OPENING STATEMENT OF COUNSEL TO THE INQUIRY

Arundel House, 7 July 2026

INTRODUCTION

1. Thank you, Chair.

2. This is the Lampard Inquiry's fourth public hearing. In September and November last year, the Inquiry heard powerful and deeply moving commemorative evidence from the families and friends of those who died whilst receiving mental health care from Trusts in Essex. In April and May this year, the Inquiry heard its first tranche of evidence relating directly to its Terms of Reference. Given the stage that the Inquiry had reached, and in light of the substantial volume of material that had been received just prior to that hearing, the April hearing was introductory in nature, setting out background and contextual matters. The Inquiry heard some very important and thought-provoking evidence, from which there emerged common themes and clear lines of enquiry.

3. In this hearing, however, the Inquiry will hear evidence of a very different kind. Over the course of the next week or so, the Inquiry will focus solely on hearing evidence from some of the bereaved family members concerning the deaths of individuals under the care of the South Essex Partnership University NHS Foundation Trust (SEPT), North Essex Partnership University NHS Foundation Trust (NEPT) and Essex Partnership University NHS Foundation Trust (EPUT).

4. This hearing provides a crucial opportunity for the Inquiry to hear from those at the heart of its work: the families who have been directly impacted

by these deaths. The evidence shared during this hearing will also help to guide the Inquiry's work and to ensure that families' concerns, experiences and unique insights are at the core of the Inquiry's investigations. The evidence received and heard will form a key part of the Inquiry's ongoing investigative process into those deaths.

5. We are extremely grateful to all of those who have provided witness statements for this hearing and for their courage in sharing the traumatic details surrounding their family member's death.

6. In both this Opening Statement and throughout the next week, the Inquiry will be referring to, and hearing about, matters that will be distressing and difficult. We will be hearing disturbing evidence about individual deaths and experiences. The details may be deeply painful as they will also resonate with the trauma, grief and loss suffered by many of those who are here today or watching online.

7. Indeed, after this Opening Statement, we will be hearing from Ben Jackson and Adam Rowe about their and their families' experiences in connection with the deaths of Ben's brother Ed and Adam's mother Mandy.

8. At the start of each day and evidence session, we will briefly summarise the evidence that will be heard in order to give those attending, watching and listening the opportunity to decide whether or not they wish to, or indeed are able to, engage with that evidence. The timetable for this hearing is also available on the Inquiry website.

Emotional Support

9. As I have said, people attending or watching remotely may find some of the matters I am going to talk about, and that we hear evidence about, distressing. Before I go on any further, I would like to make clear that emotional support is available for all of those who require it. The well-being of those participating in the Inquiry is extremely important to the Inquiry.

10. I would like to be clear that anyone in this hearing room is welcome to leave at any point. We have two support staff from Hestia, an experienced provider of emotional support, here today and for each day of this hearing. There is a private room where you can talk to Hestia support staff if you require emotional support at all throughout this hearing. The Hestia support staff are wearing orange-coloured lanyards and scarves. Or speak to a member of the Inquiry Team and we can put you in touch with them. We are wearing purple-coloured lanyards.

11. If you are watching online, information about available emotional support can be found on the Lampard Inquiry website at LampardInquiry.org.uk and under the "Support" tab near the top right-hand corner.

12. We want all those engaging with the Inquiry to feel safe and supported.

Safeguarding

13. The role and remit of the inquiry is to investigate mental health inpatient deaths. It is not the role of the Inquiry to intervene in clinical decisions for current patients or to act as a regulator or in the role of the police. However, the Inquiry has a safeguarding policy and takes safeguarding matters

seriously. Where we receive any information which meets our safeguarding threshold, we will pass it on to the appropriate organisation. This is something which has been done since the Inquiry was established and which we will continue to do.

Legal Representation

14. I am assisted at this hearing by members of the Counsel to the Inquiry Team: Rachel Troup, Kirsty Lea and Kyan Pucks. They have been working very closely and directly with bereaved families, and where applicable, their legal representatives, particularly in advance of this hearing.

15. As I have previously mentioned, the Counsel Team also works closely with the Lampard Inquiry Solicitor Team, under Catherine Turtle. We also work closely with the Secretariat Team and the Inquiry's Engagement Team, who are part of the Secretariat and with whom many of those engaging with the Inquiry have been in contact.

16. I want to be clear that my Counsel to the Inquiry colleagues and I have been instructed by you, Chair, to assist you in your important task. We are part of the Inquiry Team working for you. As you explained during the course of your opening statement, we are independent from all other organisations and individuals involved in this Inquiry, and we must be very careful to ensure that we remain so.

17. I would also like once again to introduce the lawyers who are representing Core Participants:

    a. Bereaved Families and those with Lived Experience:

Bates Wells, with their instructed Counsel Sophie Lucas;
Bhatt Murphy, with their instructed Counsel Fiona Murphy KC and Sophy Miles;
Bindmans, with their instructed Counsel Brenda Campbell KC and Tom Stoate;
Deighton Pierce Glynn;
Hodge Jones Allen, with their instructed Counsel Steven Snowden KC, Eleena Misra KC, Dr Achas Burin, Rebecca Henshaw-Keene and Jake Loomes;
Irwin Mitchell, with their instructed Counsel; Maya Sikand KC and Laura Profumo;
Leigh Day, with their instructed Counsel Maya Sikand KC and Laura Profumo.

b. Representing Organisations:
Bhatt Murphy, for INQUEST with their instructed Counsel Anna Morris KC and Lily Lewis;
Browne Jacobson, for EPUT with their instructed Counsel Eleanor Grey KC and Adam Fullwood;
Kennedys for NELFT, with their instructed Counsel Valerie Charbit;
In house representation and DAC Beachcroft for NHS England with their instructed Counsel Jason Beer KC and Amy Clarke;
Government Legal Department for DHSC, with their instructed Counsel Anne Studd KC and Robert Cohen;
Mills and Reeve, for the Integrated Care Boards with their instructed Counsel Kate Brunner KC;
Jennie Richards KC and Rachel Sullivan for the Care Quality Commission;

Bevan Brittan for Oxehealth, with instructed Counsel, Fiona Scolding KC

18. I would like to take the opportunity in giving this Opening Statement to cover the following areas:

    a. Firstly, I will report on progress made by the Inquiry since our last hearing in April and May – particularly the work that is taking place outside the context of our hearings;

    b. Secondly, I will turn to the very important evidence that you will be hearing over the next week.

THE PROGRESS OF THE INQUIRY

19. Your team continues to progress work in a variety of areas; much of which will take place outside our hearings. We are undertaking specific and targeted further work following the April Hearing – examples of which I will come to in a moment.

Listening to Core Participants

20. Chair, following the April hearing you invited Core Participants to provide written comments on pertinent issues and matters that arose during that hearing. A number of Core Participant legal teams took you up on that offer, between them representing many individual Core Participants. The Inquiry's legal team has been working through all the submissions sent in and considering each and every one of the actions proposed, as have you, Chair. Those actions included (amongst other matters); possible lines of

enquiry and investigation; potential sources of evidence; and proposals for how the Inquiry should be run.

21. The Inquiry was very pleased to receive a number of helpful and persuasive proposals from Core Participants' legal teams, including those representing bereaved Families and those with Lived Experience as well as the Providers. Some of the actions proposed – particularly the more straightforward ones – have already been actioned or are in the process of being actioned. Others are under active consideration. As part of that, I have invited the counsel teams who provided submissions to meetings with me to discuss those submissions. Some of those meetings have already taken place and they will continue into this month and a little beyond.

22. I welcome this dialogue. I will report back in relation to principal points raised, once those discussions have concluded. The meetings to date have proved positive and helpful. I also intend to invite the teams of Core Participants who did not provide submissions at the end of the last hearing to meet with me. Core Participants who do not have legal representation form an important part of those engaging with the Inquiry. We will of course be hearing the evidence of several this week. The Inquiry will be in touch with them after this hearing to offer meetings to discuss the ways in which the Inquiry is operating.

23. Finally on this point Chair, the Inquiry team will also now run a series of in-person drop-in sessions in Essex. This will be an opportunity for those engaging with the Inquiry to meet with the Inquiry team and to ask any questions or raise any concerns which they may have face to face.

Work following the April Hearing

24. By way of update, the areas for more detailed investigation identified by the Inquiry Team and suggested by Core Participants following the April hearing include (but, I should stress, are not limited to):

    a. Investigations and information collated by regulatory bodies (e.g. the Health Services Safety Investigations Body, Local Government and Social Care Ombudsman and Patient Safety Commissioner).

    b. The regulatory landscape more broadly – particularly when there are systemic issues and failures at play.

    c. Further information on the role, remit and activities of the Care Quality Commission during the relevant period.

    d. Further information in respect of the Health and Safety Executive prosecutions of EPUT (and its predecessor trusts) and any correlation with the CQC's position and responsibilities at the relevant time.

    e. Notification, monitoring and oversight of patient safety concerns more widely.

    f. A variety of specific topics and issues arising from EPUT disclosure and the evidence of Dr Milind Karale. Examples include: Policies and Documentation; Evaluation and Monitoring; Governance; Risk Assessment; the use of the Electronic Patient Record;

Neurodiversity and Autism; Culture; Screening of Referrals; Challenges/limitations related to Assessments; Psychiatric Medication versus Psychological Therapy; Coercive and Restrictive Practices; The Care Plan, The Care Programme Approach; the Community Mental Health Framework, and Specialist Units.

g. Further questions following the additional evidence of EPUT's Zephan Trent relating to the use of Oxevision.

h. The Culture of Care Programme and the issue of race equality.

i. Issues relating to the care of neurodiverse patients more widely.

j. Further examination of the Duty of Candour.

k. The death certification process.

l. The quality and availability of data about deaths in mental health detention.

25. The Inquiry continues to engage proactively with relevant organisations and individuals to secure further evidence in these areas. Rule 9 requests for disclosure have been sent out by the Inquiry since the last hearing and we are in the process of formulating and sending out further such requests. This is to ensure that the various matters arising from the last hearing are thoroughly and robustly followed up.

26. The Inquiry continues also to progress its work in many other areas - from actively exploring issues of physical and sexual safety and engaging with

Essex Police (with whom the Inquiry has in place a Memorandum of Understanding) to its investigation of private providers.

North East London NHS Foundation Trust (NELFT)

27. I would like to say a few words now about one of the other healthcare providers the Inquiry is looking closely at - the North East London NHS Foundation Trust, also known as NELFT. In addition to providing extensive mental health services for people living in various London boroughs, NELFT provides mental health services for people living in Essex and did so throughout the period with which the Inquiry is concerned. Notably, NELFT currently provides Children and Adolescent Mental Health Services ("CAMHS") to young people in Essex.

The Criminal Trial

28. Those following and engaging with the Inquiry will have noted that despite being a relevant and significant NHS provider of mental health services, NELFT did not feature in the Inquiry's April Hearing.

29. It had originally been intended that NELFT evidence, and witnesses from NELFT, would form part of the April hearing. At the beginning of April however, you decided, Chair, to remove NELFT evidence from the hearing. That was because a long-running criminal trial, in which NELFT was one defendant and a previous NELFT employee (a ward manager) was another, had reached a sensitive stage at the Central Criminal Court. Its jury was about to be sent out by the trial judge to consider its verdicts. When you made that decision, the Inquiry had been made aware that it was possible the jury would still be deliberating throughout the time of the Inquiry's April

hearing and beyond. That turned out to be the case and, in fact, the jury in that criminal trial did not return verdicts until early June 2025.

30. Whilst in many circumstances a public inquiry and criminal investigation or trial can continue alongside each other, Chair, you were concerned that adverse comments about NELFT made in public at the April hearing could have had the potential to prejudice the criminal trial at that particularly sensitive time. You therefore instructed the Inquiry to act accordingly.

31. In the event, NELFT was acquitted of an offence of Corporate Manslaughter[1] and the ward manager was acquitted of Gross Negligence Manslaughter. But both NELFT and the ward manager were found guilty of breaching the duty created by section 3 of the Health and Safety at Work Act 1974, in that they failed to ensure others were not exposed to risks to their health and safety. These criminal offences related to the self-inflicted death of an inpatient at one of its hospitals in the London Borough of Redbridge in July 2015. In short, NELFT had failed to remove known risks to the inpatient who was able then to take her own life.

Disclosure

32. Quite separately, a significant amount of material requested from NELFT was provided to the Inquiry too late to form part of the bundle put together for the April hearing. The Inquiry also requested a position statement from NELFT which was returned after the extended deadline. Given the volume of material received so late in the day, it was not possible properly to review and include it in the bundle for the April hearing. The evidence from NELFT

[1] Contrary to s.1 of the Corporate Manslaughter and Corporate Homicide Act 2007

will therefore form part of a future hearing, at which we will also require NELFT's CEO to attend and address you.

Relativity

33. Moving on to a new topic. The Inquiry has been working hard to ensure disclosure is made to Core Participants and Witnesses in a timely and efficient way. Up until now, disclosure of large volumes of material, and of hearing bundles, has taken place by way of upload to the Inquiry's Evidence Portal, eXchange.

34. The Inquiry has looked carefully at how best to assist Core Participants in their review of the documentation disclosed by the Inquiry, and it has also taken on board the representations and views of the Core Participants as to how they might best be assisted. As a result, the Inquiry will now extend the use of the Relativity platform to all Core Participants, Material Providers, and their legal representatives. This will also improve the Material Provider review process.

35. Relativity is a disclosure platform that facilitates efficient review and analysis of documents. The Inquiry intends to secure access to Relativity for all Core Participants no later than August, at which time all material already disclosed will be accessible on that platform. Any future disclosure will then be made via Relativity, including material relevant to the October Hearing and the material for future hearings in 2026. Once Relativity is up and running for Core Participants, the Inquiry does not intend to provide material through any other means, unless of course there are circumstances where reasonable adjustments are required. From August onwards therefore, all disclosure will take place via Relativity save in the case of unrepresented Core Participants with whom the Inquiry will be in

touch individually to put into place suitable and workable arrangements. The Inquiry will ensure the effective deployment of Relativity by issuing detailed user guidance, providing scheduled training sessions and offering technical support.

Disclosure Plan

36. At the same time as Relativity becomes available to Core Participants, the Inquiry will provide its Disclosure Plan. This plan will set out the Inquiry's proposals for the disclosure of evidence for its hearings, along with the proposals for disclosure of material not connected to those hearings. The plan will be provided with a timetable as to when disclosure of witness statements and other materials relevant to the Terms of Reference is likely to take place. This will allow Core Participants to plan their work and resources in advance.

List of Deceased

37. Chair, the Inquiry continues to prioritise its efforts to compile, as best it can, a definitive list of deaths that fall into its scope. At the April hearing, you set out a revised approach to two of the particulars listed under your definition of "inpatient death". In particular, you clarified the entry at (g) of your Explanatory Note, that accompanied the Terms or Reference, in relation to deaths following a mental health assessment. An amended version of the Explanatory Note was circulated on 10 April 2025. I addressed this in some detail at the start of the last hearing.

38. Since that revised approach was announced, the Inquiry has sent further requests to the relevant health care providers, requiring them to revisit the information that they hold and provide the Inquiry with revised details of

those who died whilst under their care. The Inquiry understands that for some providers that is going to involve adopting a broader approach to the disclosure of information and may take some time. The Inquiry will provide further updates on this important work as soon as it is able to do so.

39. It will be clear therefore that we still do not yet have a definitive figure for the number of deaths that come within the scope of this Inquiry. The Inquiry is acutely aware that this number is of particular interest. As you stated in September last year, Chair, the Inquiry recognises that it may never be possible to provide, with confidence, a final or definitive number of those who died in the relevant period whilst under the care of Trusts in Essex. The Inquiry considers, however, that it owes a responsibility to those who died and to their loved ones, including those who are not Core Participants, to finalise the List of Deceased to the very best of its ability. We will provide the most accurate number that we can when we have, with expert assistance, collected the data we need and analysed it appropriately.

40. It is not just the number of deaths in scope that is important, although that is very important. The information obtained about those deaths is also required to enable reliable and robust findings to be made about the themes and patterns revealed by the data.

41. Chair, I would also like to make clear at this stage that until the Inquiry receives updated information relating to those whose deaths fall into the scope of the Inquiry, we are simply not in a position to say how many of those involved serious failings or issues of concern, or were deaths that could have been avoided. The Inquiry will continue to do all that it can to provide clarity in this area. We are determined to get the most accurate figure available using all of the information and expertise available to us.

42. I am talking here about statistics. As I have said before, as an investigative process, we do have to look at information obtained in an analytical and objective way to see trends, spot issues and make findings. But we recognise that behind the figures each death was of a person with their own life and individual circumstances.

The Inquiry's Expert Statistician

43. One of the important reasons for obtaining the best information available in relation to the Inquiry's List of Deceased is to inform the work of Professor Donnelly, the Inquiry's expert statistician, and her team. They have continued their work analysing the List of Deceased and in helping to identify trends and matters of statistical significance to further inform the Inquiry's work.

44. Although it has been possible to prepare an initial analysis, there remains important work to be done before that output can be of assistance to the Inquiry and can be shared with Core Participants. The key strands of their further work include the following:

a. Firstly, as already outlined, obtaining the best available evidence to ensure that the List of Deceased is accurate and that where possible that it is triangulated against other available data such as Records of Inquest;

b. Secondly, obtaining denominator data. It is recognised that the List of Deceased, even when complete, will represent only part of the picture. To draw meaningful conclusions about patterns, risks

and potential systemic issues, it will also be necessary to obtain information about the population of patients who were admitted to the same wards during the same period. This data, known as denominator data, is being sought, but there are challenges in obtaining it.

45. Following this hearing, we intend to provide Core Participants with an interim report from Professor Donnelly setting out, in outline, her approach and work to date. Although this will not represent any final analysis, we aim to share this to help inform further discussions at the Data Discussion which I will now come to.

Data Discussion

46. Chair, you will recall during the April Hearing, that the Inquiry heard interesting and helpful oral submissions from Core Participants touching upon the topic of data, along with constructive suggestions from Counsel such as Fiona Murphy KC, Brenda Campbell KC and Steven Snowden KC on behalf of a number of the Core Participants, as to how the Inquiry might approach the questions of data and data analysis in various different areas. Certain of those submissions were echoed within the written representations provided at the conclusion of the April Hearing.

47. This is an area in which the Inquiry is particularly keen to hear further views from the Core Participants and is currently considering the most efficient way to facilitate the sharing of those views. To this end, the Inquiry intends to host a "Data Discussion" involving the Inquiry and Core Participant representatives. This may take the form of a chaired round table discussion to allow constructive suggestions as to avenues the Inquiry may wish to

explore. Further detail about the "Data Discussion" will be provided as soon as possible following this hearing.

Experts and Independent Assessors

48. The Inquiry has received and is considering submissions from Core Participants in respect of expert evidence heard at the April hearings. A number of points raised require careful contemplation moving forward. Core Participant proposals include an expert instruction protocol and additional ways in which Core Participants may contribute prior to the instruction of an expert.

49. Chair, you have firmly in mind the need for further expert evidence. We are actively considering other areas and other potential experts. We have, for example, already identified the need to obtain further expert evidence in respect of autism and neurodiversity.

Investigation of Illustrative Cases

50. The Inquiry is currently finalising the investigation strategy by which it will examine the circumstances of those who died on mental health inpatient wards in Essex. This is one of the matters I have been discussing and will continue to discuss with Core Participant counsel. Further detail about the Inquiry's investigation strategy will then be provided to Core Participants. As part of its investigation work, the Inquiry will liaise with the families and friends of those who have died, together with their legal representatives, about the matters which are of key importance or concern to them. The Inquiry will ensure that they are kept updated of its work.

51. Chair, you have chosen to receive witness statements and hear first from the families and friends. The evidence they give, and the concerns they raise, will provide the foundation for, and will inform, the Inquiry's investigations.

Staff Evidence

52. The Inquiry's investigation strategy will also influence and inform the evidence the Inquiry seeks to obtain from staff members who worked for the healthcare providers during the relevant period.

53. It has been well reported that in its non-statutory phase, the Essex Mental Health Independent Inquiry failed to secure meaningful engagement from staff who had worked for the relevant trusts and private providers. It was one of the most influential factors in securing the statutory Inquiry.

54. This Inquiry remains disappointed with the level of staff engagement. We are very grateful to those who have come forward and provided relevant evidence with openness and candour. They are few in number, however.

55. The Inquiry's investigation strategy will now allow it to take a targeted and focused approach to obtaining staff evidence. The Inquiry's investigations, which will begin with the first-hand account provided by the bereaved family, will identify the key figures involved in providing care and treatment to the deceased, both on a ward level and those in positions of management. The Inquiry will determine which staff are best placed to provide evidence that assists its work – particularly when looking at systemic issues.

56. The Inquiry will also continue to seek staff co-operation more broadly. You will recall Chair, that in April the Inquiry heard evidence of a culture of fear amongst staff working in NHS settings: a fear on the part of staff to speak up at the time they were aware of concerns, and a fear on the part of staff to speak up later when the matters were being investigated. Sir Rob Behrens CBE told the Inquiry that he had "dozens" of clinicians get in touch with him indicating that "they wanted to raise issues" but they feared they would lose their jobs and careers.

57. The Inquiry continues to encourage any person who has information that may assist the Inquiry to come forward and provide that information, particularly those who worked within NHS Trusts in Essex or for relevant healthcare providers. Chair, you have ensured the Inquiry has in place a Whistleblowing Protocol to provide whatever protection it cans for those individuals. You are also seeking the views of the Core Participants and the Inquiry as to whether providers and regulators should be asked again to give narrow undertakings in order to facilitate the flow of full and frank disclosure to the Inquiry.

58. I referred at the start of the last hearing to those undertakings. Following that hearing, the Inquiry has amended the proposed undertakings in order to make absolutely clear their intended purpose and narrow remit. They seek to safeguard the interests of those would like to raise issues. They relate only to the provision of material to the Inquiry and would not enable any individual to avoid accountability for serious misconduct. Those amended proposed undertakings will be provided to all Core Participants following this hearing, so they have a better idea of what the Inquiry is requesting. Core Participants will be invited to provide views in writing in the first instance.

59. The Inquiry has been invited by one of the corporate Core Participants to consider organising a combined discussion with various providers and regulators to discuss the undertakings you are seeking. Chair, whilst your team proactively engaged with providers and regulators last year on this precise topic, the Inquiry remains amenable to any joint and concerted effort which might assist in the furtherance of its work.

Oxevision

60. I would like to turn now to say a few words about the Oxevision evidence. During the April Hearing, the Inquiry was due to hear evidence about Oxevision, a technology that uses infrared-sensitive cameras to monitor patients' vital signs (such as pulse and breathing rate) in mental health settings. Chair, you took the decision to postpone the corporate part of that evidence on the Inquiry's receipt, very late in the day, of a new witness statement from EPUT, which set out a material change in their approach to Oxevision. In the interests of fairness, and to give all interested Core Participants and the Inquiry time to review the new evidence, you determined that the evidence from EPUT and Oxehealth should be heard at a later hearing. On 14 May 2025, the Inquiry did, however, hold a pre-recorded evidence session with Hat Porter, a representative of the campaign group Stop Oxevision.

61. As you made clear at the time, Chair, the use of Oxevision remains a matter of significant interest to this Inquiry. We are acutely aware that it is also a matter of particular concern for a number of the Inquiry's Core Participants. And I can say now that the Inquiry intends to hear the delayed Oxevision evidence at the start of the October Hearing.

Recommendations and Implementation Forum

62. At the outset of the April hearing, Chair, I outlined how you had directed that a Lampard Inquiry recommendations forum should be set up and that it is now referred to as the Lampard Inquiry "Recommendations and Implementation Forum". This is to reflect the importance not only of the making of recommendations, but also the fact they need to be accepted and implemented. All Core Participants will be able to engage with the Forum.

63. We also announced in April that the Inquiry has secured the assistance of a noted academic with expertise in public inquiries for the Forum, Dr Emma Ireton.

64. Dr Ireton will provide a paper this autumn, which will be circulated to its Core Participants. Its purpose will be to provide a contextual briefing on the framing, implementation and monitoring of inquiry recommendations. In broad terms, it will cover:

    a. the purpose and construction of recommendations;

    b. implementation and monitoring;

    c. relevant recent developments and current themes in inquiry practice; and

    d. a summary of recent inquiry approaches to implementation and monitoring.

65. The Ireton paper will be provided to Core Participants along with a paper from the Counsel to the Inquiry Team, which includes our suggestions for how the Forum should work. We will then seek the views of Core Participants and other key stakeholders about the best way forward for the Forum.

Achieving Best Evidence and Inquiry's Protocols

66. Can I also remind those following and engaging with the Inquiry that it has in place various protocols. This is with the aim of assisting those who wish to engage with the Inquiry in providing the best possible evidence, in a way that also ensures they are supported throughout the process. All documents are kept under review. They include protocols:

    a. on Restriction Orders, Redaction, Anonymity and Special Measures;

    b. on Vulnerable Witnesses;

    c. on Witness Statements; and

    d. Principles of Engagement for the July Hearing.

67. Chair, you have a wide discretion to put in place measures to support witnesses giving evidence. We will continue to work with witnesses and, where they have them, their legal representatives to take an individualised approach as far as is reasonably possible. The Inquiry also offers emotional support to all individuals engaging with it.

Lived Experience Framework

68. The Inquiry has been working to finalise the arrangements for how it will receive evidence from witnesses with lived experience of mental health inpatient services in Essex. The Inquiry has developed a framework to ensure that evidence from those with lived experience is obtained in a trauma-informed way which allows each witness to provide their best evidence. A draft version of the Inquiry's Lived Experience Framework, along with the associated questionnaire, was sent out to all relevant legal representatives in April with an invitation to provide observations. All comments then provided by legal representatives were carefully considered and taken into account. Consequently, an updated and final version of the Lived Experience Framework, along with the updated and final version of the questionnaire, was sent out to legal representatives last week and will be published on the Inquiry's website.

69. The Inquiry will afford these Core Participants and their legal representatives an extended period of time in which to complete the framework questionnaire. The Inquiry will then circulate a proposed timetable for the taking of that evidence once Core Participant responses have been received. We are grateful to the Core Participants and their legal representatives for their helpful engagement in this exercise.

JULY HEARING

70. I would like now to say a few words about this hearing, which runs from today until Monday 14th July.

71. As I set out at the beginning of this statement, over the 5 days of this hearing, the Inquiry will focus solely on evidence from bereaved family members. The Inquiry has invited these witnesses to give evidence of their recollections and concerns, and we have also invited them to give their current views on what recommendations should be made for change. This week's evidence will therefore comprise for the most part, of family members' first-hand accounts and observations of what happened to their relatives.

72. Hearing this evidence from families now and in October is crucial. As I have mentioned, Chair, you were clear that you wanted to hear first from the families at the heart of this Inquiry. This will ensure that this evidence is the driving force in informing the Inquiry's investigations. The Inquiry is aware that many families and friends have through their experiences sadly become experts in various different areas of mental ill-health, care and treatment. It values that knowledge and intends to liaise with families engaging with the Inquiry and their representatives in relation to the investigation of systemic issues where relevant in each case.

73. The Inquiry will not be seeking comments or analysis from the witnesses on documents that relate to their relative's care and treatment during the course of this particular hearing. Nor will the Inquiry be hearing other evidence relating to that care and treatment at this stage. Other evidence will, however, form part of the Inquiry's investigations and may form part of later hearings.

Witnesses

74. Over the course of this hearing, Chair, the Inquiry will hear oral evidence from twelve bereaved family witnesses. We will hear about the following people who have died:

- **Edward Jackson**, **known as Ed**, who died on 31 December 2007, aged just 18. We will hear evidence from his brother, Ben Jackson.

- **Amanda Susan Hitch, known as Mandy**. Mandy died on 12 February 2022, aged 59. We will hear evidence from Mandy's son, Adam Rowe.

- **Terence Joseph Pimm, known as TJ**. TJ died on 26 August 2016. He was 30. We will hear evidence from TJ's mother, Karon Pimm.

- **The person known to the Inquiry as W4.** He died on 17 February 2015, when he was 57 years old. We will hear from W4's sister, Janet Carden.

- **Liam Patrick Brennan**, who died four days after his 29th birthday, on 14 August 2012. We will hear evidence about Liam from his father, Patrick Brennan.

- **Pippa Whiteward**, who died on 29 October 2016, when she was 36. We will hear evidence from Pippa's sister, Lydia Fraser-Ward.

- **Stephen Oxton**. Stephen died on 1 April 2012, when he was 53. We will hear from his son, Alan Oxton.

- **Frederick Peck, known as Fred**. Fred died on 4 December 2004, at age 54. We will hear evidence from Fred's daughter, Emma Sorrell.

- **Geoffrey George Toms**, **known as Geoff**. Geoff died on 14 May 2015, when he was 88 years old. The Inquiry will hear evidence about Geoff from his daughter, Lynda Costerd.

- **Daniel Fairman**, **known as Dan**. Dan died on 17 August 2018. He was 53. We will hear from his sister, Jane Maier.

- **Susan Spring**. Susan died on 1 February 2012. She was 54. The Inquiry will hear evidence from her daughter, Emma Cracknell.

- **Richard Harland Elliott**. Richard died on 24 May 2002, at age 48. We will hear evidence about Richard from his sister, Catherine Peck.

75. From these witnesses, all of whom have set out their recollections, observations and their views on the need for change with courage and clarity, the Inquiry will hear about a number of the key themes it will be examining during the course of its work. Those include, but are by no means limited to:

- A lack of a clear or settled diagnosis.

- Those with dual diagnoses described as being bounced around between different services with no proper oversight of care and treatment.

- Failures to adequately assess, or in some cases to assess at all.

- Failures to admit or section in the face of clear and clearly reported deterioration and/or suicidal intent.

- A revolving door of repeated admissions and discharges with no apparent improvement in mental health and in many cases a deterioration.

- Failures to ensure appropriate inpatient placement and a lack of availability of beds, particularly in Mother and Baby Units.

- Ward environments variously described as “a holding pen”, “cold, sparse and inhospitable”.

- Physical injuries sustained on the ward, without proper explanation.

- A lack of staff on wards.

- A lack of psychological or therapeutic treatment on wards.

- Confusion and general mismanagement of proper checks and observations on patients who were at high risk.

- Serious failures in record-keeping and management, including in relation to failures to record properly incidents of harm or injury.

- Dismissive attitudes amongst staff at all levels and at all stages of treatment, both to patients and to families.

- A woeful lack of engagement with families, friends and support networks of patients, at all stages and across all aspects of care and treatment.

- Failures to listen to families or to seek input on patients from those who knew them best.

- Failures to carry out proper checks to ensure that patients could not access items with which to harm themselves.

- Systemic failures in relation to ligature points.

- Concerns in relation to medication, including failures to warn in respect of side effects and signs to look out for in the case of deterioration.

- Concerns in relation to discharge and inadequate assessments prior to discharge.

- A failure to engage with families in respect of the discharge decision and process.

- Poor responses to complaints or concerns raised.

- Closed, defensive, dismissive and disrespectful attitudes from the Trust and from Trust staff towards families following a death.

- Inadequate and error-ridden investigations and investigation reports.

- A lack of support before, during and after Inquests into deaths.

76. As I have said, many families have sadly become experts in some of these areas and are uniquely placed to speak to these important issues in a way that no corporate organisation can.

77. I should also reiterate, as I said in April, that the witness statements provided for this hearing by those witnesses will stand in full as their evidence. I say this as the statements will not be read out in full during the course of the hearing - rather the witnesses will be asked careful questions about what they have written.

78. Those witness statements will be published on the Inquiry's website once each witness has given their evidence. The copies of the statements that are published will be redacted in line with the Inquiry's published approach. There are three main categories where redactions may be applied:

    a. Staff Names - staff names, including those of junior staff, will generally be disclosed in the course of the Inquiry. Individuals can apply for their names to be withheld, however, in line with relevant law and the Inquiry's Protocol on Restriction Orders. Each application for a Restriction Order will be considered individually by the Chair. Some staff may need time to decide whether to apply

for anonymity and to seek legal advice. While they are given this time, their names will be redacted temporarily. This ensures fairness.

b. Methods of self-inflicted death or self-harm - details about specific methods of self-inflicted death or self-harm, as well as other highly distressing content, may be redacted to protect the public from potential harm. The Inquiry may also apply redactions where it considers the information is unusual and could instruct others.

c. Other information which may fall under the Inquiry's Privacy Information Protocol. This will be information which is personal in nature and which, Chair, you do not consider relevant and necessary to be made public. This would include details such as someone's address, or other personal sensitive information.

Timing

79. Moving now to the timetable. The Inquiry will sit on Monday to Thursday during this week. And again next Monday.

80. For this hearing, we will generally start at 10am and finish by 4pm. There will be a short break in the morning and in the afternoon in which teas and coffees will be provided free of charge for those who are attending. There will be a one-hour break for lunch each day, which will usually be from around 1:30pm to 2:30pm. This is all subject to the need for the Inquiry to proceed flexibly and take more breaks or make other arrangements as required to support witnesses.

Livestream

81. It is not necessary to attend the hearing in person to follow the Inquiry's proceedings. Core Participants and their lawyers who are not attending in person can watch the hearing live on a secure weblink. The hearing is also being live-streamed on the Lampard Inquiry YouTube Channel for anyone who wishes to follow us remotely. But please note that this will be streamed with a time delay of 10 minutes.

CHANGING MENTAL HEALTH LANDSCAPE

82. I have previously referred to the changing mental health landscape against which the work of the Inquiry is taking place. You made reference in your Opening, Chair, to the NHS 10 Year Health Plan for England,[2] which includes proposed measures of relevance to the work of this Inquiry.

83. The Plan, published last Thursday, includes the suggestion that *"The NHS's history is blighted by examples of systemic and avoidable harm"*. It makes specific reference to *"neglect and poor care of patients under the care of mental health services, including Essex inpatient services (2000-23)"*. Reference is made to other suggested examples of systemic and avoidable harm in mental health and other health settings. The Plan then says that:

"The failures that underpin each are consistent: incompetent leadership, toxic culture, rampant blame, workplace bullying, and a failure to learn from mistakes. There is also a fundamental lack of transparency, which means low quality or neglectful care does not come to light quickly; that the response is not fast or decisive enough; and that patient, staff and

[2] Fit for the Future: The 10 Year Health Plan for England

public attempts to sound the alarm go unheard. It is time for the NHS to learn."[3]

84. The Inquiry is considering this and other parts of the Plan.

RECENT CASES

85. Chair, when I delivered the Opening Statement at the April hearing, I observed how sad the Inquiry had been to learn of deaths in mental health settings occurring in 2024 and a death as recently as April 2025. I observed that these further tragic deaths may point to serious and ongoing issues in Essex.

86. The Inquiry remains deeply concerned that patients are still dying. We will continue to monitor any recent deaths of mental health inpatients in Essex. We also continue to monitor the inquests that are taking place into the deaths of those who died in the latter part of the period covered by the Inquiry's Terms of Reference.

87. We are aware of a number of inquests having taken place in the past few months in relation to deaths of mental health patients in Essex in 2023 and from previous years, following which the coroner has issued a Prevention of Future Deaths Report.

88. The recent inquest of Elise Sebastian, who died under the care of EPUT in 2021, gives rise to serious issues that this Inquiry is investigating. The coroner has indicated that a Prevention of Future Deaths Report will be

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forthcoming. Other inquests are listed for hearing later this year. In short, the Inquiry has noted that recent inquests have explored the same or similar failings and systemic issues with which this Inquiry is concerned.

CONCLUSION

89. It is against these ever present and growing concerns, Chair, that the Inquiry is determined to scrutinise what has taken place in Essex over the relevant period. You have made clear that you will make appropriate findings of fact, ensure accountability and propose robust recommendations for long lasting change. We are mindful now more than ever, Chair, that the landscape into which you will making those recommendations is a changing one.

90. That brings me to the end of my opening remarks. A written version of this Opening Statement will shortly be available on the website.

NICHOLAS GRIFFIN KC

Counsel to the Inquiry