Witness Name: Jane Lassey
Statement No.: 1
Exhibits: JL/01 – JL/12
Dated: 13 March 2025

LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF JANE LASSEY

I, Jane Lassey, will say as follows: -

1. I am Jane Lassey and my position at the Health and Safety Executive ["HSE"] is Director of Regulation. I am authorised to make this statement on behalf of HSE. This statement is provided to the Lampard Inquiry to explain HSE's regulatory role and to provide details of HSE investigations and prosecutions of NHS Trusts and mental health units in Essex between 1 January 2000 and 31 December 2023.

The Health and Safety Executive, its regulatory role and the legislative framework

2. HSE is a non-departmental public body, sponsored by the Department of Work and Pensions ["DWP"]. It is Britain's national regulator for workplace health and safety and operates across England, Scotland and Wales and its mission is protecting people and places.
   HSE was established by the Health and Safety at Work etc Act 1974 ["HSWA"] to prevent work-related death, injury and ill-health through enforcing workplace health and safety in certain workplaces, mainly through HSWA and relevant Regulations.

3. HSE's general duty is set out in section 11(1) of HSWA, namely to *"do such things and make such arrangements as it considers appropriate for the general purposes of this Part".* HSE's general powers are set out in section 13 HSWA. This includes the power to do anything which is calculated to facilitate, or is conducive or incidental to, the performance of its functions (s13(1)).

HSE's regulatory role in relation to the healthcare and social care sectors in England.

4. HSE is not the primary regulator for healthcare and social care in Great Britain. Healthcare and social care is a devolved matter and there are different regulators in England, Scotland and Wales. In England, the Care Quality Commission ["CQC"] is the independent regulator for healthcare and social care.

5. This includes the care provided by the NHS, local authorities, independent providers and voluntary organisations in registered settings. CQC register most but not all types of care. They regulate providers of:

   a. healthcare services to people of all ages, including hospitals, ambulance services, clinics, community services, mental health services and other registered locations, including dental and GP practices.

   b. social care services for adults in care homes (where nursing or personal care is provided), in the community and in people's own homes.

   c. services for people whose rights are restricted under the Mental Health Act.

6. HSE's role in relation to regulating healthcare and social care systems and how it works with other Regulators is explained in *Who regulates health and social care* which is available on HSE's website produced as exhibit JL/01.

7. HSE's published approach to enforcement action in relation to the provision of mental health services in England prior to 2015 was that, in general, it did not deal with matters of clinical judgement or clinical governance. This regulatory gap was identified by Mid Staffordshire NHS Foundation Trust Public Inquiry and was resolved by extending the role and powers of the Care Quality Commission as the regulator for patient safety matters.

8. Following the Mid Staffordshire NHS Foundation Trust Public Inquiry in 2013, the CQC was granted additional powers to regulate and enforce standards for patient and service user safety in health and social care in England. A Memorandum of Understanding ["MOU"] was agreed by HSE and CQC, which came into effect in April 2015, produced as exhibit JL/02. It was updated in December 2017, produced as exhibit JL/03. Since April 2015 HSE has continued to act as the regulator for worker health and safety and CQC has become the regulator for all patient issues relating to the delivery of registered health and social care services.

9. In general, HSE does not investigate or prosecute matters of clinical judgement and practice, and the training, systems of work etc to deliver those of doctors or matters relating to the level of provision or quality of care as explained in our guidance, *Priorities for enforcement of*

Section 3 of the HSWA 1974 (revised April 2015) produced as exhibit JL/04. In England, the CQC is the more appropriate regulator to investigate matters of this nature. CQC also deals with major non-clinical risks to patients, for example trips, falls, scalding, electrical safety etc and has a wide range of enforcement powers that can be used if healthcare services are not meeting fundamental standards. In respect of social care, the CQC regulates the providers of social care services for adults in care homes (where nursing or personal care is provided), in the community and in people's own homes. In general, CQC, rather than HSE, will deal with the majority of patient and service user serious health and safety incidents.

10. Dependent on the nature of an incident, it may be reportable to HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 ["RIDDOR"]. If incidents are reported to HSE, it will follow its published incident selection criteria and *Section 3 of the Health and Safety at Work etc. Act 1974 - HSE Policy* produced as exhibit JL/05 when deciding whether to investigate, or in England, forward reports to the CQC. During the relevant period versions of HSE's incident selection criteria dated 2005, 2010 and 2014 applied, produced as exhibits JL/06, JL/07 and JL/08. They reflect a similar approach. HSE also has guidance that assists Operations staff to make these decisions. *Guidance for Field Operations Division in responding to non-construction public safety incidents where Section 3 of HSWA applies* is produced as exhibit JL/09, *Flowchart on the response to (non-construction) public safety matters where Section 3 of HSWA applies* is produced as exhibit JL/10 and *Guidance for Field Operations Division in responding to (non-construction) public safety incidents where Section 3 of HSWA applies - situational examples* is produced as exhibit JL/11.

11. Although HSE's regulatory remit is limited to matters affecting worker health and safety, we may undertake a range of regulatory interventions across the healthcare sector, including:

    a. Inspections – these are normally pre-arranged but can also be unannounced. Such activity will normally form part of national campaigns. Some inspections may also be carried out on the basis of intelligence received by local management or following an investigation of an incident.

    b. Concerns - raised by workers, trade union representatives or members of the public about risks in healthcare workplaces. If, following an internal assessment, they are within HSE's remit they will, depending on the assigned level of risk, either be retained for intelligence purposes, or followed up remotely by our customer services team, or investigated by the local front line regulatory team.

c. Incidents – RIDDOR 2013 requires "duty holders" such as employers to report incidents resulting in harm to workers and in certain circumstances non-workers. HSE investigates all work-related deaths of workers and members of the public who are not patients and a proportion of more serious non-fatal incidents subject to the application of our Incident Selection Criteria. Whilst work-related patient deaths still need to be reported, any reports received by HSE or local authorities are forwarded to CQC to investigate as the appropriate regulator. Patient suicides are exempt from reporting under RIDDOR and are entirely a matter for CQC.

d. Responding to a Report on Action to Prevent Future Deaths – at the conclusion of an inquest a coroner may make a Report on Action to Prevent Future Deaths pursuant to the Coroners and Justice Act 2009 and the Coroners (Investigations) Regulations 2013 if they believe that action should be taken to prevent the recurrence of similar fatalities. HSE may receive such a report if a coroner determines that issues relating to work-place safety were relevant to a person's death. HSE will consider whether further action is required to address work-place health and safety risks and report back to the coroner. This may include an investigation to determine whether there were any failings by relevant duty holders to comply with their obligations under health and safety legislation.

HSE's records management policy and approach taken to provide information on prosecutions and investigations.

12. Throughout the relevant period, HSE has used electronic databases to store investigation and prosecution files and record key information, including the details of the dutyholders, offences and the outcome of the relevant activity. In accordance with HSE's records management policy, investigation and prosecution files are retained for an archive period of seven years following closure. The files are then deleted from the database. However residual information including formal enforcement actions, i.e. notices and prosecutions is usually retained for longer due to having appeared on HSE's public enforcement databases. The information provided in response to the rule 9 request as set out in paragraphs 15 to 20 is therefore limited to the information that remains available on HSE databases.

13. All our records relating to regulatory interventions, including and investigations and prosecutions, are categorised using the standard industrial classification of economic activities more generally known as SIC codes. These enable HSE to identify the general sector or area of industry relevant to a particular intervention. The provision of mental health services does not have a specific SIC code. For health and social care HSE uses the SIC code 86101 "hospital

activities" and 86220 "specialist medical practice activities" to cover the public and private sector. These SIC codes are not subdivided into subcategories such as mental health therefore, HSE is not able to extract data specifically for matters that involve the provision of mental health services. A manual review of records is required to establish whether they relate to the provision of mental health services.

14. In order to respond to this request data has been extracted from HSE systems for the relevant period covering all NHS Trusts and/or mental health units in the Essex area including the SIC codes for "hospital activities" and specialist medical practice activities". This generated 83 potentially relevant records set out in a spreadsheet *Data request Lampard Inquiry* produced as exhibit JL/12. The exact parameters used for the search conducted can be found at Table 1 of the spreadsheet. For prosecutions, 14 records were identified and for investigations, 69 records were identified. Following a more detailed examination of the records, of those 83 entries, 6 were found to be relevant to the provision of inpatient mental health services. These are explained in more detail below. However it is important to highlight that due to the limitations in the nature of the information that is retained by HSE and also the systems used to categorise interventions, it is not possible to state that all relevant records during the relevant period have been identified.

HSE prosecutions and investigations relating to the provision of mental health services by NHS Trusts in Essex and/or mental health units during the Relevant Period.

[I/S]

15. A detailed record no longer exists but residual information held on HSE systems confirms that:

    a. on [I/S] 2006 a fatal incident occurred involving deceased person [I/S] was a blind and deaf quadriplegic person with cerebral palsy who was found with his head trapped between his bedrails (bed frame and the bottom rung of a cot side). He could not be resuscitated.

    b. the investigation related to Basildon & Thurrock University Hospitals NHS Trust, the location of the incident being Basildon Hospital.

    c. the investigation was commenced on 13 November 2006. The date of the prosecution was 26 February 2010.

    d. residual records do not indicate whether a representative of the Trust was interviewed but an information was laid against the Trust for alleged breaches of s.3(1) Health and Safety at Work Act 1974.

e. the outcome was that the Trust pleaded guilty and was fined 50,000.00.

[I/S]

16. A detailed record no longer exists but residual information held on HSE systems confirms that:

a. on [I/S] 2008 an incident occurred involving injured person [I/S] , described as a confused patient was identified as missing from the ward area. During a search he could be seen directly below a 1st floor ward window, lying on the ground floor. He sustained injuries to his head, pelvis and shoulder. The window was not sufficiently restricted.

b. the investigation related to North East Essex Primary Care Trust, the location of the incident being Clacton Hospital.

c. the investigation was commenced on 6 March 2008. The date of the prosecution was 29 October 2009.

d. Dr Paul Zollinger-Read Chief Executive was interviewed on behalf of the Trust and an information was laid against the Trust for alleged breaches of s.3(1) Health and Safety at Work Act 1974.

e. the outcome was that the Trust pleaded guilty and was fined 10,000.00.

[I/S]

17. Information held on HSE systems confirms that:

a. on 4 July 2010 an incident occurred involving deceased person [I/S] likely developed post-surgical psychosis and fell from a 2nd window which was not restricted to the required standard.

b. the investigation related to Southend University Hospital NHS Foundation Trust, the location of the incident being Southend Hospital.

c. the investigation was commenced on 7 July 2010. The date of the prosecution was 1 July 2013.

d. a representative of the Trust was not interviewed, instead they provided written representations on 15 April 2011. An information was laid against the Trust for alleged breaches of s.3(1) Health and Safety at Work Act 1974.

e. the outcome was that the Trust pleaded guilty and was fined 15,000.00.

[I/S]

18. A detailed record no longer exists but residual information held on HSE systems confirms that:

a. on [I/S] 2012 an incident occurred involving injured person [I/S] was a dementia patient who was found on the ground outside the hospital building. Her injuries were consistent with a fall from a window at height. The window was not restricted to the required standard.

b. the investigation related to Basildon & Thurrock University Hospitals NHS, the incident location being Basildon Hospital.

c. the investigation was commenced on 9 July 2012. The date of the prosecution was 3 September 2013.

d. residual records do not indicate whether a representative of the Trust was interviewed but an information was laid against the Trust for alleged breaches of s.3(1) Health and Safety at Work Act 1974.

e. the outcome was that the Trust pleaded guilty and was fined 75,000.00

[I/S]

HSE has previously provided information in relation to this matter to the Essex Mental Health Independent Inquiry.

19. A detailed record no longer exists but residual information held on HSE systems confirms that:

a. on [I/S] t 2013 an incident occurred involving injured person [I/S] fell from a window that was not adequately restricted causing a fracture to her spine and a dislocated knee.

b. the investigation related to Essex Partnership University NHS Foundation Trust, the location of the incident being the Derwent Centre.

c. the investigation was commenced on 5 September 2013. The date of prosecution was 21 October 2014.

d. residual records do not indicate whether a representative of the Trust was interviewed but an information was laid against the Trust for alleged breaches of s.3(1) Health and Safety at Work Act 1974.

e. the outcome was that the Trust pleaded guilty and was fined 10,000.

Denise Gregory, Frederick Peck, Edward Jackson, Ben Morris, [I/S]
Stephen Oxton, Matthew Leahy, Iris Scott, [I/S]

HSE has previously provided information in relation to this matter to the Essex Mental Health Independent Inquiry.

20. Information on HSE systems confirms that:

a. between 1 October 2004 and 31 March 2015 vulnerable patients were exposed to the risk of self-harm by ligature from fixed ligature points within mental health inpatient wards. During this period, 11 inpatients hanged themselves using ligature points, and at least one other, tried unsuccessfully to do so.

b. the investigation related to fatalities at North Essex Partnership University Foundation Trust (which later merged with South Essex Partnership University NHS Foundation Trust to become Essex Partnership University NHS Foundation Trust), the location being The Linden Centre.

c. the investigation was commenced on 26 May 2017. The date of the prosecution was 16 June 2021.

d. a representative of the Trust was not interviewed, instead they provided written representations on 4 November 2019. An information was laid against the Trust for alleged breaches of s.3(1) Health and Safety at Work Act 1974.

e. the outcome was that the Trust pleaded guilty and was fined 1,500,000.

Statement of Truth

I believe the content of this statement to be true.

Signed [I/S]

Dated: 13/03/25