Statement on behalf of INQUEST
Name: Deborah Coles
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**THE LAMPARD INQUIRY**

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**FIRST WITNESS STATEMENT OF DEBORAH COLES ON BEHALF OF INQUEST**

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I, Deborah Coles, will say as follows:

1. I make this statement on behalf of INQUEST, in response to a Rule 9 request made by the Inquiry on 30 January 2025. I have been the executive director of INQUEST since February 2017, prior to which I acted as Co-Director from 1994, having worked for the charity since 1989.

2. Of particular relevance to the matters being considered by the Inquiry, I also hold/have held the following positions:

    2.1. Representing INQUEST on the cross-departmental sponsored Ministerial Board on Deaths in Custody.
    2.2. A member of the Independent Advisory Panel on Deaths in Custody, three terms of appointment from 2007 to 2023. The IAPDC provides independent advice to the Ministerial Board on Deaths in Custody with the central aim of preventing deaths in custody, including of those detained under the Mental Health Act.
    2.3. A member of the advisory group which led to the establishment of the Health Service Investigation Branch (HSIB).
    2.4. A member of the Expert Advisory Group to the Care Quality Commission in respect of their report 'Learning, candour and accountability review: a review of the way NHS trusts review and investigate the deaths of patients in England'.

**INQUEST**

*Purpose*

3. INQUEST is a non-governmental organisation founded in 1981. INQUEST is the only charity in England and Wales providing expertise on state-related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in police and prison custody, immigration detention, mental health settings, and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This has included work around the Hillsborough football disaster and the Grenfell Tower fire.

4. INQUEST's aim is to reduce and prevent state-related deaths. A core part of this involves work to improve the quality of post-death investigations so that they perform their important preventative function to improve systems and bring about changes to culture, policy and practice, in order to safeguard lives in the future. Our work also situates state-related deaths in their broader social and political contexts which provides an evidence base on which to expose and challenge structural racism and all other forms of structural oppression.

5. INQUEST's policy, parliamentary, campaigning and media work is grounded in the day-to-day experience of working with bereaved people. Our work is founded on an integrated model which brings together our casework and family participation teams within the organisation to help provide evidence on emerging themes or concerns which in turn feeds into the organisation's work on campaigning, information sharing and policy and parliamentary work. We work across England and Wales and have conducted discrete pieces of work in Scotland and internationally.

6. At the heart of this unique model are the experiences and needs of bereaved people. Not only does INQUEST's model ensure that bereaved families are able to access the independent support that they need during the investigation and inquest process, but that their experiences and voices are heard by parliamentarians and policymakers. This in turn can

contribute to cross sector learning necessary to prevent future deaths and ensure the improvement of systems of care. Families are experts by experience, understanding better than anyone the issues and experiences at stake and the broader context in which their relative died. They have also described the community of INQUEST families as bigger than a sum of its parts, forming a formidable collective voice, wealth of knowledge, and engine for change.

*INQUEST as an organisation*

7. INQUEST is a small organisation in terms of staff numbers, and our team of 16 people comes from various walks of life, reflecting our organisational commitment towards diversity but also the backgrounds of the families we work alongside. Our staffing roles are organised around: casework, media and policy, family engagement, specific projects, and operations. We are also assisted by volunteers and two consultants who conduct work around the organisation's database and statistics, as well as monitoring and evaluation work. In terms of governance, our board of trustees comprises 13 members. The board recently welcomed three new members from the community of families working with INQUEST, two of whom are family members of people who died whilst receiving mental health inpatient care or following contact with mental health services. INQUEST also has a Family Reference Group made up of people directly affected by a contentious death which supports and contributes to our work from a family perspective.

*INQUEST's involvement in deaths in mental health settings*

8. The role of mental health in state-related deaths has been an issue INQUEST has worked on since its inception. The organisation's initial involvement was in cases involving treatment of people experiencing mental health conditions and mental health crisis at the hands of the police and by prison authorities. Although the focus in these types of cases was necessarily on the responses on the part of police and prison officers, as the Inquiry will see illustrated by paragraphs 48, and 70-78 below, inadequacies in the provision of mental health care play a role in how

people can come into contact with the criminal justice system, such that police and prison cases raise issues which fall within the scope of this Inquiry.

9. However, over time and demonstrated through a number of key cases, it became clear that problems arising in the prison and police contexts are reflected in mental health settings. This includes, for example, the excessive and disproportionate use of force against patients, the use of seclusion and dehumanising treatment of those receiving mental health in-patient care, and a reluctance on the part of mental health providers to allow meaningful investigation of the poor treatment that patients were receiving. The circumstances giving rise to the Blom-Cooper Inquiry into Ashworth Hospital in 1992 are a key example. The inquiry had been set up after a Channel 4 documentary in March 1991 exposed physical ill-treatment at the Ashworth special hospital in Merseyside. The investigation uncovered appalling abuses, and concluded that the hospital's regime was *"brutalising, stagnant and oppressive".* This Inquiry represented an unprecedented insight into practices within mental health detention. INQUEST gave evidence to the Blom-Cooper Inquiry in March 1992, and our submissions highlighted the ways in which the families of those who had died there were experiencing an extension of that oppression:

> *"Families' experiences are characterised by a lack of information, secrecy, and often what they feel is indifference by the authorities and the institution in which the deceased has died. They have a desperate desire to know the circumstances of the death and to find out what has actually happened. What they feel is that they face a wall of silence. The system of finding out what happened is totally inaccessible."*

10. It is noteworthy that one of the first inquests that I attended of a person who had died whilst detained under the Mental Health Act was in relation to the death of a [I/S] woman at [I/S] Hospital in the early 1990s. The [I/S] woman had taken her own life yet the inquest lasted only 15 minutes. This reflected the perceived inevitability of such deaths and pathologisation of individuals detained under the Mental Health Act, as well as the appalling lack of scrutiny afforded to such deaths at that time.

11. The death of a Black man David 'Rocky' Bennett, whilst an inpatient at the NHS-run Norvic Clinic in Norfolk in 1998, due to asphyxia and following prolonged restraint, was another example of how the violence and racism INQUEST saw in prison and police contexts was also readily apparent in the provision of mental health care and within mental health settings. INQUEST supported the family through the legal processes. After the jury returned a verdict of neglect at the inquest in 2001, INQUEST continued work with Rocky's family, their lawyers and MP to bring about an inquiry to examine the circumstances around his death, the use of restraint across custodial settings, and the role that racism may have played. Evidence was given by a wide range of witnesses, including evidence on behalf of the Royal College of Psychiatrists, which observed in relation to racism that "*African-Caribbean patients on the whole received a more coercive spectrum of care in the NHS and the research indicates that psychiatrists tend to over-predict dangerousness in black people.*"[1]

12. INQUEST's evidence to that inquiry, as summarised in the resulting report 'Independent Inquiry into the death of David Bennett' (Exhibit DC/01), highlighted the lack of data to enable monitoring of deaths in mental health detention:

*"There was a gap in information, not only about who was dying but why they were dying"*

and highlighted the issues in post-death investigations which had started to emerge through INQUEST's work in mental health settings:

*"the failure by the NHS to provide information and support to families after a death had a highly detrimental effect on families' mental health. It affected their ability to grieve properly, their ability to continue with their own lives and to cope with their emotional distress.* […]

*So many families found themselves lost in the system where they did not understand what was happening and did not have anybody to advocate for*

[1] p 44.

*them. A further key point was that families should be informed of the death immediately. 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."*

13. The inquiry went on to make a number of recommendations, including that:

    13.1. There be ministerial acknowledgement of the presence of institutional racism in mental health services and a commitment to eliminate it;

    13.2. The Department of Health should collate and publish annually statistics on the deaths of all mental health in-patients, which should include ethnicity; and

    13.3. There was a need to review the procedures for internal inquiries by hospital trusts following the death of psychiatric patients, with emphasis on the need to provide appropriate care and support for the family of the deceased, as well as for staff members.

14. In 2003, INQUEST submitted written evidence to the parliamentary Joint Committee on Human Rights' ('JCHR') inquiry into deaths in custody (Exhibit DC/02). In relation to mental health deaths, our concerns followed similar lines, i.e. that the failure on the part of government or any arms-length bodies to collate and publish annual statistics on the deaths of detained patients, together with the poor systems in place for examining and reporting these deaths, gave rise to our belief that contentious deaths of vulnerable people in mental health detention were escaping public scrutiny. In December 2004, the JCHR reported its findings (Exhibit DC/03), amongst which it concluded that: *"In our view there is a case for a permanent investigatory body* […]. *Since the case for such a body has been accepted in relation to police detention (with the establishment of the IPCC) and prison and immigration detention (with powers of inquiry* […] *allocated to the Prisons Ombudsman) we can see no reason why deaths amongst this particularly vulnerable group of detained people should not be subject to a similar safeguard*."

15. By the 2010s it had become clear that there were fundamental problems with the system for investigations of deaths in mental health detention. INQUEST worked with the family of [I/S] following her death whilst a detained patient [I/S]. The stark contrast between the findings of the investigation conducted by the NHS Trust which had provided her treatment – which identified few failures in care – in comparison with the inquest which took place two years later, where the jury was highly critical of aspects of [I/S] care, laid bare the problems that the lack of independent pre-inquest investigations were causing. INQUEST continued to work with the family and provided evidence in subsequent litigation, pointing out that mental health inpatient detention was in that respect an anomaly as in contrast to all other detained settings as no organisation existed to independently investigate, prior to an inquest, the deaths of people who died in mental health hospitals. This was despite the fact that early statistics were showing that mental health deaths made up the largest proportion of deaths in state custody.[2]

16. The litigation that followed [I/S] death built on other strategic mental health legal challenges in which INQUEST had intervened in order to provide contextual and policy evidence and which concerned the rights and safety of mental health patients, namely: *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74,[3] which established that the protective duty owed by public authorities, which arose from the right to life under Article 2 of the European Convention on Human Rights, applied equally to people detained in psychiatric hospitals, as it did to any other form of state detention (such as police custody or prison); and *Rabone v Pennine Care NHS Trust* [2012] UKSC 2, where the court found that the duty also applied to patients who were not formally detained under the Mental Health Act (but were 'de facto' detained).[4]

[2] By that point, detailed statistics for the number of deaths of people detained under the Mental Health Act had been published for the first time in 2011 by the Independent Advisory Panel on Deaths in Custody, which showed that these deaths accounted for 61% of all deaths in state custody between 1 January 2000 and 31 December 2010.
[3] The deceased in that case was Carol Savage, who died aged 50 after being permitted to abscond from Runwell Hospital, which was operated by SEPT.
[4] The deceased person in that case was Melanie Rabone, who was a voluntary patient, and died aged 24, whilst on leave from Stepping Hill Hospital in Stockport.

17. These cases brought attention to the way in which patients and families were being failed by mental health providers. The number of families contacting INQUEST increased, and mental health cases steadily became a core feature of INQUEST's work: we delivered specialist casework to 51 families in 2011, 80 in 2012, 84 in 2013, and 96 in 2014.

18. By 2014 mental health inpatient deaths made up a significant proportion of our casework, and it had become clear from the recurring nature of failings in mental health care that the system for learning from deaths was not functioning properly. In November 2014 we held a Family Listening Day to inform the Equalities and Human Rights Commission's Inquiry into non-natural deaths in detention of adults with mental ill health (INQUEST Evidence Report for the Equalities and Human Rights Commission's (EHRC) Inquiry into non-natural deaths in detention of adults with mental ill health between 2010 and 2013, published in December 2014; Exhibit DC/04). As is clear from the family accounts of failings described in section 4 of that report, key themes were repeated across cases, such as a lack of support in the community, failures to involve families in care, failures in performing mental health observations, poor quality of care, and inadequate assessments.

19. Our work during this period culminated in the February 2015 report, *"Deaths in Mental Health Detention: An investigation framework fit for purpose?"* (published February 2015; Exhibit DC/05) which made a number of recommendations, including:

    19.1. the need for a single body conducting independent pre-inquest investigations,
    19.2. meaningful involvement of families in investigations,
    19.3. better collation and publication of statistics on deaths of mental health patients including characteristics such as age, gender, ethnicity, and location and type of death, e.g. self-inflicted, restraint related or from 'natural causes', and
    19.4. a better mechanism for ensuring implementation of coronial recommendations.

20. These key recommendations were reiterated in INQUEST's submission to the Care Quality Commission's review of investigations into deaths in NHS Trust (October 2016; Exhibit DC/06), along with updated analysis of repeated trends arising in INQUEST caseworkers' and lawyers' practice, and an accompanying report documenting findings from the CQC Family Listening Day (Exhibit DC/07), which the CQC commissioned INQUEST to plan and deliver, to allow evidence from families to inform the review.

21. 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 a 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 – 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.

**INQUEST'S CASEWORK**

22. A central feature of INQUEST's work is its casework. It is through the organisation's direct involvement with bereaved families, enabling and empowering them to play a meaningful part in the post death investigations and to try and shine a light on the systemic issues behind the deaths that we seek to bring about change in individual cases. INQUEST's casework represents a central source of information to inform our strategic and campaigning work. Through our casework, along with other types of family engagement, INQUEST roots its work in the priorities and lived experiences of bereaved families.

23. Most families find out about INQUEST through the internet, typically as part of a search for publicly available information about the inquest process. Other routes to us include through word of mouth via networks of bereaved families, support organisations or journalists, or through referrals from

lawyers. Our experience of families whose loved ones have died in mental health settings in Essex, is that they have been more likely to come into contact with INQUEST through word of mouth, because the issue of mental health deaths in Essex has been more widely publicised and as a result there is a well-connected community of families who can signpost each other to support.

24. Occasionally, INQUEST becomes aware of particular cases which fall within organisational priority areas of work or within communities which are less likely to seek out support. In these instances, we proactively contact the relevant coroner's office where the death occurred to introduce our organisation to the family and offer assistance. This occurs more frequently in our other areas of work (deaths in prison, immigration detention, or in police custody/following police contact) primarily because in those areas there are more advanced mechanisms by which those deaths are monitored and publicised, either by press release or through direct notification.

25. In our other areas of work, it is also more likely that families will have been referred to us by the state organisation itself (for example by a Family Liaison Officer from the relevant police force), or through the relevant oversight body (the Independent Office for Police Conduct ('IOPC'), or the Prisons and Probation Ombudsman 'PPO'). INQUEST monitors where families have found out about us and there has only been one occasion that we are aware of when a family was signposted to us by an NHS Trust. As far as I am aware, and having consulted with our caseworkers, a family has never been referred to us by the CQC.

26. Some families are also signposted or referred directly to us by the relevant coroners' office. INQUEST has established lines of communication with the coroners' courts and delivered national training organised by the Chief Coroner to coroners' officers, including on the need for families to be referred to INQUEST or signposted for independent legal advice, given the importance of early information and support in state-related deaths. In our experience, however, mental health deaths are less frequently viewed as state-related or contentious by coroners' officers, and in our experience,

families are less likely to be made aware that they may need specialist support or legal advice in mental health inpatient deaths.

27. Unfortunately, demand for our casework service far outstrips our capacity as an organisation. None of the mental health charities provide specialist advice and support in this area and none work with bereaved people. We try to address the need for support by committing to providing as much information and advice to bereaved families as we can. As an organisation, we agree on the scope of our casework services, which can broadly be described as deaths of people in state custody or care, which includes, prison, policy custody / following police contact, immigration detention, and in mental health settings, and which has changed over time. If we are contacted in relation to a death which falls outside our casework remit, we will signpost the family to organisations who may be able to assist or refer them to online materials we have produced. We also operate an advice line which is open on Tuesdays and Thursdays and is open to anyone. Even if a person's loved one died abroad or in other circumstances clearly outside our remit, we will offer signposting and practical advice as far as possible. All families can access our online resources.

28. If a family contacts INQUEST in relation to a death which falls within the organisation's casework remit, a caseworker is identified to – where possible – work with the family throughout the life of the case, however long that may be. This begins with a response to any initial contact from the family to establish as much information about the circumstances of the death as possible. Early priorities often involve the provision of key information to families about post-death investigation and inquest processes, normally by reference to our Inquest Handbook,[5] or Factsheets.[6] In considering a family's needs, we may signpost them to support, such as the organisations listed on our website.[7] Our approach to families is oriented around their needs and there is no particular difference in the delivery of casework across our different areas of work.

[5] This is available electronically here: https://info.inquest.org.uk/handbook/
[6] See here: https://www.inquest.org.uk/Pages/FAQs/Category/inquest-faqs
[7] https://www.inquest.org.uk/other-sources-of-support

29. The caseworker will also discuss the possibility of legal advice with the family, and – where public funding is available – secure legal representation for the family, normally from within the INQUEST Lawyers Group.[8] INQUEST's casework continues alongside legal representation, assisting the lawyer by identifying evidence-based resources collated by the organisation through its work and maintaining a monitoring role.

30. In the mental health context, difficulties securing legal aid funding are most commonly experienced when someone has died in the community, as the law and therefore funding criteria are less straightforward than in circumstances where someone died as a detained or voluntary inpatient in receipt of mental health care. This is because the availability of legal aid in inquest cases is contingent on the investigative duty under Article 2 of the European Convention on Human Rights being engaged. In cases where a lack of public funding limits the availability of legal representation, INQUEST's service seeks to fill the gap in specialist advice this creates: the caseworker will explore pro bono representation for the inquest, and, in any case continue to provide specialist support and information to the family, drawing on the organisation's expertise in inquest processes. The caseworker will help the family navigate the post-death investigation process, make representations to the coroner where needed, and support the family through the inquest hearing.

31. A key aspect of the caseworker's role is to gather and collate information about the case. Information is obtained directly through the caseworker's involvement, and sources include: the family's account of events, post-death investigations, documents prepared and shared with INQUEST by the family's legal representatives, and witness statements and other documents disclosed through inquest proceedings, and which can be shared with INQUEST. This enables us as an organisation to identify trends and themes arising from the work, and to develop a depth of understanding of how these issues play out.

[8] 'ILG', a national pool of lawyers who provide specialist legal advice in relation to inquests into contentious deaths. The group is co-ordinated by INQUEST and provides a forum for members to share expertise and remain up to date with coronial developments.

32. For some families, shedding light on the issues, giving a voice to their loved one and campaigning forms an important part of the healing process, and INQUEST remains available to families to help facilitate this work, whether during or after the inquest process, or indeed years later. To do this, the caseworker supports families in raising issues emerging from the case with statutory bodies, policy makers, parliamentarians, or the media – through correspondence, meetings, and the use of complaint processes where available.

33. Although the formal casework service is likely to come to an end once the inquest process has concluded, our organisation remains open to families through collaboration with family-led campaigns,[9] or other types of family engagement events or commemorative projects.[10] If the caseworker has not already provided signposting to relevant support organisations, this is reviewed at the closure of the case.

34. I have been asked to describe any difficulties, challenges, or opportunities INQUEST has identified in engaging with bereaved people with particular needs or from particular communities. There are a number of specific considerations when working with bereaved families across all our areas, such as:

    34.1. The effect of an existing disability or neurodiversity;

    34.2. Grief and/or trauma arising from their loved one's death;

    34.3. The effect of structural inequalities predicated on class, race or gender identity, usually experienced as stigma, and as an inequality of arms in comparison to state bodies;

    34.4. The ways in which post-death processes retraumatise families and limit the ability to grieve and participate, particularly when processes are delayed and families face defensiveness from the trusts or private providers;

[9] For a non-exhaustive list of family-led campaigns please see here: https://www.inquest.org.uk/family-campaigns
[10] For examples of INQUEST's work in this area, please see: https://www.inquest.org.uk/connection-and-community

34.5. Isolation, as a result of the above; and

34.6. Lack of services to support families whose loved ones died in state custody or care.

35. In relation to mental health deaths in particular, these considerations include:

35.1. The ways in which post-death processes can mirror failures experienced by families during their loved one's care, including: being shut out of relevant processes; dismissal of their concerns; lack of recognition of their expertise in relation to their loved one's care; lack of recognition of the family member as an important source of information and evidence in relation to events leading up to and the circumstances of their loved one's death.

35.2. The effect on families' ability to access treatment for their own mental health conditions, for example PTSD, depression, or complex grief disorders: the experience of being catastrophically let down by mental health services can mean that some families are unable to place any trust in mental health services: either specifically in relation to the NHS Trust in whose care their loved one died (and who is likely to be a source of continuing trauma through the post-death processes), or at all. In some cases – especially where legal representatives are involved – it has been possible to secure provision of mental health care from a different Trust, or on a private basis paid for by the Trust or provider, however this is not always agreed, and INQUEST has no experience of this ever having been proactively offered to the families it works with, indicating that despite the prevalence of the issue, it is not a routine consideration when Trusts or independent providers undertake investigations.

36. As an organisation we deploy our resources responsively to individual families' needs, as articulated by them, by:

36.1. Establishing with the family what their needs and priorities are, including what level of engagement is right for them. Our work is sensitive to the family's needs: where appropriate, the caseworker will signpost to bereavement and other specific support services, or provide practical guidance and support, for example with accessing time off work, and securing support for children. Depending on the family's circumstances, the caseworker may share our Skills Toolkit,[11] which is an online resource produced with the help of families to support the development of practical skills whilst coping with the aftermath of a death in state care and navigating the various post-death processes.

36.2. Where possible, bringing into our casework service particular cases which would otherwise fall outside remit, either because the family's level of need is very high (for example if a family member has a mental health condition or other disability which means they would otherwise be unable to engage with post-death processes or access information about their loved one's death) or because the death occurred in circumstances which were particularly contentious.

36.3. Facilitating family engagement and peer support through: family forums, which are facilitated events that take place around twice a year, enabling families to share experiences of their individual cases, seek and offer mutual support, share strategies for coping with the process and campaigning ideas; and the twice monthly Connection Café and regular Consultation Cafés, which are online support platforms facilitated by caseworkers and members of INQUEST's Family Reference Group; as well as other family engagement events such as Family Listening Days.

36.4. Advocating on their behalf, for example, by requesting reasonable adjustments under the Equality Act 2010 from investigating bodies or coroners, to avoid deadlines being set or hearings listed without

[11] http://info.inquest.org.uk/toolkit/

sufficient advanced notice, or to allow evidence to be heard in an accessible format.

36.5. Translating INQUEST written resources and ensuring that communications with the family from us or investigating bodies are translated, and engaging interpreters where needed.

36.6. Providing communications in appropriate formats according to a person's needs or level of digital literacy, e.g. in hard copy, orally, or in person.

36.7. Recognising that their experiences and needs may make it difficult for them to engage with professionals, and referring them to a number of different legal firms to find the right match.

37. Whereas our approach as an organisation is tailored to the needs of individual families, and time is taken to establish with the individuals what these needs are, such an approach is rarely taken when families come into contact with Trusts or independent providers following the death of a loved one, despite existing and updated guidance such as the Patient Safety Incident Response Framework. This is a source of further distress and trauma for families as their individual needs are not given adequate consideration.

38. In general, however, the biggest challenge for families is that they face investigatory processes which are exclusionary, delayed and defective. Families have articulated this powerfully over the years, and INQUEST has sought to create space for families to voice these experiences – sometimes directly to the relevant organisation involved – through the use of family listening days.[12] Since we started holding family listening days in March 2010 families have been telling us that:

38.1. Notifications of the death of their loved one are inconsistent and often insensitive, and there is a lack of information about the death

[12] See here for a list of family listening days INQUEST has held, spanning from March 2010 to date: https://www.inquest.org.uk/family-listening-days

(see INQUEST's CQC Family Listening Day report, October 2016 Exhibit DC/07 pp 3-5; and INQUEST's Family Consultation Day Report on deaths of people with mental ill health, a learning disability or autism, April 2023, Exhibit DC/08 pp 8-9).

38.2. There is a lack of information about what processes will follow. Families feel *"they had been "left in the dark" regarding the process, future investigations, post-mortems and inquest procedure*." (see Report of the Independent Advisory Panel on Deaths in Custody – Family Listening Day, September 2011, Exhibit DC/09 p 8) and that *"it was like being put into the world of the unknown"* (October 2016 listening day report, Exhibit DC/07 p 5). One family member described this stage of the process: *"It was just shock after shock after shock […] trying to navigate all this stuff you don't know"* (April 2023 listening day report, Exhibit DC/08 p 11).

38.3. Contact with representatives of the relevant NHS Trust is defensive. One family said it *"felt like a "fishing exercise to find out what we knew already""* (September 2011 listening day report, Exhibit DC/09 p 11). Another described how *""Our initial meeting with the trust was at 7:30pm on a Friday evening. The lady from the trust told us, 'I come to this table as a mother'. She told us how unprofessional her colleagues had been but said we couldn't expect her to sell her colleagues down the river".* (October 2016 listening day report, Exhibit DC/07 p 6). Another family described that: "*As soon as we started asking questions it was like we were interfering and that they were the professionals, not us. They became antagonistic".* (October 2016 listening day report, Exhibit DC/07 p13). One other family member recalled: *"They came to my house and said trust us, we're going to change things but how can I trust you when you killed my son?"* (April 2023 listening day report, Exhibit DC/08 p 14). Another person said: *"If I could catalogue the number of […] professionals who say, "look I can't say this publicly but …" and then make serious criticisms. They will go, "this is what the trust will allow me to say, I'll go right to the edge but I can't go further because there will be ramifications*" (April 2023 listening day report, Exhibit DC/08 p 17).

38.4. The investigations are not independent: *"the investigative process was distant, evasive and perceived to be a "whitewash" exercise or as a mechanism for protecting jobs and staff"* (September 2011 listening day report, Exhibit DC/08 p 13). One family asked, *"whose truth are they after?"* (October 2016 listening day report, Exhibit DC/06 p 10).

38.5. The quality of investigations can be poor. One family described how the investigator in their case was undertaking the investigation whilst still carrying out her duties as matron in the hospital: *""We asked how she had time to do her main job as well as helping us. She said 'most times I take it home and do it at the weekend over a bottle of wine'"* October 2016 listening day report, Exhibit DC/07 p 12). Another family described having to take on responsibility for scrutinising the details: *""They'd changed the logs so we felt we had to forensically analyse the evidence".* (October 2016 listening day report, Exhibit DC/07 p 18).

38.6. Investigations often fail to include evidence of concerns or complaints raised by families during their loved one's life. Families could not understand why their observations, sometimes regarding what they believed to be a direct risk to life, were not placed on public record as part of the investigation and reporting process (October 2016 listening day report, Exhibit DC/07 p 21).

38.7. The process is gruelling. One family member said that Trusts *"rely on exhausting you"* (September 2011 listening day report, Exhibit DC/09 p 26). Others said: *"The death wounded me, dealing with mental health services has broken me",* and *"everything is a fight when you have the least fight in you"* (April 2023 listening day report, Exhibit DC/08 p 18).

38.8. Accountability and implementation of change is lacking. One said: *""There must be a fundamental cultural change – one of cooperation and collaboration rather than seeing you as the enemy""* (September

2011 listening day report, Exhibit DC/09 p 26). Another family member spoke about the failure to implement change: *""They told me that changes had been made but then in February and March two other people died so none of the changes were actually made"* (October 2016 listening day report, Exhibit DC/07 p 29). Another commented: *""For me, the message which was raised a number of times is that the investigation process should provide hope to surviving family and reassurance that lessons will be learned, that the same thing won't happen to someone else's daughter, brother, mother or husband. The system as it stands today does exactly the opposite; it actually has a negative effect on relatives, causing mental and physical illness, work and financial pressures and is ultimately damaging for the NHS, leading to unnecessary legal claims resulting in financial penalties with no positive outcome"."* (October 2016 listening day report, Exhibit DC/07 p 31). One family described the successful implementation of change following the inquest: *"knowing that the hospital removed the doors. But that is tinged with "what about the rest of the country"* (April 2023 listening day report, Exhibit DC/08 p 30).

39. Whilst there have been some changes to the post-death investigation processes since INQUEST started holding family listening days in 2010, such as the introduction of the Patient Safety Incident Response Framework, 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 any of those changes.

40. I have described above and elsewhere is this statement the challenges arising for families in investigatory processes following mental health deaths. However, despite these, our experience as an organisation is that families are somehow able to find incredible strength to advocate for their loved ones and to work collectively to bring scrutiny and attention to the cause, under unimaginably difficult circumstances. The campaigns giving rise to this Inquiry are a perfect example of that.

## DATA AND MENTAL HEALTH DEATHS

*The data problem*

41. INQUEST carries out comprehensive monitoring and collating of statistics in relation to deaths in prison, in police custody and following police contact, and deaths of people in immigration detention. We are able to do this by drawing on official sources: there are requirements to notify the relevant oversight bodies (the IOPC and PPO), with whom we operate a reporting system which allows INQUEST to track the deaths, and cross refer that data with information arising from our casework. This means we are able to publish datasets to provide an overview of who is dying and where.[13]

42. However, we do not carry out formal monitoring in relation to mental health deaths. 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.[14]

43. The position in relation to data was recently reviewed in the context of the 'Rapid Review into Data on Mental Health Inpatient Settings' (published 21 March 2024; see Exhibit DC/10), which noted in respect of data on deaths that there was *"*[n]*o comprehensive overview of the numbers of people who died while in contact with mental health inpatient care"* and that the MHSDS [mental health services data set] recording of deaths following discharge were thought to be of poor quality, see Appendix 2 of the Rapid Review report.

[13] https://www.inquest.org.uk/Pages/Category/statistics-and-monitoring

[14] 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 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.

44. A recent Health Services Safety Investigations Body report 'Mental health inpatient settings: Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge', also highlighted the difficulties with mortality data in mental health inpatient settings (published 30 January 2025; see Exhibit DC/11). The inadequacy of data was further commented on in the Independent Advisory Panel on Deaths in Custody (IAPDC)[15] report 'Statistical analysis of recorded deaths in custody between 2017 and 2021' analysing all deaths in custody, including detained mental health patients (published April 2024; see Exhibit DC/12).

45. Instead of any central data set, there are a number of disparate sources for information about mental health deaths, key of which are:

45.1. The Care Quality Commission ('CQC'), which is notified when a patient who is detained under the Mental Health Act ('MHA'), or who was subject to a Community Treatment Order ('CTO') dies. The notification of patients who are subject to CTOs is not mandatory, however, so those figures are incomplete.[16] These figures also do not include patients who are not detained under MHA, including those who died in the community.

INQUEST's casework and policy work has also identified that despite the reporting requirements, not all deaths are reported accurately to the CQC or at all. Particular issues that have arisen in our experience are in relation to deaths that occur when a patient is Absent Without Leave (AWOL), which are not consistently reported; and deaths which are incorrectly reported to be due to 'natural causes' in circumstances where the possibility of causative failings on the part of the Trust or private provider has not been explored. An obvious example of one such death is the death of [I/S]

[15] An advisory, non-departmental public body

[16] This anomaly creates an issue with inconsistency in the data because both detained patients and those subject to a CTO are legally considered to be "detained" under the MHA because of the power of recall exercisable by the Responsible Clinician under a CTO.

[I/S]

The inquest jury found that [I/S] death was contributed to by neglect and the NHS Trust were subsequently successfully prosecuted by the CQC. However, as [I/S] was not detained under the Mental Health Act, it was not mandatory for the trust to report his death to the CQC.

In 2016, INQUEST undertook an extensive piece of work regarding the deaths of children in in-patient settings (see INQUEST's press release 'Number of child inpatient mental health deaths not known', published 11 April 2016; Exhibit DC/13) in which the number of deaths of children in in-patient settings between 2010 and 2014 revealed by Freedom of Information Act requests sent out by INQUEST was greater than the number that had been recorded by the Care Quality Commission thus indicating the significant issues around data accuracy in this area.

45.2. The National Confidential Inquiry into Suicide and Safety in Mental Health ('NCISH') publishes extensive data on self-inflicted deaths (and homicides). The NCISH does not cover deaths by other causes, for example restraint- or medication-related deaths, or avoidable deaths caused by physical conditions. Additionally, although the NCISH definition of patient suicides will include people who died in the community, certain cases falling within the Inquiry's Terms of Reference may not be captured by the NCISH definition, for example, patients who were assessed in a liaison setting (such as Accident and Emergency) and discharged with no follow-up.[17]

[17] The NCISH definition of patient suicides is: "*Patients are those in contact with psychiatric, drug and alcohol, child and adolescent or learning disability services (if they are within mental health services) within 12 months of their death, with their care usually under a consultant psychiatrist. These include a range of patients, from those seen for one-off assessments to those who had been under the long term care of services. Patients who were seen for a one-off assessment in a liaison setting with no follow-up arranged would not meet NCISH criteria for a patient suicide.*"

45.3. The Office of National Statistics publishes mortality statistics in relation to mental health establishments, which includes psychiatric hospitals,[18] however, the published data is not disaggregated in respect of particular establishments or Trusts/providers, and there is no published information about causes of death, or any protected characteristics other than age brackets. As the data is in relation to deaths which occurred in the establishment, it does not provide any insight into community deaths.

45.4. Information is published about patient safety incidents: previously, through the National Reporting and Learning System ('NRLS'),[19] which was decommissioned in June 2024 and replaced by the Learn from Patient Safety Events ('LFPSE') service.[20] NRLS data included information about patient safety incidents occurring in mental health services, breaking them down by category (e.g. self-harming behaviour, patient accident, patient abuse etc.) and degree of harm (which includes death), however the published information is not disaggregated by hospital or Trust/provider. It is understood that as NRLS was a largely voluntary scheme, the data speaks more to the patient safety reporting culture of an organisation, than the actual number of patient safety incidents occurring within that organisation.[21] The data also cannot be used to determine whether the incidents reported were preventable. As far as INQUEST is aware, data reported into the LFPSE does not currently appear to be available to the public.

45.5. The IAPDC publishes analysis of deaths in prisons, immigration removal centres, policy custody, and in detention under the Mental Health Act. It draws on existing available data to conduct the

[18] See here: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/13827numbersofdeathsfromallcausesthatoccurredinmentalhealthestablishmentsbyfiveyearagegroupdeathsregisteredin2001to2020englandandwales
[19] https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/
[20] https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/
[21] See the NRLS data principles: https://www.england.nhs.uk/wp-content/uploads/2020/08/NRLS_data_principles_December_2016_v2_1.pdf

analysis, such that it is subject to the limitations of that data. The most recent report, published in April 2024, makes this clear – the data does not identify the proportion of deaths by ethnicity/race or gender, and classification of deaths is not timely. It concludes that the "*data on deaths in mental health detention is still not good enough"* (Exhibit DC/12).

45.6. Further datasets are held by NHS England Digital, however, it is understood that they are collated to provide overviews of services to inform operational decision making and as such their contents are not readily interrogable to identify the location, nature, and cause of deaths within mental health settings.

46. The lack of an accurate and complete set of data obscures the official picture of the extent and nature of the problem which in turn limits learning and the prevention of future deaths. This is particularly troubling in relation to the following issues:

*Protected characteristics and deaths in mental health care*

47. The information we do have points to deep inequalities in access to mental health care and outcomes, particularly in respect of Black people, as set out in a recent NHS Race Health Observatory report 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review', February 2022, which concluded that "*the review provided strong evidence that there were clear and persisting ethnic inequalities in compulsory admission to psychiatric wards, particularly affecting Black groups, but also Mixed Black and White groups and South Asian groups. There was also evidence of harsher treatment for Black groups in inpatient wards from quantitative studies (more likely to be restrained in the prone position or put into seclusion), qualitative studies (beaten on wards) and our stakeholder engagement groups (Black patients feeling unsafe on wards due to abuse from staff and patients), (*see Exhibit DC/14) The review also notes that it found "*few national datasets with good ethnic monitoring data which allowed robust data analysis to investigate ethnic inequalities."*

48. A 2019 Race Equality Foundation review, 'Racial disparities in mental health: Literature and evidence review' made equally troubling findings (Exhibit DC/15) that Black and minority ethnic people are:

48.1. 40% more likely to access mental health services via the criminal justice system than white people.

48.2. Less likely to be referred to talking therapies and more likely to be medicated for ill mental health.

48.3. Black people have worse long-term outcomes of psychosis, and the police are more likely to be involved in the admissions for the follow-up of Black patients than for white patients.

49. Given these indications, and INQUEST's own experience around the prevalence of restraint of Black people in mental health care, the lack of data on the use of force is also particularly concerning. Significant progress was made on this issue in the wake of the death of [I/S], a Black man who died in [I/S] following restraint by police officers whilst an inpatient at a psychiatric hospital [I/S]. It is worth noting that despite the Independent Inquiry into the Death of David 'Rocky' Bennett (Exhibit DC/01) having recommended in 2003 that there should be a national system of training in restraint, no such system had been implemented by the time of [I/S] death. INQUEST worked with [I/S] family in their tireless work to draw attention to the use of restraint and to engage policy makers and parliamentarians, the Mental Health (Use of Force) Act 2018 – otherwise known as '[I/S]' – was enacted. INQUEST helped in the Bill's drafting and supported the family's campaign for greater accountability in relation to the use of restraint on psychiatric wards, see for example INQUEST's briefing to MPs in June 2018, 'Independent Investigations: the current system is not enough – Mental Health (Use of Force) Bill' (see Exhibit DC/16). When the Act came into force in November 2018, [I/S] brought in new requirements to develop accountability and training in respect of restraint of this vulnerable group of people. However, the provisions in section 7 (which requires the publication of statistics and analysis of information in relation to restraint) and section 8 (which requires an annual review of any Prevention of Future Death reports prepared by coroners in cases where a person died in a

mental health unit as a result of restraint) have still not been enacted. This undermines the importance of transparency and parliamentary scrutiny.

50. Nationally and over the decades, INQUEST's casework has illustrated these thematic issues of race and racism. The *Achieving Racial Justice at Inquests* guide we produced together with JUSTICE refers to issues arising from racial stereotyping and suggests methods by which legal practitioners can address them (published February 2024; Exhibit DC/17).

51. Our casework has also reflected an apparent disproportionate prevalence of deaths in mental health settings among:

    51.1. Children and young people;
    51.2. People transitioning between child and adolescent mental health services and adult mental health care;
    51.3. Women and girls, including those who have survived sexual violence and abuse;
    51.4. People who are, or are suspected to be, autistic; and
    51.5. Young transgender people.

52. Without clear data, it is impossible to address the ways in which people's protected characteristics, as well as the way they intersect and interact, leads to their deaths.

*Deaths in the community*

53. Reporting by *the Independent* published last year in relation to community mental health teams indicates that data is held by NHS Trusts regarding the number of deaths of community patients (published 22 April 2024; see Exhibit DC/18). Although these statistics do not differentiate between preventable and 'expected' deaths, the statistics are troubling, and INQUEST's own casework on mental health-related deaths in the community points to an ongoing catastrophe.

## DATA HELD BY INQUEST

54. 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.[22] This will include the deaths of people who were detained under the MHA, receiving mental health care in hospital but not detained under the MHA, and deaths in the community. These deaths may also involve other agencies, for example the police or the local authority.

55. A number of factors are relevant when considering these figures:

    55.1. For the reasons described above, INQUEST does not play a formal monitoring role in relation to mental health deaths, and therefore it collects data from its mental health cases primarily in order to deliver casework. As the collection of statistical information is not a strategic priority in this area, although the system allows caseworkers to categorise the death as either 1) in police custody or following police contact, 2) in prison or shortly after release, 3) in immigration detention, or 4) mental-health related, the completion of this field is subject to the caseworker's capacity and can be affected by human error.

    55.2. INQUEST's casework remit – especially in relation to mental health – has changed over time, largely in response to organisational capacity, which means that the figures do not necessarily mirror trends in the increase or decrease in deaths or of bereaved families seeking specialist support. Our initial work involved detained patients, as illustrated by paragraphs 8 to 19, however, over the years our remit in relation to mental health has included: non-

[22] The Inquiry will note that these figures have been extracted using information recorded by our casework system, and 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 set out in paragraph 55.

detained patients on mental health wards; mental health deaths in the community (e.g. deaths following contact with mental health services); and deaths of people who were subject to Deprivation of Liberty Safeguards (DOLS) who died within care settings. Because of very high demand arising from all types of mental health related deaths in recent years, we scaled back our remit to directly focus on inpatient deaths in mental health hospitals. The breadth of our remit reflects INQUEST's casework capacity and operational realities, and for those reasons the number and types of cases we take on does not necessarily mirror the number and types of deaths which are occurring.

55.3. Our record keeping has changed over time. Initially, INQUEST held only paper records in relation to cases we had worked on. We transitioned to our first digital database in the late 1990s, and moved to the database we are currently using in September 2021, although we continued to keep paper files for some of our cases. Our record keeping has improved over the years so that more information is held in respect of more recent cases, which is also partly due to the fact that information flow between INQUEST and ILG lawyers has increased.

55.4. Also in respect of record keeping, whereas our first digital database only allowed caseworkers to identify one setting in order to categorise the case (e.g. either police or mental health), our current system allows caseworkers to tick more than one (e.g. both police and mental health related). This means that cases stored within the first digital database which may have had involved mental health services, but where the most immediate failures are considered to have rested with another state body, will not be reflected in the mental-health related casework figures referred to above.

55.5. Not all of our Essex mental health cases will fall within the Inquiry's terms of reference.[23]

[23] Please refer to the results of our review below at paragraph 58-78 for details of cases falling within the terms of reference.

*INQUEST cases falling within the Inquiry terms of reference*

56. Our current casework system allows caseworkers to record key information such as the deceased's name, date of birth, date of death, ethnicity, state body/bodies or prison establishment involved in the death, method of death, relevant Coroner's court, and details for family members, which means that these categories of information are easily accessible through our system. Because the system is not easily interrogable in respect of further information and because our previous system did not record as much information, in order to assist the Inquiry and provide more detail about the cases INQUEST has worked on which are likely to fall within the Terms of Reference, we have reviewed the case files themselves.

57. We have set out details of relevant casework below, grouped according to whether the case occurred in a mental health context, in or shortly following release from prison, or in police custody or following police contact. In terms of these categories, the particular vulnerability of people who died in prison or during/following contact with police is an area of concern to INQUEST, and our view is that this is an area that requires specific consideration: people in prison or police custody are uniquely dependent on the detaining authority to assist in identifying the need for, and then obtaining and facilitating input from mental health professionals. Their access to mental health assessment, treatment, and second opinions is therefore limited by the circumstances of their detention.

*People who died as mental health inpatients in Essex*

58. Of the 39 cases which are identified on INQUEST systems as having involved the Essex Trusts, there is enough information held in respect of 26 cases to identify them as falling within the terms of reference (referred to below as Group 1); within this, INQUEST is aware of 17 people whose families have already given evidence to the Inquiry. There are then 3 further cases with information suggesting they likely fall within the terms of

reference (referred to below as Group 2), and 5 cases which may fall within the terms of reference (Group 3).

*Group 1*

59. In terms of time span, people in Group 1 died between 2008 and 2023. 12 are identified as female on our systems, 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.

60. In terms of location, 17 of the 26 people died during admissions to mental health wards. 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; the locations are: the Linden Centre (5 people), Basildon Hospital (3 people), Rochford Hospital (2 people), Broomfield Hospital (1 person), The Lakes (1 person), Brockfield House (1 person), Derwent Centre (1 person), and St Margaret's Hospital (1 person).

61. 9 of the 26 people died in the community, 5 of whom fall under paragraph (h) of the definition of inpatient as set out by the Explanatory Note (i.e. *"those who died within 3 months of discharge from any of the above units"*), 3 under (g) (i.e. *"those who died within 3 months of any mental health assessment provided by the Trust(s) where the decision was not to admit as an inpatient"*), and, 1 under (f) (i.e. *"those who died whilst waiting for a bed in a mental health inpatient unit within 3 months of a clinical assessment of need"*).

*Group 2*

62. In terms of time period, the 3 people in Group 2 died between 2013 and 2019. All 3 people died in the community, and all appear to fall under

definition (g). All 3 were male, and their ages were [I/S] years old. Ethnicity is only recorded for 1 of the people in Group 2, and he is identified as white.

*Group 3*

63. The people in Group 3 died between 2017-2021. All 5 people died in the community. 2 were male and 3 female, with ages ranging between 23-55. All are identified as white.

*Trends in mental health deaths*

64. INQUEST's involvement in Essex cases demonstrates that most of the common features identified in INQUEST's report in February 2015 and which INQUEST has witnessed nationally, are also apparent in Essex cases, including:

64.1. *Poor systems for information sharing and communication.* This includes concerns around staff failures to share significant information in handovers and other clinical meetings; lack of information sharing between different EPUT teams involved in a person's care; and inaccurate risk assessments.

64.2. *Failures in understanding of, and compliance with, basic policies and procedures, including around risk assessment and observations.* This includes failures in relation to: undertaking prescribed levels of observations; following policies in relation to decisions around risk and observation levels; the completion of written risk assessments; and the recording of risk incidents.

64.3. *Poor record keeping.* This is a theme that covers a variety of concerns including failures to record key incidents; falsification of records; and retrospective record keeping.

64.4. *Inadequate staffing levels and inappropriate skill mixes.* This includes wards having insufficient staff to ensure the safe care of

patients; wards having insufficiently qualified staff i.e. nurses and/or doctors to ensure the safety of patients; and the use of agency staff unfamiliar with patients and procedures.

64.5. *Inadequate levels of clinical oversight.* This includes the inadequate supervision of non-clinical staff, such as healthcare assistants, by clinical staff, including nurses and other member of multi-disciplinary teams; and inadequate supervision of junior clinical staff by their seniors.

64.6. *Inadequate treatment and response to dual diagnosis needs.*

64.7. *Poor treatment of physical health.* This includes issues around access to treatment for physical health conditions whilst a mental health inpatient; and concerns regarding the use and monitoring of psychotropic medication for those with comorbidities.

64.8. *High levels of absconscion and poor implementation of missing person policies.* These failures include issues around the environmental safety of wards; the adequacy of risk assessments of those who may be at risk of absconding; and the response by inpatient services to patients who abscond.

64.9. *Poor communication with families, particularly around care and risk factors.* This includes failures to seek information from and involvement of families from the outset of a person's care; failures to involve families in care planning, including discharge; failures to inform families of key incidents; failures to give appropriate weight to concerns raised by family members including a sense that families and patients were being 'gatekept', particularly those in the community seeking to obtain mental health support.

64.10. *Unsafe environments.* This includes access to ligature points on wards and units; access to risk items i.e. items with which a person can harm themselves; and the adequacy of search procedures.

64.11. *Inadequate emergency medical responses*. This includes failures in relation to access to emergency lifesaving equipment, for

example, access to ligature cutters or working defibrillators; poor use of emergency lifesaving equipment by staff; and inadequate training of staff on emergency procedures. Inappropriate use of restraint (both physical and chemical). This includes issues in relation to staff training; failures to deescalate; and the excessive use of restraint.

64.12. *Failures to provide any therapeutic input*, that is any therapeutic measures beyond performing 'whereabouts checks'. This includes access to 'talk time' or 1:1 contact with a named staff member; access to psychological therapies; access to meaningful activities in ward environments; and facilitating family contact.

64.13. *Oxevision.* In particular, the use of Oxevision as a means of rectifying safety concerns caused by fundamental deficiencies in care caused by a lack of training, inadequate staffing, or culture – the effect of which was to exacerbate existing issues.

64.14. *Lack of autism-specific provision.* This has particularly arisen in relation to autism specific services within the community but there are also concerns regarding the ability of inpatient wards to meet the needs of autistic individuals.

64.15. *Failures in early intervention*, often leading to escalation, causing crisis or repeated admissions. INQUEST's experience of working with families is that it is often possible to trace failures in the cases of those who have died whilst an inpatient to failures that occurred in the community.

64.16. *Inappropriate follow-up or provision following presentation at A&E.*

64.17. *Inappropriate decisions to discharge patients.* This includes decisions to discharge being made by insufficiently qualified individuals; discharge based on incorrect/incomplete information; and individuals being discharged without appropriate support in place to ensure their safety.

64.18. *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.

*Trends: a closed culture*

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, i.e. *'a poor culture that can lead to harm, including human rights breaches such as abuse'.*[24] Where closed cultures exist, people are more likely to be at risk of deliberate or unintentional harm. Key examples of this culture which have been uncovered to date, and about which the Inquiry will no doubt hear evidence from the families themselves include:

65.1. A lack of compassion or empathy in the delivery of care: see, for example the account given by one person shortly before her discharge from the Linden Centre, that she was crying and crying and no staff came to help; and, in the case of another person who was admitted to Rochford Hospital, comments made by staff on the day of her death about her appearance.

65.2. A belittling or derisive attitude toward the person receiving care: for example a coroner's comments at the inquest of another person, who noted that email exchanges between consultants discussing the person were *"inappropriate and unprofessional".* The coroner specifically noted that this was not the first occasion that he had encountered inappropriate and disparaging comments of that kind in EPUT cases. The coroner also agreed with the independent investigators that *"inappropriate judgements"* were made about the person's family.

[24] We use here the CQC definition of 'closed culture': https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures

65.3. Abuse, as documented by the Dispatches documentary, perpetrated in moments where patients were at their most distressed and vulnerable.

66. The experience of INQUEST caseworkers who have supported Essex families and therefore seen evidence emerging from post-death investigations and the inquest process have included:

66.1. Imbalanced power dynamics between staff, and patients who are in a position of vulnerability, manifesting in unnecessary restraint, or treating people's needs as a 'nuisance', or manipulative or attention seeking;

66.2. A high prevalence of falsified observation records, and little observable organisational action to tackle the issue;

66.3. The journey of an inpatient not being thought of in terms of recovery, but rather of containing a patient until they are well enough to be discharged.

67. This closed culture has carried over into the conduct of EPUT's staff and their legal representatives post-death, and appears to manifest itself in an entrenched and almost reflexive default to defensiveness, as illustrated by conduct during inquests, about which the Inquiry is likely to hear more:

67.1. The adjournment of an inquest due to the late disclosure on the part of EPUT of thousands of pages of relevant evidence;

67.2. Coroners and juries making findings that evidence given by EPUT staff was not in fact true: for example, the coroner's comments in the inquest referred to immediately above that he found the psychiatrist's evidence "*impossible to reconcile"*; or another inquest, where the jury found that the final observation due to have taken place – contrary to the staff member's evidence – did not in fact occur;

67.3. Fabrication of evidence: such as evidence coming to light that a person's care plan had been falsified after his death;

67.4. A closing of ranks: one example was an inquest in which none of the EPUT staff members who gave evidence admitted to having deactivated an alarm which ought to have prompted a physical check: this suggests that the unidentified individual responsible may still be working with vulnerable people.

68. INQUEST caseworkers have also experienced, through their involvement in supporting families in post-death investigations and inquest process:

68.1. Coroners taking the unusual step of preventing EPUT witnesses from observing each other's evidence and of imposing reporting restrictions, to prevent witnesses from colluding; and

68.2. Aggressive tactics employed by Trust legal representatives: such as contesting pen portrait material, seeking to persuade coroners not to make Prevention of Future Death reports, or refusing to make admissions either at an early stage, or at all. The latter may be followed by formal legal admissions made privately following the inquest in the context of civil claims. This results in family members having the jarring experience of having to fight tooth and nail to uncover failings while the Trust denies the reality of what their loved one endured, followed by a swift U-turn acknowledging that they were right all along. This gives rise to a feeling of having been gaslit. Families describe this moment as a double-edged sword: on the one hand you are vindicated and you have shone light into the darkness, but on the other, you now need to confront the traumatising truth – that what you thought was done to your family member did really happen, and that it was not all just a bad dream.

69. In the experience of our caseworkers, the dynamics of post-death conduct are closely related to the ability of an organisation to deliver safe care: a closed culture in relation to care, drives post-death defensiveness, which in turn creates a culture which accepts that a death within an inpatient unit

is unavoidable and therefore discourages any willingness to change. The existence of such an attitude amongst those who deliver care is dangerous, further causing a deterioration in patient safety, and further driving the cycle of toxicity.

*People who died in HMP/ YOI Chelmsford or shortly following release*

70. Of all 28 families of people who died in or shortly following release from HMP Chelmsford with whom INQUEST has worked, there is enough information within our records to identify 3 deceased people as falling within the Inquiry terms of reference (referred to below as Group 1). There are 8 people in relation to whom information held by us suggests they are likely to fall within the Inquiry terms of reference (referred to below as Group 2)). Information in relation to the remaining HMP Chelmsford cases indicates they would fall outside the terms of reference. When conducting this analysis, it became clear that further information is required from EPUT in order to understand when and what mental health provision it and its predecessor Trusts operated within HMP Chelmsford during the relevant period.[25]

71. The people in Group 1 died between [I/S]. They are recorded in our system as having been white, male, and aged between [I/S].

71.1. Person A died in [I/S]. Prior to entering HMP Chelmsford, he had been detained under section 136 of the MHA and assessed at Rochford Hospital, run by EPUT. He was discharged to the family home, where an incident then took place during which Person A also attempted to take his own life. Person A was arrested and taken to Basildon Police Station, where he was assessed but not seen by any mental health professionals. Instead, he was charged with an

[25] From a combination of publicly available information from the HM Inspectorate of Prisons ('HMIP') and the CQC, we understand that the responsibility for mental health provision within HMP Chelmsford sat with:
a) NEPT (there is also reference to seconded SEPT staff) – dates unclear, but referred to in a May 2011 HMIP report
b) Provide Community Interest Company – dates unclear but prior to April 2015
c) Care UK – April 2015 to 27 May 2017
d) EPUT – May 2017 to April 2019
e) HCRH (aka Castle Rock Group) – April 2019 to present.

offence and remanded to HMP Chelmsford, two days after the admission at Rochford Hospital. Mental healthcare at the prison was delivered by a private company, Care UK, and the jury at Person A's inquest identified a number of serious failings on the part of Care UK which led to Person A's death. He died 19 days after his assessment at Rochford Hospital. The jury concluded that it was unclear whether sufficient enquiries were made to find Person A a mental health bed out of the local area.

71.2. Person B had a history of mental ill health and suicide attempts. He died in 2018 in HMP Chelmsford, having been transferred there directly from Basildon Hospital, run by EPUT, where he had been a voluntary inpatient having previously been detained under the MHA. Upon entering HMP Chelmsford, Person B was seen at reception by a prison officer and a mental health nurse. His transfer paperwork included a report by his psychiatrist which said that he should be monitored in prison. Mental health care at HMP Chelmsford was delivered by EPUT at the time. Neither the prison officer nor the mental health nurse considered opening suicide and self-harm monitoring procedures (the 'ACCT' process, see more below). Person B died 9 days after being transferred from Basildon Hospital and entering HMP Chelmsford.

71.3. Person C died in [I/S] in the community, four weeks after having been released from HMP Chelmsford. He had complex learning difficulties and schizophrenia. During his time on remand at HMP Chelmsford, he had spent almost a month at Brockfield House, run by EPUT, as he was experiencing acute psychosis. He was transferred back to HMP Chelmsford just over 3 months before his death. 8 days after his release from HMP Chelmsford, Person C was triaged by EPUT's Access and Assessment Team and offered an appointment with a consultant psychiatrist at the Linden Centre, but died before the appointment.

71.4. In relation to Group 2: Two people were subject to Assessment, Care in Custody and Teamwork ('ACCT') procedures at the time of

their deaths. ACCT is a care planning process for people in prison who have been identified as being at risk of suicide or self-harm. The exact procedures have changed over time since ACCT was introduced in 2005, however generally, the ACCT process has required reviews of the person at key stages, to include attendance by healthcare or mental healthcare staff. Depending on the person's risk, care plans often involve the person being subject to observations to manage their risk of suicide or self-harm. A third person died within two days of having been moved from the healthcare unit (where he had been subject to ACCT procedures) back to the general wing.

71.5. Two people had been seen by a mental health nurse at the police station and/or at court immediately prior to being transferred to HMP/YOI Chelmsford. Those contacts took place two and three days respectively before their deaths. It is understood that that contact may have been with the Essex Health & Justice Service, run by EPUT.

71.6. The remaining 3 people in Group 2 had been assessed by a psychiatrist whilst in HMP Chelmsford, each of whom had formed the opinion that there was no evidence or insufficient evidence that the person was experiencing mental illness. These assessments took place 2 days, 3 days, and 3 weeks before their deaths.

71.7. All of the people in Group 2 were male; one person is identified as white/Irish Traveller, and one person as Black African, and the remainder are recorded as white. Their ages range between [I/S] .

72. All of the deaths in Groups 1 and 2 were self-inflicted or occurred as a result of self-inflicted acts.

73. Repeated themes in relation to patient safety of those who died in or shortly after having been in HMP/YOI Chelmsford reflect national issues arising in our case work and include:

73.1. A failure on the part of mental health professionals to recognise that a person in prison is experiencing symptoms of mental ill health, as opposed to, for example, 'behavioural' issues. Our experience as an organisation suggests that this occurs due to stigma against prisoners and is a national issue in the delivery of mental health care to people who are in prison or otherwise in contact with the criminal justice system.

73.2. Inadequacies in the implementation of the ACCT process.

73.3. Failures to divert people suffering mental ill health – sometimes very acutely – from prison.

73.4. Inadequacies in the emergency response, for example due to a lack of functioning equipment or insufficient staff training.

*People who died following contact with Essex Police*

74. Of the 23 cases involving police in Essex, we have enough information on our systems to identify one death as falling with the Inquiry terms of reference ('Person A') and another as likely falling within the terms of reference ('Person B'). Both these people are recorded in our system as having been of mixed ethnicity, and were aged [I/S] at the time of their death.

75. Person A died in [I/S] following restraint by officers from Hertfordshire Police;[26] prior to which he had been seen by the psychosis team within EPUT on two occasions: two weeks and two days respectively before his death. His family had raised concerns about Person A's mental health prior to his death.

76. Person B died in [I/S], following restraint whilst detained by Essex police. He experienced psychosis and had attended A&E at Southend University Hospital whilst experiencing a mental health crisis the day before his death,

[26] This is the only case involving a police force other than Essex Police. It has been identified by the fact that EPUT was identified on the system as the relevant NHS Trust involved.

where he was given medication to calm him down. The next day Person B came into contact with Essex Police after being found acting strangely in public. He died following a restraint by police that took place in transit to police custody.

77. Themes in relation to patient safety of those who were experiencing mental health difficulties but died during or following contact with the police include:

77.1. The particular mental health difficulty experienced by people who die following police contact is likely to be psychosis-related. The racial disparities in treatment referred to at paragraph 48 (in relation to worse outcomes in respect of psychosis and higher frequency of police involvement in respect of readmissions of Black people) also appear to play a role.

77.2. Inadequacies in police responses to people experiencing mental health crisis, which are well documented and disproportionately affect Black or racialised men. See, for example, Chapter 2 of the Report the Independent Review of Deaths and Serious incidents in Police Custody conducted by Dame Angiolini (published 2017; Exhibit DC/19), in relation to restraint and mental health, and Chapter 5 on race, within which paragraphs 5.18-5.27 include reference to what INQUEST describe as the 'double discrimination' of Black people experiencing ill mental health, namely:

*"The stereotyping of young Black men as 'dangerous, violent and volatile' is a longstanding trope that is ingrained in the minds of many in our society. People with mental health needs also face the stereotype of the mentally ill as 'mad, bad and dangerous'.*

77.3. Failures on the part of mental health services to adequately risk assess and admit or treat people experiencing acute mental health crisis, leading to a failure to treat, or an escalation of symptoms and therefore contact with police.

77.4. A lack of alternatives to policing for people in acute mental health crisis.

*Homicide cases*

78. Within the 23 cases identified on our system as having involved Essex Police, three people whose families INQUEST supported died due to homicide. Although our understanding is that these homicide cases do not fall within the Inquiry's definition of 'inpatient deaths', the information we have about these cases indicates that each of the people who carried out the fatal acts were either under the care of EPUT, or had recently been assessed by clinicians who are understood to have been employed by EPUT. The coroner in one of these cases referred to the mental health assessment which took place before the fatal act as having been "fundamentally flawed". These cases took place between 2016 and 2019.

**Use of INQUEST data: policy, liaison, and campaign work**

*Key strategic objectives*

79. INQUEST's experience with families whose loved ones have died in mental health contexts over the decades has led us to the same conclusions: that structural change is needed to address the gaps in data about who is dying, where, and why, and that there needs to be an independent and automatic system of investigation for mental health deaths established.

80. Furthermore, we have witnessed the repetition of concerns and systemic failings raised following deaths, which has also made plain the urgent need for the establishment of an independent public body – which INQUEST has termed a National Oversight Mechanism – responsible for collating, analysing and following-up on recommendations arising from inquests, Inquiries, official reviews, and investigations into state-related deaths. The need for this National Oversight Mechanism and a proposal for what such a Mechanism might look like has been clearly articulated in INQUEST's 'No More Deaths Campaign'.[27]

[27] https://www.inquest.org.uk/no-more-deaths-campaign

81. INQUEST also believes that improvements to the collation of data on mental health deaths, and reforms to the investigatory and oversight functions following such deaths must be accompanied by an end to defensiveness and "cover-ups" on the part of state bodies, through establishing an enforceable, legal duty of candour on public authorities, public servants and corporations who hold responsibility for public safety. INQUEST welcomes the progress being made on the Hillsborough Law, also known as the Public Authorities (Accountability) Bill.[28]

*Mental health policy work*

82. Within these key strategic objectives, INQUEST has worked with a wide range of organisations to share organisational concerns and information.

83. The primary way in which we share information arising from our work is through the development and publication of INQUEST reports referred to throughout this statement. We disseminate these through our website and refer relevant bodies to these publications where relevant.

84. As described above, the main source of information driving our policy work comes directly from our casework. However, and within the limits set out in paragraphs 41-54, INQUEST also engages in informal monitoring of the mental health landscape which extends beyond our immediate casework. This takes a number of forms, for example we may discuss internally particularly troubling trends or priorities emerging from any contact with families, including one-off or helpline contact, and then make proactive call-outs across the ILG network to identify the scale of the issue.[29] We are also able to monitor existing trends and their geographical spread through

[28] https://www.inquest.org.uk/hillsborough-law-campaign

[29] One example of an emerging priority is the prevalence of a particular substance in self-inflicted deaths in the community, and the role of particular websites in enabling these deaths. Where we are contacted by a family affected by this issue, we explain that it falls outside our current casework remit, but we signpost them to relevant organisations and seek consent to retain their details on file to monitor the issue, and in case we are able to use the information, or connect the family with relevant journalists or support organisations in the future.

Prevention of Future Death reports, which are available online, and bulletin summaries which we receive directly from the IAPDC.

85. INQUEST's policy and campaigning work which is relevant to the Inquiry's Terms of Reference includes historic work referred to already in this statement, as well as more recently:

85.1. Working with the Health Services Safety Investigations Body in relation to their investigations on which INQUEST have relevant expertise. As an organisation, we have met with many of HSSIB's investigation teams who have conducted reports into emergency care in prison, mental health in prison, deaths of those in receipt of mental health services, and NHS oversight arrangements. As a relevant stakeholder, INQUEST receives copies of HSSIB's relevant reports prior to publication for comments and identification of factual errors.

85.2. Joint work and information sharing with partner organisations on relevant issues, e.g. JUSTICE, Rethink Mental Illness, MIND and Young Minds. This is done on an ad hoc basis, where a need or opportunity is identified. It can include sharing information on themes emerging from INQUEST's casework to provide briefings on draft legislation, select committee hearings or parliamentary debates, or in some cases media work. It has also involved collaboration to support related campaigns or sharing of information for consultation responses to national and international bodies.

85.3. Briefing MPs on reforms required to mental health legislation to improve patient safety, see for example the 'INQUEST Briefing - Mental Health (Use of Force) Bill - Independent investigations- the current system is not enough' (June 2018; Exhibit DC/16) and 'INQUEST Briefing: Mental Health Act Reforms', 25 July 2019 (see Exhibit DC/20).

85.4. Briefing Professor Sir Simon Wessely and his team as part of their 2018 independent review of the Mental Health Act. INQUEST

highlighted issues around the lack of independent investigations and the need for an independent body following deaths of those detained under the Mental Health Act, the need for legal aid for related inquests and concerns about treatment and care in mental health settings including the excessive use of restraint. His report published in December 2018, 'Modernising the Mental Health Act – Increasing choice, reducing compulsion: Final report of the Independent Review of the Mental Health Act 1983' recommended better treatment of bereaved people, non-means tested legal aid for families of those who died unnaturally, violently or by suicide whilst detained under the Mental Health Act and reiterated the importance of ensuring "all investigations are robust, appropriately independent, and involve families" (see Exhibit DC/21). Seven years on, many of the concerns raised by INQUEST remain.

85.5. Liaison with UN and Council of Europe human rights bodies: including on the topic of prison mental healthcare in INQUEST's submission to the UN Committee on the Prevention of Torture, March 2019 (see Exhibit DC/22); and in relation to racial inequalities in mental health in submissions to the Working Group of Experts on the People of African Descent in advance of their country visit to the United Kingdom, November 2022 (see Exhibit DC/23).

85.6. Supporting the Essex families in seeking a public inquiry by briefing MPs on the areas of concern as set out in INQUEST's briefing to MPs 'Westminster Hall debate: Deaths within mental health care', 30 November 2020 (see Exhibit DC/24).

85.7. Liaison with Select Committees, including by way of submissions to the Justice Committee on the inquiry into mental health in prison, June 2021 (see Exhibit DC/25);

85.8. Corresponding with the CQC to draw attention to concerns around patient safety arising from our casework or monitoring: for example, we wrote to the CQC in relation to concerns about Greater Manchester Mental Health NHS Foundation Trust, following

INQUEST's contact with a number of families whose children had died in CAMHS units (16 September 2021; see Exhibit DC/26).

85.9. Correspondence with the Joint Committee on the Draft Mental Health Bill, highlighting the need for an independent investigatory and oversight body in respect of mental health deaths and a mechanism for systemic review of Prevention of Future Deaths reports (December 2022; see Exhibit DC/27);

85.10. Liaison with DHSC, for example in relation to the rapid review into data on mental health inpatient settings in March 2023, in which INQUEST raised the deficiencies in existing published data, and set out what information we would want to see published (see Exhibit DC/28).

85.11. Correspondence with the Health and Social Care Committee in relation to concerns arising from INQUEST's casework about the need for high quality and independent post-death investigations, the prevalence of deaths among autistic children and young people in our casework, and the lack of data around these deaths (6 October 2023; see Exhibit DC/29).

85.12. Producing jointly with JUSTICE the 'Achieving Racial Justice at Inquests, a Practitioners Guide' in February 2024 to assist lawyers and practitioners to raise issues in relation to race in the context of post-death investigations (Exhibit DC/17).

**Conclusion**

86. The failings in care in Essex summarised above starkly demonstrate how catastrophically families and patients have been failed and how despite the evidence of ill treatment and failures in care, there has not been not been meaningful change. I understand that at a later date the Inquiry intends to seek evidence from INQUEST regarding its experience of working with bereaved families nationally in relation to mental health deaths and changes that are required to improve patient safety and prevent future

deaths in mental health inpatient settings. I look forward to being able to assist the Inquiry by providing that evidence.

**Statement of truth**

I believe the content of this statement to be true.

Signed [I/S] ……..

Dated…01.04.2025……