CLOSING STATEMENT OF COUNSEL TO THE INQUIRY

Arundel House, 15 May 2025

Chair,

1. The evidence that we have heard from Paul Scott this morning brings us to the conclusion of the April Hearing.

2. On behalf of the Inquiry team, I would like to begin these closing remarks by thanking all those who have provided evidence to the Inquiry so far, whether or not that evidence formed part of this hearing. We are very grateful to those who have provided witness statements, of which there are many, and to those who have taken time to come and give oral evidence to you and to answer questions.

3. Whilst this hearing has been introductory in nature, and was intended to set out background and contextual matters, we have already heard some important, and at times, shocking evidence. It is clear, even at this early stage, that there are common themes emerging. These include:

The Importance of Data

4. It is abundantly clear to the Inquiry and to those engaging with it, that issues relating to data, including (but not limited to) lack of data, the collection, collation and retention of data, how data should be used and interpreted, will form an important part of the Inquiry's work.

5. Issues with data have featured in a number of different ways during the course of the hearing. The following are just some examples:

a. Dr Davidson, the Inquiry's Expert Psychiatrist, flagged lack of outcome data relating to the provision of mental health services generally. He explained that whilst there is good information in relation to deaths by suicide, this is not a helpful tool by which to assess how mental services are being provided overall.

b. Deborah Coles, Director of the charity INQUEST, gave evidence of the absence of centralised, coherent and complete set of statistics in relation to those who die in mental health detention, and the effect of that data gap. Ms Coles emphasised the need for a centralised data set which could identify where, how many, and why people were dying in mental health detention.

c. Furthermore, it is clear following the evidence of Dr Karale, that considerable further probing will be required in order to understand what data may be available from EPUT to inform the Inquiry's work. There were a number of instances in which Dr Karale was not able to assist the Inquiry in relation to how various aspects of the delivery of care were being monitored, and what information might be available for the Inquiry to interrogate.

6. The Inquiry will consider all of these matters carefully with the assistance of Professor Donnelly, the Inquiry's Expert Health Statistician, and her team.

Concerns in relation to the Investigation of Deaths and Serious Incidents in mental health settings

7. The Inquiry heard concerning evidence from Sir Rob Behrens CBE, former PHSO, and Deborah Coles, in relation to the system by which deaths in mental health settings are, or are not, investigated. Of particular impact was the evidence the Inquiry heard of the way in which families are treated as part of this process. The Inquiry is already seeking evidence on this topic and will continue to explore this further.

8. Furthermore, Sir Rob and Ms Coles both emphasised the need for some improved mechanism by which the implementation of formal recommendations should be monitored. As I outlined at the opening of this hearing Chair, this is something the Inquiry is looking at carefully.

Institutional Defensiveness and the Duty of Candour

9. Another theme to emerge was that of institutional defensiveness along with failures in the duty of candour. The Inquiry is aware of families whose experiences, following the death of their loved one, have included healthcare providers withholding information or attempting to cover up serious failings, adding considerably to their distress. The Inquiry was deeply concerned again to hear evidence from both Sir Rob and Ms Coles which underlined those experiences; and revealed that time and time again, providers have been less than frank in their communications with families and, later on, with those investigating deaths and serious incidents in mental health settings. Sir Rob also gave evidence of considerable reluctance on the part of many health care professionals to come forward and provide information about what happened, for fear of reprisals. Sir Rob emphasised the need to provide better legal safeguards for those who wished to disclose information. Ms Coles advocated the need for improved powers to ensure the enforcement of the duty of candour.

10. This is a matter the Inquiry has very much in its sights. In fact, as has been outlined repeatedly by those representing Core Participants, one of the reasons this Inquiry was afforded statutory status was as a consequence of the inability of the previous independent inquiry to engage co-operation from those who had worked in mental health units. I will return in just a moment to the question of the undertakings that have been sought by the Inquiry.

Crowded and Confused Regulatory Landscape

11. The Inquiry heard evidence about the regulatory landscape which, taken as a whole, ought to have guarded against failings in care and delivered accountability. In opening, I described the picture as a crowded one where it was not clear how the various organisations fitted in. Having heard further evidence, that observation remains apt.

12. Jane Lassey, Director of Regulation at the Health and Safety Executive ['HSE'], identified what had been perceived as the regulatory gap in respect of inpatient care. In 2015, following the Mid Staffordshire NHS Foundation Trust Public Inquiry, this resulted in the Care Quality Commission ['CQC'] being given new statutory powers to prosecute healthcare providers for failing to provide treatment in a safe way. This was followed by a memorandum of understanding between the CQC and HSE as to who was responsible for investigating deaths and serious incidents, depending on the circumstances. The 2020 prosecution of EPUT was undertaken by the HSE rather than the CQC. This is something which the Inquiry will consider further.

13. Evidence summarised from the healthcare professional regulators underlined the high threshold for action against individual

professionals. Their initial data shows a high number of concerns having been raised and a relatively small proportion of cases where action was taken on a professional's registration. Many of the professional healthcare regulators' cases were closed due to the concerns being of a systemic rather than individual nature or because individually, concerns were not sufficiently serious to justify further action.

14. It is the CQC's responsibility to investigate and address broader concerns relating to provision of inpatient care. The Inquiry intends to explore further whether, and to what the extent, the various regulators acted together effectively to prevent cases falling into "the gap". Set against the known failings at EPUT, reflected in both CQC inspections and the HSE's prosecution, it will be important to understand fully the absence of CQC criminal prosecutions and the limits of civil enforcement action.

15. The Inquiry will also carefully consider the Penny Dash review into the effectiveness of the CQC and the extent to which concerns raised there are applicable to the CQC's role in Essex.

Early indications are that Essex is not an outlier

16. There are early indications from the evidence heard so far including that of Sir Rob, Ms Coles, Dr Davidson and Ms Nelligan, that some of what was occurring in Essex may reflect the national picture.

Other Evidence

17. Chair, I turn now to consider some of the other evidence the Inquiry has heard during the course of this hearing.

Inquests

18. The Inquiry heard a CTI presentation on inquests which summarised the coronial process in England and Wales. The paper explored particular difficulties faced by families including the length of time which inquests take, the lack of funding for representation, and their legal complexities. Challenges facing families were further highlighted on behalf of Core Participants by Fiona Murphy KC and Steven Snowden KC. Both they, and Deborah Coles of INQUEST, gave particular emphasis to the issue of prevention of future death reports ['PFDs'] and the lack of an effective system to ensure their implementation.

Dr Davidson and Maria Nelligan

19. The Inquiry heard expert evidence from Dr Davidson and Ms Nelligan which sought to provide a high-level overview of some of the key principles and good practice in respect of mental health inpatient care nationally during the relevant period. They provided important national context to some of the issues which we will be examining more forensically within Essex. Their evidence explained some of the obstacles and shortcomings in the provision of high-quality inpatient care. These included:

    a. The increased demand for mental health services which was not always matched by adequate resources in the teams which needed them;
    b. Delays and challenges with getting those in crisis admitted to an inpatient bed at the optimum time to provide the most effective care and treatment;
    c. Shortages of registered nurses in inpatient units and nurses leaving roles in inpatient services. We heard how this was made

worse by often more attractive conditions in newer and specialist community teams and also by a lack of time to deliver to therapeutic interventions to patients. We also heard about the increasing reliance on Healthcare Support Workers;

d. A fear culture amongst mental health professionals where many felt they would be blamed if things went wrong, whatever decision they took. We heard that this could result in compassion fatigue and undue focus on restrictive practices to try and reduce or manage risk rather than a focus on treating a patient's underlying mental health condition. This was entirely consistent the Sir Rob's experience;
e. We heard more broadly across a number of areas of the dangers of trying to manage or eliminate risk at the expense of delivering effective care and treatment of a patient's underlying condition.

20. As was stated at the outset, this was introductory evidence and represents the start, not the end of the expert evidence which the Inquiry will consider. We are considering what further expert evidence is required.

Dr Karale

21. Dr Karale is the Executive Medical Director at EPUT - a position he has held with EPUT and before that, SEPT, since 2012. He was the first witness from EPUT to give oral evidence to this Inquiry.

22. In summary Chair, the rule 9 requests to EPUT for information about pre-admission assessments and the inpatient pathway made it clear that the Inquiry sought:

a. a broad explanation of the forms of mental health assessment that EPUT's patients received prior to admission over the Relevant Period;
b. a description of the mental health treatment and care the Trust delivered to inpatients over the Relevant Period;
c. an understanding of the guidance and policies that applied to the provision of those services;
d. explanations of how the Trust monitored and evaluated performance to check whether those services were being delivered as intended.

23. Whilst Dr Karale's evidence in relation to both of those areas was helpful in setting out a broad overview of the structure and processes in place over the Relevant Period, you may think that his evidence was marked as much by what he could not assist with, as the questions he was able to answer.

24. In relation to monitoring and evaluation for example, Dr Karale's response in his statements and to Miss Harris KC's questions was very limited.

25. Furthermore, the choice of documents exhibited to Dr Karale's witness statements might be considered somewhat haphazard. In some cases, historic and out of date documents were produced, in others, the documents relied upon remained in draft form. There appears to have been no consistent or systematic approach evident in the documents supplied.

26. This raises questions about the state of the Trust's policy and document library, quality assurance, and the processes in place to enable staff members to access the right policy at the right time. The Inquiry intends to revert to the Trust and to ask again for a complete

overview of the documentation which is actually available from the entire Relevant Period and more significantly, a proper understanding of staff access to policy documentation over that period.

Paul Scott

27. Chair, we heard this morning from Paul Scott, the Chief Executive Officer at EPUT. He was asked a number of questions in relation to a Position Statement that he provided to the Inquiry on behalf of the Trust. Whilst he did not accept that the tone of his statement was aspirational, his evidence focused to a large extent on change and plans going forward. It was of note that he gave evidence of the complications of commissioning, and he described the regulatory landscape as "overwhelming".

28. Mr Scott told the Inquiry that since he started at EPUT, there had been no financial constraints, but the greatest challenge was the supply of staff. Asked further about staffing issues, and in particular the difficulties with staff coming forward to speak up, Mr Scott agreed that there was still a lot of work to do to ensure that staff felt safe and supported at work. He accepted that "closed cultures" did exist at EPUT, and that staff do not feel confident about speaking up at the Trust. There is ongoing work to try and change the culture at EPUT.

29. Mr Scott told the Inquiry however, that EPUT is giving consistent messaging to staff about the importance of sharing information with this Inquiry. He said that EPUT will offer support to those staff members if required.

30. Mr Scott accepted that the Trust's responses to, and learning from, coronial reports was slow. He acknowledged that it had been an

oversight on the part of EPUT not to have a central record of PFDs and that it might also be a good idea to have older records incorporated into that central register. Asked about the inclusion of families in the investigation process, Mr Scott said that it was his understanding that many families appreciate the involvement of the family liaison officer and feel more included.

31. Chair, on Monday of this week, you determined to postpone the public hearing of evidence about the use of Oxevision. The reason for this was the late disclosure by EPUT on Friday last week, of a statement in relation to major policy and procedural change in their use of Oxevision. EPUT's position in the new statement was a very different position than that set out in the Trust's initial statement just six weeks earlier. Furthermore, prior to last week EPUT had given no notice to the Inquiry of the potential change, notwithstanding the fact EPUT were aware many weeks ago that change would be effected.

32. Chair, you have already expressed your dissatisfaction about this. This morning I asked Paul Scott to honour the commitments that EPUT set out in its Opening Statement to the Inquiry in September last year, and to demonstrate those commitments through its actions rather than words and broad assurances.

Next Steps and Future Work

33. I would like now to say a few words both about next steps and about the future work of the Inquiry. The Inquiry's work will continue, without break, to investigate the issues required in order to meet its Terms of Reference.

34. The Inquiry's next public hearing will be in July. The July Hearing will be focused on those who died whilst under the care of EPUT's

predecessor trusts, NEPT and SEPT. The Inquiry is in the process now of receiving witness statements and will be inviting oral evidence in July from a number of the families and friends of those who died, as to what actually happened to their loved ones.

35. The Inquiry undertakes its work in parallel however, both in and out of hearings. The Inquiry will continue to seek and share information and to publish evidence as appropriate, outside public hearings. The Inquiry is also exploring different ways to obtain witness evidence and will remain flexible in its approach. Since the start of this hearing, the Inquiry has granted Core Participant status to British Transport Police and St Andrew's Healthcare.

36. In the meantime, Chair, you have invited any Core Participant who wishes to, immediately following this hearing, to provide written submissions addressing you and your team on pertinent issues and matters arising during the April Hearing. This provides an opportunity for Core Participants to engage with the Inquiry's work in what we hope will be a constructive and collaborative discourse.

37. The Inquiry will also reflect independently on what it has heard and learned during the course of this hearing. The Inquiry will consider all possible lines of Inquiry; many of which have already been identified. This will include whether to seek further evidence from and/or recall witnesses that it has already heard from.

38. As I stated at the outset of this hearing, and in light of the evidence we heard from Sir Rob Behrens CBE, the Inquiry is interested in the views of the Core Participants as to whether it should pursue undertakings from healthcare providers and regulators. Sir Rob's view, given in oral evidence, was that the "duty of candour does not work" and that "the law on whistleblowing doesn't work either". He

told you Chair that he had had “dozens” of clinicians get in touch with him indicating that “they wanted to raise issues” but they feared they would lose their jobs and careers. The proposed undertakings seek to safeguard the interests of those would like to raise issues. They relate only to the provision of material to the Inquiry and would not enable any individual to avoid accountability for serious misconduct. Set against the background of such limited staff engagement with the previous independent inquiry, Chair you considered these undertakings were a necessary and proportionate method by which healthcare professionals and employers might be encouraged to come forward and give evidence to the Inquiry now, without facing reprisals for not having come forward before.

39. Finally Chair, I emphasise again that this hearing represents only the start of the Inquiry’s consideration of the issues and themes that have been raised over the past few weeks, and certainly not the end. Although the end may still be a little way off, we offer all those participating in this Inquiry and the public, the Inquiry’s assurance that we will continue to work to uncover the truth, expose wrongdoing, and to allow us to establish facts and make recommendations for real and lasting change.

NICHOLAS GRIFFIN KC
Counsel to the Lampard Inquiry
15 May 2025