implemented some aspects of it. For example, integrating -- better integration with the primary care. I think almost all services in Essex now have primary care nursing teams. One of our areas, West Essex, was the pilot -- one of the 11 pilot sites and they focused on the physical and the mental integration, and there is a joint care coordination centre with both physical and mental health nurses. So GPs that require any care, whether it is physical or mental, it will go to that common coordination centre.

But the core component of moving away from CPA has been a challenge. It is a significantly major project. We have done a lot of base work, we have got the new plans, CPA care plans, which incorporate the outcome measures. There have been, there -- we are not behind other -- there are certain IT challenges where -- as

a result of which, the new care plans have not been uploaded and implemented. These IT glitches are being worked through, especially with one of the IT providers.

We are in the process of implementing the move away from CPA. The patients are used to having a care coordinator, so it is how we manage the significant change in the country. If you -- if one of the things which is very close to patients in the Community Mental Health Team is they ask for a care coordinator and, if you are moving away from a care coordinator, it has to be done carefully and we are on that journey.

Q. Can I ask you --

A. We should be able to provide the transformation plans if the Inquiry team requires/needs them.

Q. Is there any engagement, for example, in replacing the categorisation of CPA and non-CPA, which is something indicated?

A. So the move away from CPA section is about moving away from the Care Programme Approach and not having a CPA and non-CPA. It relies -- the idea is to provide an intervention-based treatment rather than a continuum. However, there is an acknowledgement that certain patients are complex, would require some element of care coordination.

Q. You say you can provide the Inquiry with the information

of the transformation and what has been done so far?

A. That's correct, that's correct.

Q. Can I move on then quickly to touch upon some aspects of risk assessment. We have already looked at your paragraph 15, and you refer to what is required for a risk management plan. You said:

"Regarding risk assessment, a comprehensive history eliciting various risk and mitigating factors, along with detailed mental state examination is key in understanding the risks and formulating a risk management plan."

What information do you say should be gathered in a risk assessment in order to obtain a comprehensive history about a patient?

A. So our risk assessment section is at the bottom of the full comprehensive assessment. So only after undertaking a full comprehensive assessment can one provide a formulation of what the risk is, and I gave you an example around a person presenting with self-harm episode, how you would want to -- in addition to knowing whether the person has a mental illness and because that's -- all the aspects that I mentioned here are relevant to understanding the risk.

If you take past history: has the person taken overdoses in the past? How serious have they been?

Have they required inpatient admission every time? Does the patient not have -- are these in context of his or her depressive symptoms or depressive illness or are they in context of a personality profile?

So each aspect -- substance misuse, you can't undertake a full risk assessment unless you understand the substance misuse history. Alcohol alters a human being's perception, your thinking, your mood. Is the person drinking alcohol to cope with the depressive symptoms or is the alcohol itself, being seen as depressant, is contributing to the depression. So you can't undertake an assessment in isolation.

Forensic history: you know, does the person become a risk to others because of his hallucinations or the paranoia or not? And that, again, you have to take a forensic history.

So the point I am trying to make is risk assessment is just a formulation and summarisation of a comprehensive detailed assessment. It is important to know a person. If you don't know what his strengths, what his weaknesses are, what his support network is, you can't get an idea about how -- what the risks are and how we would manage those risks.

Q. Could I just pick up on a specific issue: presumably you would add to that list it's relevant for an autism

diagnosis or suspected autism diagnosis to require consideration as part of a risk assessment?

A. Absolutely. Absolutely.

Q. Can I ask you this: what procedures or specialist input is in place or has been in place at EPUT to ensure that that particular aspect -- autism, or potential autism, or suspected autism -- is incorporated in a risk assessment?

A. Autism is -- so when we talk about -- we don't -- in the risk assessment, we don't talk about conditions. So schizophrenia or -- it's a condition. And I think the training provided to the staff, the Oliver McGowan Training, is about being mindful and being aware of what the presentation is. How you undertake an assessment for someone who is autistic, in a calm environment with someone who is there because they don't like change; we would be mindful of the communication challenges. An autistic person saying "I am suicidal", is to be taken very seriously because of the concrete way of thinking, whereas sometimes people use these terms, "I feel -- I don't feel -- I wish I don't wake up early", as an oblique end. It may not mean that he is wanting to end his life.

The certain behaviour is in terms of how they don't regulate themselves when they are stressed. All these

are part of a training. When you give a diagnosis, you know depression, risk of suicide is higher; schizophrenia, risk of suicide higher; autism, definitely; eating disorder is a high risk. So that's just one aspect of the assessment of risk and we know that, as you mentioned, autism definitely needs to be considered because there are lots of challenges an autistic man -- person would face and one needs to be mindful of those.

Q. At paragraph 106 of your statement, you say that the details of the risk assessment and ongoing risk should clearly be evidenced in the case notes. At EPUT, are patients' notes checked or audited to check that that's happening, to ensure that it's happening?

A. It takes us back to Dr Davidson's argument. You know, it is the reliance on risk assessment being done and giving a false sense of security. It has been done, what -- how it is done is more important than whether it is done or not.

The there are two aspects to it, one is the quantitative aspect, whether the assessment has been done and these are -- you will undertake audits around risk assessment, completed or not. That will not give us an idea or feel of whether that assessment was meaningful and therefore there are several tiers and

layers in any mental health services.

So if for trainees, for doctors, they would have -- there will always be a consultant available for discussion. They will have one-to-one supervision where they will be expected to discuss these cases. Each team -- it's a crisis team, every new patient will be discussed in the morning and you may not look at the form but you get an idea in the way the person is presenting the history, whether he has undertaken a comprehensive assessment and a risk assessment. In mental health teams, which they meet once a week, they -- all new cases, the nurses, whoever undertakes an assessment, will be expected to discuss. That's where you get an idea of quality -- it is very difficult to audit quality at an organisational level because you may check the forms and the forms might be half filled but is it because the patient was not cooperative, or is it because ...

Q. I don't want to interrupt you but my question was around what's recorded in the records. Your statement says that details of the risk assessment and ongoing risks should clearly be evidenced, so that is the information that was obtained as part of the risk assessment.

Would that, for example, include emails that have been sent in about a patient?

A. No. That person would take that into consideration in undertaking a risk assessment, so look at the -- if there are any notes a person has written some final notes or suicide note, as you would call it, or any emails, any information that's been shared from the family.

But you wouldn't necessarily include it in the clinical records, in your assessment records.

Q. Just so I can understand, are you saying that information provided by the family, or emails, or correspondence might not appear in the details of the risk assessment that's recorded in the case notes?

A. They would inform the risk assessment so, if when you talk to the family you listen to what the family has mentioned, and you would expect either to document that in the family's express concerns, the family has shared that X and Y happened, or the family shared that this person has been aggressive, has been aggressive towards X family member, that would be taken into consideration but you wouldn't just copy an email and put it in an assessment.

Q. Just briefly, because I note it may be time for a short break, can I just ask you about assessment tools. You observe that, in addition -- this is at paragraph 33 for those following -- that in addition to the Trust

assessment documents described, clinicians also use a range of tools which inform the overall assessment and, at paragraph 34, you observe that the Trust's current clinical assessment and safety management policy, which is your MK-15, outlines that risk assessment tools should not be used on their own -- you have already touched on this, I think, earlier -- but as part of a comprehensive assessment at points of key decision-making. You say that some of the tools require specialist knowledge and, to the best of your knowledge, there is no single universally accepted standardised tool to assess suicide risk.

At paragraph 36 of your statement, you list some of the tools, including at the bottom of what is our page 1045, the early intervention suicide risk assessment tool.

Can I just ask you some brief questions. Firstly, how, in practice, when you are there on the ground, so to speak, are these tools accessed by healthcare practitioners and for whom are they accessible, who can access those tools?

A. So there are tools which certain specialist teams will use. So an Early Intervention in Psychosis team will have their own sets of tools and forms, which they will use. They would be available and accessible to that

team but, if it goes on an electronic record, those electronic records are accessible to whoever needs to access those records.

Q. You have talked about some tools require specialist knowledge. Is that, do you say, related to the attempts or is specialist training provided?

A. Specialist training. One, HCR-20 is an excellent example and it is one of the reliable assessment tools, historical risk management tool that requires training.

Q. Who provides that training?

A. It could be internal, it could be external. Forensic services -- you know, they are the ones who every patient who is taken on secure unit will have an HCR-20, so if there is an internal HCR-20 training programme, you might want to undertake training programmes provided by the Royal College or external training.

Q. If, as you say, there is no single universally-accepted standardised tool to assess suicide risk, how does a practitioner, or a healthcare practitioner at EPUT, determine, how do they decide which tool to use?

A. As I mentioned earlier, it's undertaking comprehensive psychiatric assessment. It is a skill, it is understanding a person, understanding the context, the strengths, what are their abilities, the psychosocial factors influencing playing at the time, the role of the

mental illness and, at the end, your documents.

So on all our forms are -- the core assessment forms have risk assessment at the bottom, which means that we expect a person to undertake a psychiatric assessment before completing that risk assessment section.

Q. So when you say that it is used occasionally, I think is the words in your statement, what do you mean by -- why is that tool only used occasionally?

A. Sorry?

Q. Sorry, at the bottom of the paragraph, at your 36, you say that the early intervention suicide risk assessment tool is used occasionally. What do you mean by that?

A. That's an early intervention risk assessment, it is a specific tool I am not familiar with. But the tools that probably they are using in their own specific team. Early Intervention in Psychosis patients they will deal with patients who present with psychosis, and they will probably want to focus risks in relation to a psychotic presentation, which would be slightly different to a risk of suicide. So -- or the patient has schizophrenia, psychosis -- I think we are going in specifics here -- risk of suicide, in terms of voices asking them to harm themselves or others, or when you recover from a psychotic episode and you realise the impact of the illness and then the whole life -- the

post-psychotic depression.

So there are certain elements which might be very specific. I am assuming here because I haven't seen that tool but that is not a generic suicide assessment tool. That is maybe specific to that particular -- that would not replace a comprehensive psychiatric assessment and understanding of the patient.

MS HARRIS: Chair, we have been going for about an hour and a half. I think a short break of 10 minutes.

THE CHAIR: 10 minutes.

(3.30 pm)

(A short break)

(3.45 pm)

MS HARRIS: Thank you, Chair.

Dr Karale, can I move to a different topic now, which is the question of referrals and screening in relation to assessments. We have already seen, and we don't need to look at them again, from the various documents that you will get or referrals can come from a number of different -- from a whole variety of sources and those include GPs, social services, neighbours, family, organisations and so on.

At your paragraph 47 you pick up the wording from the SEPT policy and you say:

"It is important to establish that the referrals

[I think] are eligible for assessment by the mental health team practitioner receiving the referral."

Later on you say:

"A screening assessment should be carried out and the outcome of this assessment should determine whether further CPA assessment is required."

So put shortly, is this, in effect, an assessment as to whether there should be an assessment?

A. It will depend on the team. For non-urgent, non-urgent care pathways primary care referral use -- and this is we are talking about time at the time when GPs used to refer patients to the mental health team, they would do an initial screening of the referral letter. The GPs would write a letter and see whether the information was enough, adequate to make a decision.

That would be an opportunity for the person who was undertaking the screening to ask for more information if required and then to decide who was the best person, placed best in the team to undertake that assessment if required.

I gave an example at the time and this distinction is probably not there now. But at one stage there was a distinction between mental health services providing severe and enduring treatment for severe and enduring mental illness and primary care managing most of the

depression and common mental illness. Dr Davidson also draws that distinction between severe mental illness and common mental illness. And that referral was a way of screening that, establishing whether the thresholds were met, the adequate information was there and who was the best person placed to undertake and how soon the assessment needs to undertake.

Q. So various elements. More information, or whether you need more information, who are the best team, whether there should be an assessment at all?

A. At all, that's true.

Q. You --

A. This has changed, evolved over time and again, as I said, and if you look at the urgent care pathways the screening undertaken by the crisis response service now is more comprehensive because we are dealing with urgent matters. So different teams have different screening processes.

Q. I will come back to that in a moment. Can I just ask you about the clinical assessments service, which appears in the SEPT handbook this 2007.

First of all, what is the clinical assessment service?

A. So SEPT, in the Community Mental Health Team, they had a section of the Community Mental Health Team would

specialise in undertaking assessments. They were called clinical assessments, it's called clinical assessment services.

It consisted of a group of nurses, senior nurses who would be allocated to take the initial assessment, the comprehensive assessment. But over a period of time they realised that they were undertaking assessments and the teams and the patients were then waiting for allocation in the Community Mental Health Team. So that was then changed to a first response team, which meant that those people, the staff members who were undertaking the assessment could follow a brief, provide some brief interventions and treatment and the teams got divided into a first response team and a more comprehensive treatment team.

First, the idea was that in the mental health team when the patients were referred they would stay in for a very long time and is there -- was there a group of patients, sorry -- is there a group of patients who can be managed quickly, provided an intervention, and discharged back to the GP and that was the concept of CAS, it used to be called Clinical Assessment Service, leading to the first response and recovery teams, they were called recovery teams.

We are back to the Community Mental Health Team now,

and I think there is something similar in North Essex.

Q. In relation to NEPT, you identify in your statement that all referrals at NEPT went to a single point of contact.

Can you help or not? Was there screening at NEPT or was that just a case of managing and making sure the referrals went to the right teams?

A. I can only talk of when we took over, when SEPT -- EPUT was formed. NEPT had a clinical -- has an access and assessment service team, which would receive, assess requests for assessments and they would undertake the initial assessments. That team again has been disbanded back into Community Mental Health Team.

Prior to that, I'm not sure what the function -- how the referrals were screened.

Q. Dealing then with EPUT, which is an area you say I think you can help, you say at your paragraph 54:

"All referrals are considered against service criteria to maximise the availability of the service. Screening of the referral will take place to determine an outcome."

At your paragraph 60, you say:

"The screener reviewing the initial referral will review the available information against the criteria of the service to which the referral has been made. Screeners have knowledge of other Trust services to make

an informed decision on the referral outcome and an outcome of the screening can include the referral being forwarded to a more appropriate team."

When you make reference to service criteria, do you mean the criteria for which team? The team that it's been referred to or the --

A. So if -- patients could be referred to the mental health services for various reasons. If the -- if, say for example, a patient is referred from psychological interventions, then those referrals will be forwarded to the psychological services for -- or a crisis response service receiving a referral might feel that the Home Treatment team is the better team to provide that input and would divert that referral to that team. So teams would identify which team is best placed to provide, undertake a comprehensive assessment if needed and provide the treatment.

Q. So is the service criteria the criteria to the proposed team?

A. Yes.

Q. Thank you. Is the more appropriate team, the team that the referral is then forwarded to, are they obliged to report back to the screener and say whether they have taken the patient?

A. Yes, they would be. There should be some way of

acknowledging that the referral has been accepted.

Q. So not just acknowledgement of receipt but of acceptance?

A. If accepted, yes.

The responsibility, I mean -- okay. Generally in medicine when you make a referral, good medical practice suggests that until the referral has -- the referring team has accepted the person referring/the team referring continues to have some responsibility.

You cannot -- you need to hand over the case and ensure that the referral or the care has been accepted by the team.

Q. How are decisions made to accept or reject at the screening stage? You said that one of the options was that there shouldn't be an assessment at all?

A. It would be -- it will be based on the clinical presentation, and teams or whoever is undertaking that assessment would have an option of gathering more information.

There are now some specific tools used, for example, Crisis Response Team uses a tool which categorises how soon the assessment needs to take place and whether -- and which team needs to undertake. So they use A, B, C, D and E. So A is the patient needs to be seen urgently; B is within four hours; C between 12 hours; but then the

rest of them are probably not suitable for that service and they are diverted to some other services.

So each team would have a way of identifying. Predominantly it will be based on the clinical presentation. How --

Q. Sorry.

A. And if the information is not there, request more information so you have -- the person who is making that decision has a good understanding of how soon the patient needs to be seen or whether the patient needs to be seen.

Q. Is there any concern that screening runs the risk of people being turned away or people who need help being turned away?

A. If we look at the number of referrals that are coming to mental health services, there has to be a way of, some way of managing those referrals and it's a dialogue. If the referral is not accepted from, say, from a primary care -- now every primary care the referrals come through the primary care nurses, psychiatric nurses.

If a primary care psychiatric nurse refers a patient to secondary care there would be a dialogue between the two. But to accept every referral that is coming in it's -- we don't have the resources to manage that.

Q. That leads me on to my next question, which is, to what

extent are referrals rejected at the screening stage due to funding or resource considerations?

A. It will -- it should be a clinical decision rather than a resource decision. What tends to happen at times is the risk of developing waiting lists and patients waiting for a long period.

ADHD and ASD assessments are excellent examples where patients wait for -- ASD for five years.

Q. We'll come back to that in a moment. But in light of what you have just said, do you have a sense or do you consider that referrals are rejected to stop services becoming overstretched sometimes?

A. That's a difficult question to answer. It shouldn't happen. It's the responsibility of a clinician who's undertaking that assessment to make a well-informed clinical judgement to decide whether the referral is -- and if a person requires an assessment who's the best team to assess and how soon the person should be assessed.

Q. In your statement, you refer to Key Performance Indicators, KPIs.

Can I just ask actually, very briefly, that we put up your table 3, which is the statement bundle at 1052, the core bundle at 1052. You have made reference to these already, in fact, or in passing I think some of

the times. There we can see some of, as I say, the KPIs which is in terms of screening.

Crisis Response Services: "The Trust monitor the number of calls which are answered within 60 seconds."

Hospital Liaison Services: "The Trust aims to triage a referral from the general ward in acute hospital within one hour ..."

Dementia Intensive Support Services: "Initial contact following an urgent referral ... within 24 hours [and then]

"... following a routine referral ... within 72 hours."

Then for Eating Disorders: contact, for 18 to 25, within 48 hours.

A. This is not comprehensive and each team would have same issues as 28 days' assessment. So I just want to clarify that.

Q. Okay. So this is not a comprehensive table, you make clear.

A. Not a comprehensive table.

Q. But my question is this: do you think matters such as response times and the monitoring of the response times undermine the efficiency and integrity of the service because people are concerned about meeting the KPIs?

A. Once a clinician starts undertaking an assessment, he

would want to undertake a comprehensive assessment because it's his clinical assessment and judgement.

It would put pressure on the teams because of the number of referrals that are coming in, but if a patient requires and deserves an assessment, the team should offer an assessment.

THE CHAIR: Do you think that the screeners are ever influenced by these KPIs in terms of where they actually agree that someone will be referred to?

A. That's a difficult question to answer. They shouldn't.

If a patient requires an assessment and your team is the best team to offer an assessment, then you would offer an assessment and if the likelihood is that the patient will have to wait and may go on a waiting list.

But just rejecting a referral because you have got time pressures to meet...

THE CHAIR: I was also thinking about whether they might send to a different service, not necessarily the optimal service?

A. The different service would be smart enough, I presume, not to accept and point it back to the referral saying that, "Your team is the best placed to accept that".

THE CHAIR: Sorry.

MS HARRIS: Some specific questions then about the screening. You have repeatedly said that it's open to

the screener to get more information. Can you give me an example of the circumstances in which further information might be sought?

Sorry, the slide can come down now, thank you.

A. It's common practice for the screeners to contact the GP asking for more information if the referral letter is not comprehensive. Now it's the primary care liaison nurses, but at the time when the referrals used to come from the GP you used to ask for more information.

There are -- the crisis team, if a patient is referred to the crisis team by a GP, they would often try to get more information from the GP. Sometimes key information is missing about patient details or, you know, in order to -- in order for the team to contact the patient. So it is not uncommon for the referral to go back to the person who has referred to -- for the assessor to go back to the referrer.

Q. What are the expectations on staff though for other information? What if the patient for example is not registered with a GP or what about contacting the family? Would screeners look for further information from a family or carer?

A. They would, and --

Q. You say they would?

A. I give you an example. For eating disorder assessments,

you know, if there is a request for an admission to an eating disorder unit, it's common practice for the consultant or whoever is there to contact the family, the parents, get more information because they are relying on a form rather than -- the decision to be made on a form. So they have sent some information; it's a nationally-recognised form. But they have to contact the -- would contact the family, the parents, the mother.

Q. You give eating disorder as an example. But, what about in other cases, is there a provision, is there a procedure by which family can offer further information at the screening stage?

A. It's very difficult at the time when you receive a referral how much involvement the patient wants to have from the family. It's good practice to contact, but it would be good practice to actually talk to the patient first so that the patient's aware that someone is talking to the family and it shouldn't come as a surprise to the patient.

Screening is just gathering -- most of the time it's just gathering more information and deciding who's best placed to undertake that assessment.

Q. Do you have a --

A. As a part of the assessment, especially in a mental

health team, when gathering more information from the family members sometimes family members attend, come with the patient and you would then --

Q. Sorry to interrupt. You're talking about the assessment now, aren't you?

A. Yes.

Q. I'm asking you about the screening stage and the extent to which it might be obtained at the screening stage to prevent people falling through the gaps at the screening stage?

A. It -- it would be -- I don't think it will happen routinely. If required.

I can think of Mental Health Act assessments where the AMHPs would contact the family. It's a legal requirement, it's a requirement under the code of practice as well. So certain assessments are more geared towards gathering more information --

Q. Again we are talking now at the screening stage --

A. The screening.

Q. -- which was what ...

Just in terms of communicating screening outcomes, you deal with that at your paragraph 59. We know that to the Crisis Resolution Home Treatment Teams, they are required to contact patients within four hours of referrals; non-urgent outcomes are by letter. Can you

help us: what's the basis for setting the four-hour response time for the CRHT?

A. It's the -- it's the maximum. I -- if -- talking to the crisis team, and I have worked in the crisis team, if a referral is urgent they would contact the patient straight away. So it is...

I'm not sure what is the -- what is the reason for setting that four-hour target.

Q. At your paragraph 61, you say that, where physical health is deemed to take priority, that the patient's physical needs will be dealt with first, in effect.

Can I just ask you this: at the screening stage, if it's been identified that mental health input may be needed as well, how is that recorded? How is the need to refer to the Mental Health Liaison Team, when well enough, physically recorded? How do we make sure that the patient stays in the system at that point?

A. Sorry, can you explain?

Q. Yes. At 61 --

A. Yes.

Q. -- you say:

"There are occasions when reviewing the referral and engaging with the patient the screener determines that the patient's primary need is physical healthcare."

A. Yes.

Q. "In such cases, a joint decision is made with the patient to redirect them to appropriate services to address this need first with mental health assessment to follow thereafter."

You go on then to say that, once they are stabilised, they can be referred to the Mental Health Liaison Team. I have jumped forward to the end there.

A. So --

Q. How is it ensured that the patient stays within the system and then moves to the mental health liaison team?

A. I think this primarily refers to the urgent care department.

We do a screening as soon as the patient comes in and if a patient has taken an overdose or if we think that the mental health needs -- sorry, the physical health needs are such that the patient needs to be treated in the acute hospital, because it refers to the mental health liaison teams which are based in the acute hospitals, the patient would be sent to A&E or acute hospital and get the medical treatment and we can ask our liaison teams to assess the patient there.

Q. Can I ask you about your paragraph 63, in which you say:

"Prior to the formation of the current Trust Urgent Care pathways [to which you have been referring] patients in crisis were advised to attend A&E

Departments in the acute hospitals and were supported in the community by primary and secondary care services."

First of all, when did the Urgent Care pathway come into existence?

A. So this is before the -- when the -- before the establishment of CRHT, Crisis Resolution Home Treatment teams, patients did not have -- there was no Urgent Care team.

The subsequent next thing was the -- and the patients would, when -- even with the crisis teams, the patient -- during the working hours crisis teams would be the teams dealing with the urgency. But in the evenings, after working hours, patients only had the option of going to the A&E, Accident and Emergency. The Accident and Emergency Services at the time would have a liaison nurse --

Q. Sorry, I don't want to cut across you --

A. Sorry.

Q. -- but my question was when that changed?

A. I think that has evolved over a period of time with crisis teams, then subsequently the crisis response services which now became a 24-hour service, and then now the Urgent Care Department, where patients can just walk in to access that service.

So it's been a journey from not having any crisis --

Urgent Care services to establishing some Urgent Care services through the crisis -- CRHTs, CRHTs working 9 to 5, not weekends, to CRHTs working weekends and even CRHTs required patients to be referred by GP or a professional. Now, and CRS is where 111/2, anyone -- you don't need to go through a mental health professional, you can just pick up a phone, dial 111/2, and you will be put through to a mental health professional.

So that's been a journey for the mental health services.

Q. Can I move then to the arrangements for assessment. At paragraph 65, you say:

"Once the decision is made to assess the individual and the purpose is established, the assessment will be arranged in line with the screening outcome, identified risk and the relevant service pathway, taking into account expected timelines and target KPIs for assessment delivery."

Would you agree that that reads like an aspirational paragraph?

A. The KPIs are monitored and there could be breaches. Especially for 28 days in community mental health, those are monitored --

Q. In terms of -- sorry?

A. I was just thinking --
Q. If that's what should happen --
A. -- as a clinician, when I am being referred a patient, I am less likely to think about the KPI than the patient needs to be seen and that is, one would expect, from a clinician -- from a clinical perspective.
Q. My question is 65 looks to be a paragraph of what should happen, rather than what actually happens every time. You asked me to identify them, when I asked at the beginning --
A. Yes.
Q. -- and I asked whether you agreed with that as a proposition.
A. Yes, I take that it can be that.
Q. I'm sorry, I am mindful of the time, so I am going to move quickly through. You move on to arrangements for assessment and if you start off with location, we are now at the point where the patient has got through screening and a formal assessment has been arranged. From 67 to 69, you deal with where assessments can be carried out, so a variety of possibilities. At paragraph 70, you set out the advantages of doing so in a patient's own home, where possible.
Can I just clarify that with you because that would, wouldn't it, on many occasions, afford the opportunity

to obtain information from the family and the support network?

A. That's right.

Q. At paragraph 72, you say that there is often time required following assessment to liaise with, and you say, significant others. Can I just explore who that might mean. Would that include family, significant others?

A. Include family and GP.

Q. GP, who else?

A. Carers, if a person is living in a care home or residential home, some care agencies are involved. So it could involve a number of other people.

Q. This is --

A. So voluntary agencies.

Q. This is terminology you also use -- I won't take you there -- later on when you are talking about gatekeeping assessments and it is the same principle then, isn't it?

A. That's right.

Q. Who takes responsibility for liaising with significant others if the assessment is for admission in an out-of-area place?

A. Assessment for out-of-area placement?

Q. Yes, is it still the same clinician?

A. Yes, the -- you would want to admit the patient closest

to the patient's home and only if a bed is not available and the patient requires a bed urgently that you go out-of-area. So the out-of-area assessment should not be different to an assessment undertaken to admit a patient locally.

Q. Is there greater expectation that there will be liaison with others in a case where the patient lacks capacity?

A. Yes.

Q. It's clear from your paragraph 73 to 75 that patient involvement is key and, again, at page 76 onwards, your statement recognises the importance, as we have said of family and carer involvement. Can I just ask this, were there any relevant national or local standards, or protocols, or guidance, or best practice at the relevant time which informed how to involve family and carers in these assessments?

A. For Mental Health Act there is a code of practice and the AMHP is expected to contact the family members and, for other assessments, I am not aware of any document but it is common practice, even on our assessment forms we have a section of family and carers' views and opinions and patients' views and opinions. So it is accepted it's part of a standard -- you know, wherever possible, you want to get information from the family.

Q. Do you think it would help at working level if there was

more specific guidance drafted or available to practitioners about getting family involvement, about what to do with the information, raising the expectations?

A. CPA and other documents do mention about the importance of -- so there are policies and procedures around stressing the importance of family involvement and gathering information from the family and, as a clinician, some -- I would want to know what's happening at home because sometimes patients are paranoid, psychotic, they don't want to give you information, and the only source of information then is family members or others -- others as I mentioned.

Family patient involvement can be very variable. We are probably -- we have to undertake assessments, even when patients at times don't want to. It's less likely to happen in other specialities.

Q. At paragraph 77, you note that consent to share information with a person's family and carer must be obtained and patients give varying levels of consent. Do you accept, however, that there are fewer obstacles to receiving information --

A. Absolutely.

Q. -- and listening to carers?

A. Absolutely.

Q. Is this stressed to those that undertake assessments at EPUT?
A. Yes, we have had a number of training sessions as well and that's one of the issues in mental health. I think Dr Davidson also touched on it. There's a feeling among a number of clinicians that if a patient doesn't want you to talk to the family, it means you can't even gather information, and we have had training sessions, even with legal professionals explaining what capacity, consent -- sorry, what consent means.
Q. Sorry, does that training stress the importance of engaging?
A. Absolutely, absolutely.
Q. In terms of those who are involved in the criminal justice system, we have already talked about other agencies, at the time or over the relevant period have you ever had a protocol or memorandum of understanding with external agencies, the police or probation as to how you will deal with them?
A. Yes, there are understandings.
Q. There are, are there?
A. Yes.
Q. Are they in existence now?
A. ISAs they are called, Information Sharing Agreements between various professionals, various organisations.

Q. They apply at the moment?
A. There should be ISAs with different -- but there is an ISA -- Information Sharing Agreement with police.
Q. You could provide those if required?
A. The Trust should be able to provide those.
Q. If a person who presents for mental health assessment is also facing criminal proceedings, does this affect their access to obtaining the assessment?
A. The purpose of the assessment is important. Is it a forensic assessment and what's the purpose? The forensic assessments could be to assist the court in understanding the person or diverting the patient, but if a person has an offending history, that shouldn't preclude him -- that person from accessing mental health services. In fact, forensic history forms a core component of a psychiatric assessment.
Q. In terms of the assessment itself, which healthcare professionals can carry out those assessments?
A. The forensic assessments?
Q. No, the first mental health assessments that we are talking about, following the --
A. A qualified clinician, it could be a doctor, a nurse, a psychologist, a social worker. They need to have qualifications. We don't -- non-qualified and medical students do not undertake assessments on their own.

Q. Who can make a decision to admit?
A. There are decision makers, they would be qualified nurses. There are decision-making teams and the staff working in those teams. So the decision -- the gatekeepers decision making teams, the Crisis Resolution Home Treatment, so the nurses working in the crisis team, the consultant for the crisis team, the Crisis Response Services, the mental health A&E -- sorry, Urgent Care Mental Health Department and the -- for elderly care, the intensive support team. So the staff working there would be the staff who would make that decision whether to admit or not to admit.
Q. You make reference in your statement to limitations to assessment, that's your phraseology.

You deal with non-engagement, including patient choice. You make a number of references to non-engagement in your statement: is there a reason you have placed emphasis on that? Do EPUT focus on non-engagement?
A. Engagement of a patient is a core component of a psychiatric assessment. You know, we stress too much on whether we are able to build a rapport with the patient because it gives us a lot of information about the patient. A paranoid patient will not want to talk to you but a manic patient will want to give you a lot

of information and it is a skill how you contain that and gather the information in a relevant period. An anxious person may want to spend a lot of assessment time seeking reassurance.

So the patient's engagement is a key component of understanding the patient's presentation and also helps us in planning subsequent treatment.

Q. You deal at paragraph 87 very specifically with intoxication. For those working at EPUT, when presented with intoxication, what factors would inform the decision as to whether to proceed with the mental health assessment?

A. It's a clinical decision. If the clinician feels that the patient is sober enough or you are able to undertake an assessment, you would undertake an assessment. It's not an exclusion, it's not a criteria for not to take an assessment. However, there are merits in undertaking an assessment once the person is more cooperative.

Alcohol colours our perception, you know, influences our thought process and some of -- someone who might feel quite hopeless when in an intoxicated state might have a different mental state after the effects of alcohol wear off but it is not an exclusion criteria.

Q. Are you aware of patients being refused assessments because they are intoxicated or because someone has

incorrectly judged that they are intoxicated?
A. Not that I am aware of. It used to be a practice many years ago in mental health services where a patient -- intoxication and was an understanding of patient needs to be completely sober before an assessment takes place. So mental health services have moved away -- moved on from there, from that position.
Q. You refer to neurodiversity and you have acknowledged earlier on that an assessment involves identifying social and psychological factors contributing or leading to the presentation.

Would you agree it's important and relevant to identify the presence of those kind of conditions at the outset?
A. It is. One needs to be mindful of these conditions. You may not diagnose but you are aware of these and you provide a needs-based care because their needs would be somewhat different.
Q. Are there procedures in place to support clinicians to identify those at the time of assessment?
A. The McGowan training and the training forms a part of that.
Q. I think we will hear evidence about the McGowan training tomorrow but you have said twice that's what you rely on as indicating that staff are equipped to deal with these

issues?

A. Certain services where they are likely to face more patients with autism, like CAMHS services, they have their own bespoke training and I have provided some evidence in terms of that the training they provide, it is a two-day training at induction for every staff member who works on a CAMHS unit. Likewise, the Learning Disability Service, where it is more likely to be present.

Q. As I say, we will come back to that tomorrow. I don't want to cut across you.

A. Yes.

Q. Are reasonable adjustments made for those that require them for neurodevelopmental conditions at the assessment period time?

A. Reasonable adjustments should be made.

Q. Are you aware to what extent that has been happening at EPUT?

A. We have sensory rooms. In most of the places, there are sensory aids and tools. In a number of places there are, especially in CAMHS this document Close the Door Slowly because of the number of patients who have autism. So there is increased awareness about these conditions and provisions made.

Q. You emphasise feigning and malingering in your

statement. Is this a particular challenge for EPUT?

A. It's something one needs to be mindful of. Not -- it is something probably more common -- not common -- you're likely to face in forensic services, where, to avoid legal -- dealings with the legal services, that one might want to go down the health route.

Q. Is it monitored by EPUT?

A. It's not monitored by EPUT. It is a clinical decision and a clinical judgement.

Q. Just in terms of an outcome of assessment, you note -- this is at paragraph 93 -- that individuals sometimes may wish to raise concerns and you say that the services have systems and processes in place. Can you explain the systems and processes in place at EPUT for peer discussion and review for people to raise concerns about the outcome of assessments?

A. The patient can raise concerns with the clinician who is assessing him, can raise concerns with PALS, and there are patients who write to the headquarters directly, patients can go through -- often there is a complaints procedure for raising concerns.

For doctors, it would be the Clinical Directors who would deal with the complaints and offer second opinions or address these issues raised in the concerns and, likewise, similar managers for other professionals.

Q. So you are dealing with the arrangements for making a complaint, in effect?
A. You would want to deal with it at informal level and address it at a local level.
Q. You also recognise at your paragraph 94 that families have concerns and that they may be urgent and you make reference to on-call arrangements.

How was the on-call arrangement or the availability to speak to somebody urgently, how was that communicated to patients or carers?
A. This is for the out-of-hours assessments, if the families have concerns? The families necessarily wouldn't know about the on-call consultants but they -- yes, I do take that point. They probably wouldn't be aware of the on-call consultants and the on-call managers.
Q. So they wouldn't be aware of who to contact?
A. They would go to the PALS.
Q. But that wouldn't be an urgent response, would it, to go through PALS?
A. That wouldn't be an urgent ...
Q. Again, mindful of the time, can I just ask you about some of the types of assessments that you have referred to. You say that there are 1,500 types of assessments. Why so many?

A. I think this is over 20 years. Before the electronic records, there used to be paper records and my understanding is that there was several iterations and teams would have changed their forms slightly. But with electronic, with -- but still there are a large number of forms in the mental health services.

This is because there are forms for specific conditions, maybe you would want an assessment -- for a falls assessment there is a separate form, if there is a thrombus/embolism, there is a separate form. There are separate forms for each condition, each professions have their own -- each psychologist will have a battery of their forms. Occupational therapists will have their forms to assess a person's -- whatever they assess. The social workers will have their assessments. And, in addition, there are scales and tools which often, you know, used as assessment forms.

So there is a large number of assessment forms -- a large number of assessment forms in mental health.

Q. Can I ask you quickly, please, about gatekeeping assessments. Again, you talk about them at paragraph 120, as an assessment undertaken to access an inpatient bed. To what extent are gatekeeping assessments used to reduce bed use?

A. I think the reduction or management of beds doesn't

happen at a gatekeeping, it happens now at a management -- at a bed management level. The gatekeeping assessment would decide what's the best place to manage and treat a patient.

Q. I am again mindful of the time. Just note that you have a table at Appendix 2 of your statement, for those following the documentation that's 1094. Who makes the referrals to the gatekeeping teams?

A. Anyone, it is for Crisis Response Services. Even a patient can call 111 and dial 2 and ask for an assessment: families, GPs other professionals.

Q. Is there a screening process for gatekeeping assessments?

A. The Crisis -- CRS screening tool is a fairly comprehensive tool, gathering the current presentation, the past history, medications, it's almost a mini assessment. So there is a screening tool for these gatekeeping assessments.

Q. We have touched on this. Is there documentation policies, procedures, guidance, handbooks to govern gatekeeping assessments?

A. The teams will have their own operational policies and procedures for gatekeeping. Gatekeeping is just a term used for an assessment that decides whether that particular service is going to accept that patient.

Q. As we just looked at, as identified in your statement.
A. Yes.
Q. But you say those teams will have their documentation --
A. Yes, yes.
Q. -- and you could provide that to the Inquiry as requested?
A. Yes, we should be able to, for the gatekeeping teams.
Q. Is there a standard template used for gatekeeping?
A. The Crisis Response Services have their template in place and the CRHT use the templates, there are templates for those assessments. They are not different to, as I mentioned, the two core assessment forms. We base these forms predominantly on those core psychiatric assessment forms.
Q. If a person or if a gatekeeping assessment determines not to admit, is that, in effect, overruling the referral from the team that made it?
A. That's one of the options available. You know, they can be managed they can be with the Home Treatment Team, if that's the best option, that the patient can be treated at home safely, or there could be other services where you have got crisis cafés, crisis homes in Essex. Sometimes they accept certain patients for a brief -- for managing brief crisis. So there are various options available.

Q. At paragraph 123, you say the patient will be actively involved in the decisions about their care, with their consent family members and significant others may be included. When you are considering an assessment for an admission into hospital, do EPUT consider that obtaining collateral information from family and carers, say, and from other agencies, need to be heightened at that stage to be even more important?

A. Yes, if available. A lot of patients -- I mean, we may not always be able to contact family members. They may not have -- patient may not have family members.

Q. How long would you expect a gatekeeping assessment to last for?

A. Standard one hour. Depending upon the patient's presentation anyway, so that's ...

Q. I appreciate you haven't been asked for precise information but are gatekeeping assessments evaluated/ monitored for the number of referrals, the proportion of referrals, the number of admissions, the proportion of admissions; is that type of monitoring and information available?

A. So the number of referrals and the time in which they are undertaken, they are KPIs and the outcomes, in terms of the -- once a decision is made to admit the patient, there is a fluent capacity process, which I think I have

quoted in my second statement but I am happy to discuss if you want to take me through what happens.

Q. We will deal with your second statement tomorrow.

Sorry, I am just keeping an eye on the time, Chair, aware of the need for others to be able to communicate and also the finish time of 5.00.

Can I just ask you some brief questions about Mental Health Act assessments. You deal with these in your statement, in any event. You have already touched on the importance of obtaining information from family and carers in relation to mental health assessments and I think you referenced a code of practice. But can I ask you this: what should the AMHP do in practice if, subsequent to an assessment, they contact the nearest relative or a relative provides them with significant information that contradicts information that was provided by the patient?

Is there some procedure by which decisions can be revisited?

A. The AMHPs usually contact the family before the assessment together. As a part of gathering relevant information, they would contact GP, whoever they can do, and then have that information for the two doctors who would go and assess the patients with the AMHPs. So one of the core responsibilities is to gather as much

information before an assessment takes place.
Q. In terms of other specialist assessments, you deal with in your statement diagnostic assessments, memory assessments, eating disorder assessments. But you also issue assessments of neurodivergence, which are very specialised assessments. Can I just ask you, in the last couple of minutes, one or two questions about this?
A. Yes.
Q. You observe that a delay to wait for an assessment of neurodivergence, I think you mentioned this, is four years?
A. Five years.
Q. Five years?
A. Yes. So can I -- when you talk about neurodivergence, the ASD service and ADHD services are two distinct, how they are managed and I think it is slightly confusing and I apologise for the way it's been worded and combined.

But the ASD services in the south and northeast, and the ADHD services are two separate services. The waiting period of four or five is years is for the ASD service. ADHD is still -- it's slightly less than that.
Q. But still a long time?
A. Still a long time.
Q. Can I just ask you this: in light of what is a very lengthy waiting period, would you agree that it's really

important then to implement reasonable adjustments and factor in those possible diagnoses, even when it hasn't been made when you are considering mental health assessments?

A. Absolutely. It is a needs base, rather than a diagnostic base because of the long wait.

Q. You referred at paragraph 175 to collateral information being essential, which is often obtained from a family member. What were and what are EPUT doing to triangulate information from the family and the support network, particularly in the case of neurodiverse people both at the time of a mental health assessment and then at a time of any other specialised assessment? What has been happening to ensure that appropriate information is obtained?

A. Other than being mindful of the -- what needs to be considered when assessing a patient with neurodiversity, the assessment should pretty much be the same. You gather -- you talk to the patient, you gather the relevant information in a structured way, you talk to the family and just, as I said, in case -- in patients with neurodiversity, you then ensure that someone who knows the person is there, it's done in a calm, composed way, be mindful of the language challenges and the way they communicate.

But in assessment, the core assessment would still be pretty much similar. As part of an assessment, you would want to talk to the family members where possible.

MS HARRIS: Chair, mindful of the time, unless there is anything you wish to ask at this stage?

THE CHAIR: I have got one question, if that's all right.

MS HARRIS: Yes, please.

THE CHAIR: You said earlier that out-of-area assessment shouldn't be different to an assessment undertaken to admit locally. But can I ask what you really meant by that?

Is there consideration given within the general assessment about the suitability for out-of-area placement, or is it necessarily covered by the assessment, or do you mean that nothing is done to consider the specific effects of an out-of-area placement?

A. So, Chair, if it is for a specialist unit which is not provided locally, then, yes, but if it is just for a general adult bed or a bed for an old age ward, that decision -- the decision would be to admit -- whoever is assessing would not think of whether the patient goes within the locality or out of. His aim is to undertake an assessment to decide whether the patient needs a bed or not.

THE CHAIR: Would they consider the suitability of an out-of-area placement?

A. Out-of-area placements, if certain -- if it is required, yes. Certain specialist areas where we don't provide, if we talk about, say, an eating disorder unit, we don't have eating disorder unit in Psychiatric Intensive Care Units and, if our units are full then, yes, those things would be considered. Also, I am referring more to the generic adult and old age bed admissions.

THE CHAIR: I have no more questions.

MS HARRIS: Could we have a 10-minute break? Thank you, Chair.

THE CHAIR: 10 minutes.

(4.44 pm)

(A short break)

(4.57 pm)

THE CHAIR: Ms Harris.

MS HARRIS: Thank you. Just a couple of further questions, please.

Dr Karale, the first is this: you have given evidence about the CPA framework and we have also referred to gatekeeping assessments.

Should a gatekeeping assessment prompt the referral of a patient onto the CPA pathway in circumstances when they are not otherwise open to the Community Mental

Health Team?

A. Yes. If they are referred to the Community Mental Health Team and the team feels that the patient requires ongoing treatment, then they would go on a CPA.

Q. We have heard reference to you seeking to implement the framework, the Community Mental Health Framework. Is there any collaboration with patients and families about how that should be done?

A. I will be able to provide more information but most of our transformation programmes have patients and service users involved.

Q. You gave evidence about the reasonable adjustments that are being made for those with neurodevelopmental conditions, during the assessment period. You talked about sensory rooms and other aspects. When were those reasonable adjustments implemented; how long have they been in effect for?

A. So I am talking about -- when I talk about sensory rooms, I am talking about inpatient wards. I just want to clarify that.

Q. Which we will deal with tomorrow.

A. It is more about providing a calm environment and it is -- the adjustments are more clinical adjustment than structural, or any procedural adjustments. So being mindful, as I said, that to undertake an assessment not

in a busy you know area, move to a calmer area, make sure that they have support of whoever is there accompanying them.

Q. Maybe the same question then, how long have those been carefully put into place or considered at the time of assessment?

A. There is an increasing awareness of ASD and neurodiversity in the last few years, there has been in the last few years.

Q. By "last few years" when do you mean?

A. However, I would assume that -- this especially psychiatrists, they are skilled to, you know, recognise autistic traits -- traits for autism and would take that into consideration.

Q. How long then has there been a wider awareness at the time of assessment?

A. There's definitely been more recognition post-Covid.

Q. Okay, so since 2020/21?

A. Yes.

Q. All right. When conducting a comprehensive assessment and eliciting a comprehensive history, how do clinicians account for the effect of the mental illness itself, as rendering the history potentially unreliable?

A. You have to take that into consideration and psychosis is an excellent example. It's very difficult to get

a history from a person who doesn't believe he's unwell, doesn't want to see you, doesn't want any treatment and the mental illness does influence the history taking. Therefore, either you undertake subsequent assessments or you rely on significant others to obtain the information.

Q. Finally, this, and this is my fault: you told us at the very beginning of your evidence that you are a consultant psychiatrist. Do you still see patients or is your role purely managerial at the moment?

A. I have got one clinical session. So I was a full-time -- I had -- when I was a Deputy Medical Director -- until 2012, my predominant role was clinical successions. After becoming a Medical Director, it was reduced to a sessional input, which has initially -- I started working in the assessment unit and therefore I have understanding of the assessment unit and I set up the neuro, the RTMS service and moved my clinical role there, and did a few -- for a few years worked in Loughton, in the outpatient clinics, and more recently, after setting up the Mental Health Urgent Care Department, I moved my clinical role there.

Q. I said "finally" but I perhaps should ask you this: in light of your last answer, how do you inform yourself of what's going on day-to-day on the ground at EPUT, in

terms of clinical practice?

A. So several ways. I have -- so I manage -- I have Clinical Directors. Each Clinical Director in each locality will have a consultant meeting. The consultants will raise any issues, which they feel is are relevant around quality safety to the Clinical Director. The Clinical Directors will provide a report to the Medical Directors' meeting. So that's my way of knowing and, obviously, there are structures within the organisation in terms of governance, where the Director of Governance, so the nurse, would be able to give you more information.

We also have visits on the inpatient units and services, where you would talk to the staff, patients and get an idea. There are CQC compliance visits and the other regulatory visits.

So I rely on my consultants and Clinical Directors. For trainees, there are again -- they have several forums, Guardian of Safe Working and their forums where they can raise any issues around patient quality or safety.

MS HARRIS: Thank you. That's all I have to ask.

Chair, did you have anything else arising?

THE CHAIR: No, thank you very much.

MS HARRIS: Thank you very much. We will sit again tomorrow

when Dr Karale will be back but this time to deal with his second witness statement when the Inquiry will hear evidence about the inpatient pathway and admission onto the unit.

THE CHAIR: 10.00 tomorrow.

MS HARRIS: 10.00. Thank you, Chair.

(5.06 pm)

(The Inquiry adjourned until 10.00 am on Tuesday, 13 May 2025)

I N D E X