Monday, 8th December 2025

Opening statement by MR GRIFFIN

MR GRIFFIN: The Inquiry's holding a virtual hearing to hear from its Core Participants on procedural matters, including the Inquiry's draft Statement of Approach on investigating illustrative cases of those who have died.

The Inquiry is in listening mode and will consider with care the submissions being made. The background to the hearing is this: on 3rd October this year, the Recognised Legal Representatives acting on behalf of the bereaved and lived experience Core Participants provided a written submission asking for permission to address you at the outset of the evidential hearings, which were to start on 13th October.

The submission referred to concerns arising from a lack of an Inquiry roadmap to a final report; a lack of clarity about the Inquiry's investigative plan or strategy; the absence of information about the Inquiry's plans to identify samples of cases or illustrative case examples; limited disclosure and the Inquiry's approach to Rule 10 questions.

It was not possible to hear those submissions at the start of the October hearing. Chair, you were concerned about the disruption that hearing submissions on the first day of the October hearing would have on the

Inquiry's hearing timetable and the consequent impact of that disruption on the bereaved family witnesses who had been asked to attend to give their evidence over the following days. Further, the Inquiry was intending to share with Core Participants its investigative strategy in November.

Consequently, and given the focus of the issues the Core Participants wished to address you on, you determined that holding a hearing after that strategy had been shared would enable a more effective hearing to take place.

At the start of the October hearing I provided an opening statement that referred to the Inquiry's approach to its illustrative cases and its investigative strategy and I spoke of other work undertaken by the Inquiry in parallel with this.

Following the October hearing, on 13th November, the Inquiry circulated to Core Participants its draft Statement of Approach on investigating illustrative cases of those who have died.

It set out the factors the Inquiry intends to consider in order to select cases for investigation: how we will identify and explore the issues and themes raised by those cases in accordance with its Terms of Reference; how the Inquiry proposes to approach the

gathering and testing of factual evidence and how families, providers and other agencies may engage with the Inquiry's investigations.

The document concludes by saying that the Inquiry is aware of the importance and urgency of its task. This draft Statement of Approach therefore sets out a process that, whilst being appropriately thorough, allows for its Terms of Reference to be met and for recommendations to be made for lasting change with all due expedition.

Core Participants have been invited to make submissions on the draft document at this procedural hearing, with skeleton arguments to be provided in advance.

Other procedural matters can be raised at this hearing without the need for written submissions in advance. We have in fact received some further written submissions on behalf of the clients at Hodge Jones and Allen addressing a matter of law.

As I have mentioned, the hearing is being held virtually. It is being live-streamed and can also be viewed on the Inquiry's YouTube channel. In the usual way, a transcript and video of today's proceedings will go onto the Inquiry's website.

Chair, with that, may I introduce the legal representatives who will be addressing you today. We

will hear first from Maya Sikand KC on behalf of the client Deighton Pierce Glynn. We will also hear from Eleena Misra KC on behalf of the client Hodge Jones and Allen, then Fiona Murphy KC on behalf of the clients of Bhatt Murphy, Brenda Campbell KC on behalf of the clients of Bindmans, Sophie Lucas on behalf of the Bates Wells clients and Anna Morris KC on behalf of the organisation INQUEST.

Chair, EPUT (Essex Partnership University NHS Foundation Trust) and NELFT (Northeast London NHS Foundation Trust), NHS England and Melanie Leahy have provided written submissions but will not be addressing you today.

Most speakers have been allocated a maximum of 45 minutes to address you with no further time being allowed beyond this for any speaker, and less where they have indicated they require less time. For those who are about to speak, may I ask that you follow this approach:

Please keep your cameras and microphones off unless you are addressing the Chair in your allocated slot, and the starting time provided for each speaker are indicative only, we will move from one speaker to the next as soon as the previous speaker is finished, subject to taking breaks. I will introduce each speaker.

Chair, we can now move on to the submissions themselves. I therefore call on Ms Sikand KC to address you.

THE CHAIR: Thank you.

Submissions by MS SIKAND

MS SIKAND: Good morning, Chair. I appear today alongside Laura Profumo on behalf, in fact not just DPG, but three RLRs -- Leigh Day, Irwin Mitchell and DPG -- who represent between them the interests of six Core Participants, comprising five bereaved families and one former patient.

With apologies for not indicating this earlier, Chair, you may be pleased to hear that I will not need the full 45 minutes allocated, a generous time slot for which we thank you, but given our many written submissions, including the ones on the draft investigative strategy, I intend to take probably only half of that time.

I won't be addressing you, Chair, on Oxevision as others with directly affected clients will do so.

Chair, as it happens, today is the last day of National Grief Awareness Week 2025, which makes this opportunity to address you directly more poignant. We have wanted to address you directly on the key procedural concerns which our clients hold in respect of

the management of this Inquiry for some time. It is not lost on those who represent that this is the first opportunity we have been given to orally and publicly address you on such matters since the opening of the statutory phase of this Inquiry in September 2024.

It is also not lost on them that this hearing has only come about further to a joint written application just before the beginning of the October hearings, as Mr Griffin has just set out in detail.

Chair, we don't say this out of blunt criticism or for point-scoring, but rather to emphasise that this hearing, which falls now just beyond the halfway mark of the Inquiry's current timetable, marks a critical juncture at which to pause and reflect on its direction and the steps that we consider are now urgently needed in order to ensure the Inquiry is capable of meeting its statutory objectives.

Chair, like me, you will have read the skeleton submissions of all the CPs and you will have noticed that in several fundamental respects we speak with one voice, bereaved families, former patients and corporate CPs alike. Independently we all ask you for the same thing -- transparency, openness and clarity -- and a time-limited and achievable roadmap to fact-finding and recommendations.

Chair, unfortunately the only clarity we have as I address you today is that the draft investigative strategy raises more questions than it answers, not just about that particular strategy, but everything else the Inquiry has yet to achieve, but needs to if it is to be true to its terms of reference and its list of issues.

Whilst Mr Griffin indicated in his October hearings that the Inquiry was leaving no stone unturned in its investigative efforts, it included seeking extensive evidence from providers and third party agencies as well as rigorously exploring and obtaining data on core issues and research materials. We have yet to receive any indication as to the remit or outcome of those inquiries.

The Rule 9 requests and the long list of materials that Mr Griffin indicated the Inquiry has made -- evidential requests in respect of obtained data in relation to -- remain unpublished and undisclosed to us, with no timetable for disclosure.

Chair, how do we advise our concerned clients as to what this material is, when we are getting it, where it fits in and what role our clients will play in responding to it? Who are these key individuals referred to as authors and historians? Chair, these should not be secrets.

I'm deeply conscious of the fact that today's hearing will come across as a giant moan, Chair, and it will be difficult to hear criticism as opposed to an appreciation of what the Inquiry has done to date. We absolutely recognise that we wish to put the experiences of the bereaved first; that they, having relived their deeply traumatic experiences in the public domain, want to know exactly what is next and how the Inquiry is going to examine not just the detail of their own cases, but also how it is going to determine any failures in governance, both at a micro and macro level.

The Inquiry's desire to hear bereaved voices as quickly as possible meant that the Inquiry opened without any modular structure, quite unlike any of the other 2005 Act inquiries that our legal team and other teams have experience of. A glance at the Inquiry's website will tell you almost nothing. In February we are told we will hear important further evidence from bereaved families with "further focus on selected themes relevant to EPUT investigations".

On one part of the website, April and July hearings will apparently include considerations of "selected themes relevant to Inquiry investigations"; "wider themes and the national picture", and "corporate evidence and responsibility".

In another part of the website, April and July remain marked as "TBC". Even the wording that there is is, with respect, Chair, unhelpfully vague, especially given the late stage of this Inquiry. What are the selected themes? Why aren't they published? How can they remain unpublished when time is so short?

There are something like 36 sitting days of evidence left on the current timetable. Chair, it is obvious to every CP that, without a robust and urgent roadmap to direct the Inquiry's progression from the current hearings to its conclusion, there is a real risk that this Inquiry will not be able to fulfil its statutory objectives within the allotted time and that, in its expeditious attempts to do so, the voices of bereaved and lived experienced CPs may be displaced from the centre of this Inquiry.

Having made those general observations, Chair, I turn to some detail. You have our written submissions which address primarily in accordance with ILT's request the draft Statement of Approach, which I will refer to as the draft SOA. I do not seek to repeat all the matters covered in those submissions, Chair, but only to underline certain key areas which bear on our clients' wider concerns over the investigative direction of this Inquiry and their engagement in its important work.

First, a primary concern for our CPs and which we note runs through nearly all other RLR's written submissions, is the lack of clarity as to how this draft SOA fits in with the various other work streams that the Inquiry is, or will be, undertaking. We recognise that this draft strategy will assist in fulfilling some of the terms of reference. We do not, however, understand this (audio breaks) amounts to the totality of the investigative work the Inquiry is proposing to undertake and CTI has made that clear.

Despite its limitations, the draft SOA is of course welcome, but it provides us with no insight whatsoever into what other areas the Inquiry will be examining and in what detail. For example, whilst the Inquiry will be required to interrogate under its tools the relevant Trust's culture, management and governance structures at the time, and we hope that also includes the extent to which any such failures contributed to preventable deaths, we have yet no indication on how it proposes to achieve this.

We are likewise still in the dark as to the final proposed areas on which expert evidence will be sought, far less so which experts will be instructed. These and all other strands of the Inquiry's investigations outside of the draft SOA remain elusive, Chair, as

I said at the beginning.

We have yet to hear any substantive evidence from the providers, clinicians or CPs with lived experience on the key issues within scope, let alone the experts. That is the case now over a year into this public inquiry and with not much time left to run. That is a matter of significant disquiet for our CPs.

We ask that this state of affairs is rectified as a matter of urgency and that the Inquiry legal team provides a clear plan or roadmap as to its proposed investigative approach for the remainder of this Inquiry within achievable timelines. This must set out all other proposed work streams, including the scope and timescale of the Inquiry's evidence gathering processes, including obtaining and providing expert evidence, the proposed systemic issues such work will address and how these areas will interact with and inform the clustered thematic issues proposed by the draft SOA.

This roadmap we say, Chair, must include the disclosure plan which CTI spoke of at the opening of the July 2025 hearings and has yet to materialise. It is vital this plan is provided as soon as possible in order to afford a meaningful pre-publication window of consultation with CPs.

Chair, we fully appreciate that ILT have been

working hard behind the scenes to progress the investigative course of this Inquiry. However, in the context of a public inquiry where there is a presumption of openness, it is not enough simply to tell CPs that the work is underway and to limit their public involvement to the provision of evidence alone. CPs must be apprised of the key investigative work the Inquiry has already undertaken and what remains to be done, even if it has not been conducted within the four walls of the hearing room, to enable us to effectively engage with, understand and assist this Inquiry. Without this understanding of the wider investigative picture, Chair, you will appreciate that our comments on the draft SOA are necessarily siloed at this stage.

We note that in the October opening, Mr Griffin said that a clear investigative strategy was finalised and due for publication in November. It cannot be right that this strategy was finalised in October, given the draft we have been provided with.

A key concern we have highlighted in our written submissions, echoed by others, is the lack of clarity as to the evidence base for the figure of 140 deaths, which is referred to at paragraph 11, which ILT proposes will form the illustrative case sample.

Whilst we understand that this number comprises all

bereaved families in this Inquiry under category 9A, in addition to the additional categories of cases identified at 9b to f, this has yet to be formally confirmed by ILT to all CPs. Whilst we welcome the inferred indication that all bereaved CPs' cases will fall within the illustrative cases, the Inquiry's methodology for case selection remains opaque, in particular how the categories of cases identified at paragraph 9 are said to apply and discharge the criteria at paragraph 8.

For example, it is not clear to us what, if any, expert or statistical analysis has been sought in order to ensure that the cases within these categories comprise overall a proportionate cross-section of the issues identified at paragraph 8 accounting for appropriate weighting between different patient cohort and trust sizes. Nor is it clear how and on what bases the selected categories beyond those of bereaved CPs have been identified. For instance, and this is supporting the observations made by INQUEST, why only cases concerning inquests with neglect findings are included at paragraph 9B, as opposed to those where critical causative findings have been made.

Chair, we direct you to our written submissions for further observations on this particular issue.

Put plainly, without clarification from ILT on the methodology behind its case selection, our CPs cannot be assured that these categories are sufficiently and fairly representative of the key issues which underpin the Terms of Reference.

The draft SOA is also inexcusably silent on the timeline for completion of the various investigative stages outlined. Not even a preliminary indication of any such timeline has been provided, which is particularly concerning given the few sitting days left.

A clear and realistic timeline must be disclosed to us now for the provision of all draft 140 case summaries and the disclosure of the thematic clusters grouping these cases, building in sufficient time for CPs to feed into and comment on each stage.

ILT must also indicate what stage of the proposed investigative work has so far been reached, given the seemingly ambitious remit of this strategy and the various other work streams which must run in parallel.

For our clients to understand and accept this draft SOA as both sensible and necessary, they need to believe it is achievable, Chair. Our CPs also have significant reservations over the asymmetrical approach to disclosure and evidential input that the draft SOA appears to envisage. The strategy seems to indicate, as

per paragraph 51(c), that only CPs within the same cluster will have sight of the case summaries within its grouping, in addition to those with direct equity in that case summary.

This approach is not rationalised, nor can it be acceptable for CPs to be in different states of knowledge, depending on their thematic grouping. The current proposed approach would risk a dangerously unbalanced process whereby only the Trust providers would have sight of all relevant case summaries, despite these forming the basis for the thematic clusters and in turn key findings and conclusions which you, Chair, will draw from these. Additionally, the draft SOA appears to restrict consultation on the development of the thematic clusters only to those CPs within the identified cluster.

It is imperative that all CPs are offered a meaningful opportunity to engage and feed into the formulation of these case clusters, even if not within that particular cluster. Without such collective engagement, CPs can have no confidence that the appropriate systemic issues will have been identified and sufficiently interrogated. This is particularly important given the strategy's indication at paragraph 54. That is that all clusters will be

(inaudible) evidence.

Chair, the exclusion of patients with lived experience from this draft strategy is also a matter of significant concern to our clients, in particular X1, a former patient under the care of NEPT. The failure to include those with lived experience within the draft SOA is indicative, we submit, of the Inquiry's general approach to this cohort to date, having failed to engage with and assure the CPs as to their fundamental role within this Inquiry. The fact the Inquiry still has not provided any indication in its timetable as to when it intends to hear evidence from those with lived experience, despite being pressed repeatedly, including in our phase 1 closing submissions, is unacceptable, Chair. In his October opening, Mr Griffin said:

"Furthermore, the Inquiry is making considerable progress towards obtaining evidence from those who have lived experience of mental health services provided by Trusts in Essex."

I'm afraid we have not seen any evidence of that.

Rule 9s are said to be coming for those who have filled in the form, but again there is no clear timetable for this. Certainly X1 filled in that form a long time ago and has had no Rule 9 request. Chair, so concerned has she been that, as you know, she wrote

to you directly. Those like her with lived experience will provide valuable, first-hand evidence on the key systemic issues which underpin this Inquiry, ward safety in particular, be it sexual safety, or general safety, ligature points, use of restraint, overuse of medication and many other aspects on which bereaved families are not, understandably, in a position to assist.

We believe that they are a relatively small cohort. Their evidence should not be siloed or treated as a bolt-on consideration by this Inquiry. It must be heard rooted in its appropriate context alongside the evidence from providers, bereaved families and external agencies contemporaneous to the issues raised.

The suggestion raised by the ILT team correspondence that the Inquiry cannot accommodate lived experience CPs within the draft SOA due to the fact that their evidence has yet been obtained is no excuse. This is especially so in circumstances where the delay in obtaining lived experience CPs' evidence is down to the Inquiry's own dilatory approach to publishing its lived experience framework, which was not finalised until July 2025.

The absence of written statements from family CPs does not, it rightly appears, exclude them from being an illustrative case. The same approach must apply to lived experience CPs. Their evidence, Chair, is no less

valuable to this investigative process and must be anchored at its very centre.

We ask that the Inquiry communicates now, as a matter of utmost priority, when it intends to hear from lived experience CPs, such as X1. This is an issue which must also be reflected clearly and given precedence within the Inquiry's awaited roadmap.

It is hoped, Chair, that moving forward the work between ILT and CPs on these pressing issues can be genuinely collaborative and two way. We and many other CPs have raised our concerns repeatedly as to the ways in which we continue to find our CPs' ability to effectively engage in this Inquiry constrained. To date, we have provided the following written submissions to the ILT in order to assist:

1. Closing submissions at the end of phase 1 on behalf of Leigh Day, dated 30th May 2025, raising numerous procedural issues, including the Rule 10 process, disclosure, the lack of engagement of lived experience CPs, timetables for evidential hearings and the absence of any judicial procedure for applications to be heard.

2. Closing submissions on behalf of Irwin Mitchell, dated 29th May 2025, addressing disclosure and evidential hearing phases timetables.

3. Draft undertakings, written submissions on

behalf of all of our CPs, dated 27th August 2025.

Instruction of neurodiversity expert, written submissions on behalf of all of our CPs, dated 24th September 2025.

Contrary to the approach taken in various other public inquiries that we have been collectively involved in, the Inquiry has not formally responded to any of these submissions or simply told us where they are at, nor have they published them. We work hard on each of these pieces of work, Chair, asking our clients to turn their minds to each of these issues before submitting them onwards to you, Chair, only to be faced with a wall of silence.

For example, did you agree with our observations on the scope of instruction of neurodiversity experts? What about the crucial issue of undertakings? Has that been resolved? If not, what is the current position? And what are the delays, if any? Are you likely to make a ruling on this issue? If so, when will we hear, Chair?

Additionally, the Rule 10 process remains unaltered and unworkable. Re-examination of our own witnesses should be a given, but yet we don't have mics. The process for replying to questions directly remains unclear and in any event pointless without our own mics.

Again, we do not know your view, Chair.

We hope this hearing will mark a welcome shift in the relationship between the ILT and CPs and that the urgent concerns we now raise are not simply received into the ether along the lines of our previous submissions. We urge a renewed focus, Chair, on the principles of transparency, openness and effective participation that should underpin any public inquiry.

As the first statutory inquiry into mental health provision, to our CPs this feels like a once-in-a-lifetime opportunity to embed desperately needed change. Our CPs want you to be able to make far reaching recommendations, but those recommendations will only be meaningful and respected if the springboard is a public evidence base with clear findings of fact.

We will do our best to respond to the RIF suggestions as directed by 12th September, Chair, but until we understand the fundamental structure of the remaining work, focusing on the RIF feels like we are being asked to put the cart before the horse.

Chair, those are our submissions and we hope that they are of some assistance.

THE CHAIR: Thank you, Ms Sikand. Thank you very much.

MR GRIFFIN: Thank you. Chair, we now hear from Ms Misra KC on behalf of Hodge Jones and Allen.

Submissions by MS MISRA

MS MISRA: Good morning, Chair. You will have received two sets of submissions on behalf of the clients represented by Hodge Jones and Allen, all of whom I represent, together with my learned junior, Dr Burin, Ms Moradi and Ms Henshaw-Keene who are with me today. Mr Loomes, who is also a member of our counsel team, is attending an important client event in Chelmsford with the rest of our legal team which unfortunately clashed with today.

With your permission, Chair, and having obtained your permission to put in submissions on Article 2, I will address you on the Article 2 submissions with a focus on what we say that means in practice, and my learned junior, Dr Achas Burin, will, again with your permission, address you on the submissions on the draft investigative strategy flowing on from those.

You may know, Chair, that I joined as a leading counsel in only July of this year, whereas my juniors have been involved from the outset with Mr Steven Snowden KC. We will of course remain within our allocated time.

Before I move on to those matters, Chair, having heard the submissions of learned leading counsel Ms Sikand KC, I would of course endorse the themes that

she raised when she said what her clients are looking for is transparency, openness and clarity. I am sure that is an aim shared by all of the Core Participants from whom you will hear today and also a bit of a theme of wanting to co-operate, wanting to participate in a meaningful way, but finding it very difficult to do so particularly when information is provided in a silo in many instances. But as I say, the focus of my submissions to you, Chair, this morning will be to deal with two things in particular.

First of all, we respect that this is your Inquiry and it is one in which independent decisions will be taken. So the plea for greater participation from us and across all of the submissions that you will have received is not a plea to cross that line, but simply a plea to place the Core Participants at the heart of the process.

Secondly, we say that what we describe in our submissions as a necessary pause and reset is necessary to ensure that the investigative strategy, and indeed the other strands of the work of the Inquiry, whatever and wherever they may be and when they take place, take full account of Convention rights now and not later, so that the Inquiry respects those rights and embeds them in the strategy to be adopted. So that pause and reset

will, we say, save problems further down the line and improve the output of the Inquiry overall.

So, in that regard, Chair, we seek a ruling from you in relation to the applicability and the way in which the Convention rights will, if they are found to be applicable, be embedded in all of the strategies of this Inquiry going forward. Now we say is that time before that draft investigative strategy is set in stone.

I turn now to the submissions on Article 2, and Chair, you will know that in those submissions I refer to there being other Convention rights which are very likely at play as well, but in the time that I have, and because it is important to focus on the points that we say are very important at this stage, I will necessarily focus on Article 2. That is not to say that we abandon the position that other rights may be at play and indeed you may have seen that I said that Article 8 may be an important factor in relation to redaction and disclosure strategies.

So in relation to Article 2, we understand that stepping back from the Terms of Reference to which, Chair, you have rightly anchored the work of this Inquiry, the Inquiry is focusing on systemic issues by investigating inpatient deaths and near misses and it is doing that to a sufficient degree to be able to

appreciate what the systemic issues are and what they continue to be in some cases, and crucially, Chair, to use that information to inform the recommendations that this Inquiry seeks to make.

Chair, I will say nothing about the recommendations and implementation forum because that is not the purpose of today's hearing other than it is (audio breaks) very, very welcome development so far as the Core Participants I represent are concerned and so we are very concerned to make sure that those recommendations are made in the best possible way.

What is it that every single person that we represent, what is it they want? They want to be heard. They want their evidence to be considered to make for meaningful change. It is the change that is at the heart of everything they are driving for. So, Chair, I invite you to take everything that I and my learned junior say today in that spirit. We want to make sure that we work with you so that when those recommendations are made, those being your recommendations, they are the most well-informed recommendations that they can be and they are in a state that they can be implemented in a timely and meaningful way.

Of course it is trite to say that the Inquiry is a public authority within the meaning of the Human

Rights Act 1998 and therefore it is for the Inquiry itself to fulfil its own duty to consider its obligations under the Convention. And so I can only apologise if that is legal advice which has already been obtained or given behind the scenes, and indeed if there is already a view that has been formed as to whether any of the rights should form part of the work of this Inquiry. Because I do not know, as I say, I can only apologise, but I will, at this point in time, focus my submissions on Article 2 on the basis that that has not been a decided point.

Now, the nature of the article duties was very comprehensively decided in a case called R (Morahan) v West London Assistant Coroner judicial review which I have already cited extensively in the submissions together with my juniors, and that judgment was upheld by the Court of Appeal.

You will have seen from my submissions that the point that we seek to make is that really this focuses in on the positive duty to protect life which itself subdivides into the framework duty and operational duty and, critically, we say, at this juncture in time, given the draft investigative strategy, an investigative duty to inquire into and explain the circumstances of a death.

So looking at the positive duty, that also breaks down, as I say, into two subheadings, if I can put it that way: the positive operational duty and a framework duty. In relation to the positive operational duty, Lord Justice Popplewell very helpfully explains that to us in the Morahan case by saying:

"The positive operational duty arises where the state agency knows or ought reasonably to know of a real and immediate risk to an individual's life and requires it to take such measures as could reasonably be expected of it to avoid such risk ..." Eventuating effectively.

So in that context, just to break that down, risk means a significant or substantial risk. So that's something more than remote or fanciful.

I make these points not because as I say in my submissions that arid submissions on law would help us, because I'm going to tie this into why I say, given the evidence that you have received to date, Chair, we are in that territory.

"An immediate risk to life means one that is present and continuing. The relevant risk has to be to life rather than of harm or even of serious harm and the meaning of 'real' in this context focuses on what was known or ought to have been known at the time."

Just pausing there, it is clear that in many regards

this is going to be what the Inquiry is looking at in any event in order to focus on the Terms of Reference as currently drafted, which is, as I say, rightly the anchor for you, Chair, but looking at the systemic issues. We are concerned not to upend the strategy that has been drafted to date, but to make sure that it is effectively cognisant of Convention rights and it is strengthened to make sure that if, Chair, you were to determine at some point in 2026 -- because it may be that your view is that at this point in time you cannot be sure, you cannot take a firm view -- but it may be when you have received further evidence, when you have seen the output from the legal team working for you collating different strands of evidence, you may pause next year and say: in fact, I think that Article 2 is arguably engaged here.

The difficulty that we face is that if we do not make these submissions to you now, firstly, we would rightly be criticised for leaving them until next year, but secondly, I appreciate we have made those submissions in opening submissions, but it is incumbent on us to reinforce them because the simple point is this. If in your role as Chair next year, having taken your own advice that the answer is that in fact Article 2 arguably applies, it may be too late to pivot

the strategy to make sure that it is fit for purpose in that regard.

For those who have access to our submissions, I'm at paragraph 13, just to give it that reference point. But you will see, Chair, that we refer to the case of Rabone, which is a very important case, concerning in that case the self-inflicted death of a voluntary psychiatric patient during a home visit, so different facts to those that you have heard in many instances. But it is an important case which sets down key factors which provide, whilst not necessarily providing a sure guide, as Lord Justice Popplewell says in Morahan, does provide some very important indications of the factors to look out for.

The four factors are:

(1) The existence of a real and immediate risk to life as a necessary but not sufficient condition of the existence of a duty.

(2) And, Chair, I say this is important in the context of what you have heard so far, an assumption of responsibility by the state for the individual's welfare and safety including by the exercise of control.

(3) The especial vulnerability of the individual.

(4) The nature of the risk being an exceptional risk beyond an ordinary risk of the kind that

individuals in the relevant category should reasonably be expected to take.

Indeed, it was in the Rabone case that the Court of Appeal found that the risk of suicide in that case had been real rather than remote or fanciful where there had been a five per cent risk of suicide at the point that the deceased was allowed to leave the hospital.

So I hope, Chair, that that gives some helpful steer as to the kind of trigger points we are looking at in relation to Article 2. I won't, Chair, but I will be very happy to answer any questions arising, go into the authorities in too much more detail. You have my learned junior's skeleton argument in this regard.

But why do we say this matters? Because these are pointless submissions unless, we say, they should change the way the Inquiry is doing things.

First of all, we say that the factual matrices that have already emerged from the evidence that has been heard to date, putting to one side whether that evidence can be categorised as flushing out concerns and issues of the Core Participants or something else.

Chair, you have heard first-hand evidence which certainly in our submission shows that there is, at the very least, a strongly arguable case that the Inquiry

will find that the Essex NHS Trusts were under a positive operational duty in some cases and that this was breached in circumstances of real and immediate risk to life, assumption of responsibility for welfare and safety, including exercise of control, vulnerability and exceptional risk.

We say the Inquiry must take steps now to ascertain whether the positive operational duty has or has arguably been breached by the state while it is finalising its plans to investigate illustrative cases and to create a final roadmap to the end of the Inquiry and not later when it might be, and probably will be, too late to pivot to meet the task at hand.

So, I move on now, just keeping an eye on time, from the operational duty to the framework duty.

The other aspect of the positive duty is also well dealt with in the Morahan case which we have cited from quite extensively in the submissions. But, Chair, what I ask you to take particular regard to is paragraph 19 of the submissions where we say this. Citing the case in question, R (L(A Patient)) v Secretary of State for Justice, per Lord Walker:

"There is often no clear dividing line between the positive operational duty and the systems duty below the national level."

We are of course concerned in this Inquiry with cases that do fall below the national level, regional cases in Essex and we say that is a particularly apt point to bear in mind in this particular stage.

We also, Chair, ask you to pay particular regard to the case of Savage. That was a case concerning a self-inflicted death by someone who was mentally unwell and as we have flagged in our submission very pertinently, a death that was in fact within the scope of this Inquiry.

We say that in the Savage case, Lord Roger observed that:

"The systems duty meant that the hospital had, for example, to employ competent staff, take steps to see that they were properly trained to high professional standards and that their systems of work, plant and equipment had to take account of the risk that detained patients might try to commit suicide."

Of course, Chair, you know very well that many of the patients we have considered through the prism of the evidence to date were indeed detained patients, though not all of them.

So at paragraph 21 we say that the facts of Savage actually have a very strong resonance with the evidence that this Inquiry has heard to date and that you, Chair,

will be aware of factors such as the Oxevision evidence which was heard so recently, the use of the equipment and the systems for monitoring patients.

There are also very clear common themes that have been emerging in relation to staff training, competence, and resuscitation for example and addressing physical health concerns in elderly patient. Those are just a few of many examples.

Chair, you will also be well aware of the change in the risk assessment model which happened in April 2025 this year. So that assessment model is to be used by the NHS from April onwards, but that of course poses the question why did this need to be changed? It does indicate a systemic issue before. Although I make no submission at this stage as to whether it has been effective in changing for the good, if I can put it that way, it is another flag that needs to be considered at this stage.

Finally, Chair, I am certain you will be well aware of the Mental Health Bill and the serious impetus for legislative change which is ongoing and indeed we expect an Act very shortly.

All of this goes to my point on behalf of our clients, which is we fully understand the Inquiry doesn't want to lose the wood for the trees in this

Inquiry, but its focus, its correct focus in many instances on the systemic issues, is precisely what engages Article 2. So what we are asking is for the pause and reset to take that into account.

I will now touch upon the investigative duty. Chair, if it assists I'm at paragraph 23, page 7 of our submissions on this point. Here, the investigative duty again splits down into the substantive duty to investigate every death as an aspect of the framework duty and the procedural obligation that arises in some cases where there is a possibility and it is important to note it doesn't have to be a conclusive finding of breach, but possibility of a breach by an agent of the state of one of the substantive operational or systems duties.

So because I have just made the submission to you on behalf of our team that we say that we are clearly at the threshold point of finding that possibility of a breach of this substantive operational systems duty, it now tips us into this obligation in relation to the investigative duty.

What we say here, the procedural implications of that is that we say that the enhanced investigative duty is very likely engaged. I won't repeat, Chair, but if it is helpful, at paragraph 29 we set out that

investigative duty at its core, and we say that there is a requirement -- there should be a real evidential basis which makes the suggestion of a breach of a substantive obligation by the state a credible one.

I simply say this. Anyone who has followed this Inquiry to date, anyone who has been watching this online, attending the hearings, participating, they cannot fail but to have come to the conclusion, and it is only this, a conclusion that there is a real evidential basis that there has been a breach of a substantive obligation by the state at regional level in Essex.

Now I come on to what are the procedural implications, Chair, if you are with us, that this at least deserves a pause and reset to make further enquiry as to whether this Inquiry will centre Article 2 in what it is doing.

We say that having taken such advice as you consider appropriate, Chair, in your independent role, and of course taking into account such of our submissions as we have made as you consider helpful at this stage, the Inquiry must embed into its strategies a process that is suitable for, first of all, giving meaningful consideration as to whether there has been an arguable breach of a positive duty, either by way of the

operational duty or the systems or framework duty. And what is the most effective way of doing that we say is that there should be a baseline for findings in respect of each of the deaths which form illustrative cases, with clear conclusions as to whether there have been arguable state breaches in respect of those cases and in those circumstances to hold the investigation, however that is to be done, in a way that is sufficient to examine the circumstances of the death and to hold those involved, whether because they contributed to the death or whether because they were involved in the circumstances leading to it, to account. Of course accountability is such an important strand of what it is that everyone involved in this Inquiry as a Core Participant seeks.

The difficulty we find is that at the moment, as currently envisaged in the draft investigation strategy, this illustrative Statement of Approach, there is very little time for the Core Participants to comment on case summaries and this is a vital juncture at which their input is needed and it is I say a critical point at which the Inquiry should give active consideration to Convention rights and in particular Article 2.

I want to make one thing very clear. We understand that at the moment the Inquiry doesn't have a full set

of data that would allow the Inquiry to understand exactly how many people did die in the relevant timeframe. We know there are pieces of data that are missing in that regard.

We are not asking, I should be very clear about this, for there to be Article 2 compliant investigations into every death that took place in Essex in the index period. What we are asking for is for an Article 2 compliant investigation in relation to all of our clients, and indeed anyone who falls within the scope, as it were. We don't make our submissions selfishly, if I can put it that way. Of course we represent the largest cohort of bereaved families in this Inquiry.

This also has an important impact on disclosure. I want to flag up, Chair, that some of the questioning that has already been undertaken by your team of Counsel to the Inquiry has been Article 2 compliant. It has asked all the right questions. It has gone into the detail and depth that would be required. So we don't wish to criticise some frankly excellent examples of questioning that we have heard to date, but we don't see consistency in the approach taken to different Core Participants giving evidence and perhaps crucially and most disappointingly of all, and here we say is another ask of ours, all questioning has been conducted without

exhibits and without proper disclosure we say in this case.

I won't stray into that area too much because my learned senior junior will address you on that. But what we say is that, if I can just go now to paragraph 38, if I may, of our submissions, Chair. What are we asking you to do as well as make a formal ruling on the engagement of Article 2 and any other Convention rights you consider are or are potentially engaged?

First of all, we ask this Inquiry to make Rule 9 requests of the NHS Trusts in each illustrative case where a Core Participant has outstanding questions that they want answers to, to forward those answers to the Core Participants and to then determine whether oral evidence is required in consultation with Core Participants.

We say this, there may be some instances where having received those answers, those Core Participants don't want to give oral evidence. They don't want to participate further beyond being kept up to date. That may in fact reduce the scope in some instances of the oral evidence which could have been anticipated.

We also ask for there to be full and timely disclosure to further the duty of candour and this goes to the point that it will not be sufficient for those

who are tasked with at least partly behind the scenes investigation to look at the medical records without disclosing them because, as is picked up in our other set of submissions about the strategy, in order to triangulate evidence and to get the best evidence you can, Chair, to inform the recommendations that you may wish to make, you would want there to be an opportunity, we would submit, for Core Participants to see the medical records, to say, for example, actually I know that's what the records say, but that's not what happened and actually I can show you some evidence that that meeting never happened, or that was not the treatment that my loved one was receiving, that's a complete mistake or error. To then add that to their lived experience of what happened to their loved ones, these are the people they are talking about, the people they hold so dear to them to this day and to give you the ability to carry out, as I say, that vital triangulation with your team.

We also ask that those who experienced less than full Article 2 inquests, either because there was no inquest or because there was no Article 2 inquest, get a fuller examination into their loved one's treatment and decision-making.

We have provided to you, Chair, to try to be

helpful, a list of our clients and to try and pull together those who have had inquests, those who have had Article 2 inquests and those who have had no inquest. You will also have heard evidence and received documentation as to where things have, to put it very bluntly, gone wrong in the inquest process as well, particularly because some of the prior investigation that informed the inquest, for example investigations carried out by the NHS Trust, were themselves flawed.

I do understand and recognise that, quite rightly, in the illustrative investigation strategy the Statement of Approach envisages that there will be a caveat so that there will be some cases where there needs to be a certain going behind findings of inquests or of civil proceedings. I don't focus so much on the civil proceedings.

But with the inquests what we ask, Chair, is that we get to grips with this issue now to make sure that that part of the process can be finessed and tightened up. And we offer our co-operation, we offer our help to the extent we can be helpful, as I say, without wishing to cross that line and trespassing into the fact that this is your Inquiry, Chair.

Finally, we do ask that the experts are instructed in good time on the full range of issues and that we

have enough time to be able to contribute what we hope would be useful observations and information, not simply following the clustering process as it is currently envisaged.

I do not, in the time I have, as I say, wish to address you, Chair, on the other Convention rights that may be at play. I can only apologise to the extent that you have received advice in the background about these Convention rights. As I say, we are not cited on that but I will now, with your permission, if I may, hand over to Dr Achas Burin, my learned junior, who has been involved in the Inquiry to date and she will deal with our submissions on the strategy.

And I just want to check that I have your permission in that regard, Chair, consistent with the Lady Chief Justice's approach to bringing juniors in. Thank you.

THE CHAIR: Of course.

Submissions by DR BURIN

DR BURIN: Thank you, Chair. I will address you on the nitty-gritty of the investigative strategy, but my points have a wider resonance as well in terms of the other work streams for this Inquiry.

I will also attempt to address some of the written submissions that have been very helpfully disclosed on Relativity to us in the short time that we have been

able to review those, and in my submission, there are two key themes emerging from all the written submissions before you.

The first is some submissions concentrating on what is missing from the draft strategy, whilst others concentrate on what is said in the draft strategy, but they make alternative proposals, and these submissions do a little bit of both.

In outline, what is missing from the draft, we say, is that there are aspects where the draft seems vague, incomplete or badly needs supplementing by a clear understanding of other work streams and indeed the timelines for doing all of that and our clients endorse all the requests for clarity that have been put forward by all the parties before you today.

In short, Chair, you will see from our written submissions that our clients' perspective is that this strategy by itself is too little too late and our lay client, Melanie Leahy, has felt so strongly about this that she has put in her own independent set of written submissions to you.

In terms of what we say can be improved about the draft strategy, our overall submission in this regard is for the Inquiry to please continue to engage Core Participants throughout in just the way that we are

doing today and we appreciate that, as a result of today, you have received a range of views. However, we observe that there is a lot of common ground between everyone here and that undoubtedly the Inquiry will function better as a result of taking these views into consideration even if the draft strategy itself takes a little longer to finalise as a result of any pause or re-set. We note that the strategy states that it will in any event be kept under review and we ask to be involved in that process throughout.

So I will speak in general terms about the way in which our clients wish to participate in the Inquiry generally of course focusing on the shape of the draft strategy, but there is also a separate question about how individual Core Participants can input into their own investigation in their case together with those who advise them. So I will turn to that second and conclude with some brief observations on points of detail.

So, Chair, to begin, as Maya Sikand KC has stressed, our clients are encouraged by this hearing listed as it was on the application of the family Core Participants jointly, as indeed Mr Griffin KC has outlined. As you have said, (audio breaks) is at the heart of this Inquiry and for families to be at the heart of the Inquiry means, amongst other things, they have a say in

how the Inquiry conducts its proceedings.

There are at least four ways to date reflected in this Inquiry to varying extents that Core Participants can and have inputted into the Inquiry's processes directly themselves or indirectly through their RLRs. So as today, we can have the ability to directly address you, the decision-maker, in a traditional tribunal setting, in public and indeed with the involvement of all the others present here today.

Chair, I commend to you the expertise ranged before you. You not only have the lived experience of those who instruct us, so our lay clients, but you also have the legal experience of many of the other Recognised Legal Representatives including ourselves, and in your opening statements in the past you have emphasised the experience of your legal team, rightly so. But in hearing from all of us, may I suggest that you benefit from an even broader base of expertise than simply that of your own legal team.

The subject matter of this Inquiry is complicated, both legally and factually. Nobody would deny that. The coverage of medical issues and issues about how the state should relate to citizens are broad and complicated, but there is strength in numbers, as my learned leader has said, and hearing submissions can

only strengthen your investigation.

And we say authentically that everyone here stands ready to help. An Inquiry is not an adversarial process so you can take this offer of help at face value and I will be telling you some ways in which, specifically in relation to the draft strategy, our legal team can help you. As my learned leader said, what our clients seek from you therefore is opportunities for meaningful input.

Of course, as I have alluded to, you will receive a range of views and you may have to decide between them if they are incompatible. If it would further assist you, Chair, again we are happy to set out in writing specific points of agreement or disagreement between our clients and the skeleton arguments of others. We can also help you with future scoping exercises as to the conduct of the Inquiry by telling you what we anticipate to be in each of our clients' cases the most contentious issues or perhaps the witnesses that may further need calling, documents that they haven't received and those kinds of detail. That is why we set out in the appendix to our skeleton argument information about inquests into the deaths of our clients' loved ones.

That we hope assists you and indeed everyone here in understanding the impact of Article 2 on the

investigative strategy. You will see that some cases have had Article 2 compliant investigations already, but that is not the case for all.

So given that Recognised Legal Representatives have the most in-depth knowledge as to each of their clients, can I suggest to you that the individual Core Participants' representative should be the Inquiry's first port of call when determining next investigative steps in their case.

As my learned leader has said, after all this we hope to receive a ruling from you and our clients have repeatedly asked for more communication from the Inquiry. They have asked for regular updates from the Inquiry relating to its work behind the scenes.

We are grateful for CTI's openings and hearings but for our clients this may be too infrequent and too formal. Informal updates via the website would be extremely welcome and the more open and forthcoming the Inquiry is, the more our clients' confidence in the Inquiry can grow. As I am sure you are aware, Chair, if this Inquiry carries out its work behind closed doors, it will lose the trust of those we represent.

It bears repeating that justice in order to be just must not only be done, but must be seen to be done, and we say that there are ancillary benefits to public

proceedings such as the (audio breaks) one because if there is to be sustained political will to implement recommendations, there needs to be press and media attention. For press and media attention there need to be public hearings.

Further, Chair, an investigative phase that takes place largely on paper is too reminiscent for our clients of the internal investigations that the NHS Trusts carried out for themselves which families often found did not foreground their views.

Chair, while I don't for a moment suggest that this Inquiry does not intend to foreground our clients' views, there is an element to which a trauma informed approach requires taking their prior experience and low levels of trust into account.

I turn therefore to other ways that our clients can be more involved in this Inquiry in addition to procedural hearings like this one.

A second way that Core Participants can be involved is to make suggestions through less formal channels. For example, Chair, we welcome the engagement that RLRs have with your Inquiry team in ongoing meetings. We do say though that meetings cannot take the place of formal liaison in the form of correspondence, rulings and hearings and this is simply because members of the

Inquiry team do not have the power to determine all matters aired in those meetings and so the discussions themselves do not bind you and we cannot report on the outcomes of those meetings to our clients because nothing can be promised. So they are helpful for day to day issues, but they cannot be the main forum for our clients' participation in the Inquiry.

A third way, therefore, that Core Participants can input into the Inquiry is by attending meetings themselves and in that regard Core Participants appreciated the surgery that took place in person in Chelmsford, but again those kind of forums require delicate coordination and organisation at the outset in order to be effective.

In our closing submissions, following the hearing in May this year, we asked for a consultative panel of Core Participants to be established, similar to that that was commended to Government from the Independent Inquiry into Child Sexual Abuse, and indeed the consultant psychologist to your Inquiry was instrumental in the setting up of that consultative panel.

To date, Chair, we have had no response to that. Indeed, we have never had any response to any written submission that we have made since May 2025, whether by way of correspondence or a ruling, and that includes, as

Maya Sikand KC has set out, submission solicited by the Inquiry itself on matters such as undertakings and instruction of experts.

In November, Chair, we made further submissions to try to narrow the issues of this hearing today but have had no response to date.

In the submissions on behalf of Deighton Pierce Glynn and Leigh Day, the question of the number of 140 deaths was raised and that is at paragraph 11 of the draft strategy. Although we know that that is expressed to be a round figure, we, the legal team on behalf of HJA, do not know at present whether those deaths comprise non-Core Participant witnesses. So as you know, Chair, we represent clients who are not Core Participants and, for example, whose loved ones died in 2024, which is outside the relevant period in terms of the Terms of Reference.

Even though these cases fall outside the relevant period, they are extremely salient to the making of recommendations. Indeed, in the submissions made on behalf of EPUT, it is recognised that recent deaths are salient to (audio breaks) recommendations. In our submission, these non-Core Participant deaths ought to be included within the investigative phase and yet we do not know if they are.

Likewise, Chair, you have previously said that the evidence of those who are not Core Participants is equally valuable to you as compared with those who are Core Participants, but to date those who are not Core Participants have never been given an opportunity to provide evidence. So we ask for clarity on that. How will evidence from non-Core Participants be heard?

I will move on, Chair, to discuss more specific matters about the investigative strategy, but just to summarise these requests, we ask that going forward into the investigative phase this Inquiry behave more like the tribunal that it is. We ask that it conducts its proceedings in public, in Rule 10 questions and put them to witnesses and that it hears submissions at critical stages. It goes without saying that such hearings or submissions should be followed by rulings or definitive outcomes communicated by correspondence.

Outside of hearings, we ask that the informal liaison meetings be supplemented by correspondence and monthly written updates about the progress of the Inquiry that can be shared with our clients.

A fourth way, aside from hearings, meetings and forums, that Core Participants can contribute to the Inquiry is by filling out a form, which is what is proposed at paragraph 51(a) of the draft strategy.

Chair, I am sure you will understand the reasons why Core Participants are wary about responding to their investigations by filling out a form. Many have had very poor experience of communicating with the Trusts about their concerns when their loved one's treatment was ongoing. And to them, therefore, there seems to be an inferior method of engagement in a crucial part of the process. Indeed, as outlined myself, Core Participants have not had a good experience of written engagement with the Inquiry either, for example the lack of response to submissions and to written Rule 10 questions submitted by the Inquiry pro forma.

Chair, I turn to the purpose of the investigations to be carried out. A number of the submissions before you have raised the question about what the purpose may be and I can distil from my own reading of this strategy several possible purposes, all of which may be concurrent.

First of all, we suggest that there may be an administrative function to these case summaries. For example, the draft strategy says at paragraph 26 that the written case summary will summarise the family's witness statement. I offered my assistance and that of our team to you, Chair, because it may not be obvious to others that we, the legal team, have already provided

summaries of our clients' evidence insofar as those who have given oral evidence to date.

That work was done by sending summarises of our clients' main concerns to the CTI in question who conducted the oral evidence. So that information should already be available to the Inquiry and if the purpose of these investigations is a crib sheet for the Inquiry's experts, can I suggest to you, Chair, that those existing summaries are an excellent starting point because they have already been summarised with the assistance of Core Participants and we suggest that this is a good place for the investigative unit to start.

If instead the case summary is a scoping exercise to see what further witnesses need to be called or if disclosure exists and what more is needed, again we can help with that. We say that in almost every case there is some disputed fact, but we anticipate that in only a few cases are there major disputes.

What would be unacceptable to our clients would be if a paper exercise was the primary basis for making findings of fact. I do not suggest for a moment, Chair, that that is what the draft strategy intended to convey, but it gave rise to a rational fear that this might be the case.

Quite clearly, determinations of fact can only be

made by you and they cannot be done by paralegals, medical assessors, RLRs, CTI experts or anyone else. Findings of fact should be on the basis of evidence that has been thoroughly and rigorously tested, not merely summarised from documents on paper.

Chair, I want to emphasise that not all the findings of fact that we will ask you to make relate simply to cause of death. Cause of death may well have been satisfactorily determined in an Article 2 compliant process or perhaps it may not have been. But there are very relevant findings of fact that do not relate merely to cause of death.

Chair, if new disclosure emerges during the investigative phase, we need to see that disclosure. It is not sufficient to see a summary of it. That would be plainly unfair, bearing in mind section 17 of the Inquiries Act 2005, but not only that, Chair, on a human level we have examples of Core Participants finding out incredibly sensitive and meaningful information for the first time from disclosure, for example, such that a post mortem took place that they were previously unaware of. There is a family that found out that a loved one had suffered childhood abuse from their medical records for the first time.

Chair, it is not appropriate for the Inquiry to have

to make these kinds of determinations on an individual document-by-document or case-by-case basis about what disclosure a family should see in circumstances like that. Yet paragraph 51(a) of the strategy --

MR GRIFFIN: Sorry to interrupt, just to say you have one minute left.

DR BURIN: Thank you.

Chair, you have our written submissions on disclosure, so I won't stress that further.

I could address you on common themes and clusters. What we will say is we don't think the clusters approach is necessarily workable, but that in terms of common themes we wish to propose some for the Inquiry and we don't suggest that experts should be instructed only after clusters have been established.

I will leave others to address that in further detail and as I have said to you, Chair, we can provide written submissions to you on the skeleton arguments of others where that would be helpful.

Finally, Chair, I wish to address you briefly on a point about interim recommendations. You will have received submissions both from ourselves and from those who are represented by Bindmans on interim recommendations including a recommendation on Oxevision.

May I clarify that insofar as we have both made

submissions on Oxevision, we will support the recommendation suggested by Bindmans and we suggest that it is for your consideration ahead of our own because it is more wide-ranging.

Chair, I will wrap up simply by saying this. Whilst Article 2 provides the onus on public inquiries to initiate investigations, you know very well that our families had to fight for this Inquiry, and when they did so, they had a vision of an inquiry that was independent, impartial, thorough and forceful and, Chair, they place that faith in you still to carry out the inquiry that they envisaged.

THE CHAIR: Thank you.

MR GRIFFIN: Chair, had I known that Ms Burin would be talking, I would also have introduced her.

That takes us to our first break. I suggest that we reconvene at 11.40 am, in 15 minutes. Thank you very much.

(11.26 am)

(A short break)

(11.40 am)

MR GRIFFIN: We will now hear from Ms Murphy KC.

Submissions by MS MURPHY

MS MURPHY: Good morning, Chair. I appear with Sophy Miles, instructed by Jane Ryan and (inaudible) Bhatt Murphy

Solicitors.

You will recall the impactful evidence of our client, Ben Jackson, at the beginning of July concerning the death of his 18-year-old brother, Ed Jackson on New Year's Eve in 2007 on Maple Ward, and the evidence given together by Alexander and Paul Guille at the beginning of October in relation to their sister, Bethany Lilley, who died on 16th January 2019 on Thorpe Ward.

We will also make submissions this morning on behalf of X4, who seeks to contribute to your Inquiry from his lived experience of mental health services in Essex.

You have our written submissions addressing your counsel's draft Statement of Approach to the illustrative cases of those who have died, including our proposals as to how that strand of the Inquiry's work might be optimised and integrated with the other strands of the investigative strategy.

We do not intend to repeat those observations orally but to highlight our key points and offer some broader observations. We anticipate that we will be less than 30 minutes.

Our clients wish to acknowledge their positive experiences of the Inquiry to date and to acknowledge the very real challenges faced by you and by your team. They welcome this opportunity to address you in public

regarding the Inquiry's approach. Our clients greatly value your determination to place the bereaved at the heart of this process, to listen and to be informed by their experience.

We will address the contribution of those with lived experience separately.

The counsel-to-counsel meetings have also been greatly appreciated but we do highlight the point we make in our written submissions that the value of those meetings may well be enhanced if they were to result in routine circulation of decisions made on the matters discussed and action points.

As my learned friends, Ms Sikand KC, Ms Misra KC and Dr Burin have emphasised, the effectiveness of your Inquiry will be enhanced by openness and transparency in all aspects of its work.

We acknowledge that your Inquiry faces significant challenges. You have already heard significant and shocking evidence regarding failures in the delivery of patient care resulting in tragic and avoidable deaths and you will continue to hear further evidence next year.

It is of course important that you fully understand each of those individual tragedies and the horrific suffering of the bereaved families. But, in addition,

the evidence to date establishes, if there had ever been any doubt, that there was a catastrophic breakdown in the provision of inpatient mental health services in Essex over the relevant period. A wholesale failure to deliver a safe service.

Leadership, governance and oversight have come clearly into focus as an essential area to be the subject of forensic examination by your Inquiry. This creates priorities to identify what went wrong in the system overall, what steps were taken to remedy those deficiencies in light of internal and external challenge and why such remedial action as was taken was so utterly ineffective.

This Inquiry must, in a phrase of your counsel Mr Griffin KC, be from "ward to board". We do not suggest that this is in any way straightforward. It is essential that this work is undertaken in a manner that is true to the foundational principles you have established. The work must be open and transparent. It must consult and engage the bereaved and lived experience Core Participants. It must be predictable. All Core Participants are keen to see the Inquiry planned out carefully with appropriate timelines and timetabling published well in advance.

Before turning to our first topic, which is

disclosure, our clients also wish to acknowledge your responsibility under the Inquiries Act 2005, section 17(3) to "avoid any unnecessary cost".

I wish to make plain that their concern is to offer their fullest possible assistance to you in this as in every other respect.

Our first topic, disclosure. As has been emphasised and indeed acknowledged by your team, timely and sufficient access to documents is essential to retain the trust and confidence of the bereaved and those with lived experience.

Given the particular characteristics and needs of the traumatised bereaved families and patients who participate in this Inquiry, it is vital that disclosure is provided in timely and predictable ways. Their needs include being able to rely upon their legal teams to marshal relevant information for them and to structure their engagement with it, to minimise the emotional and practical impact upon them.

This is essential also in the interests of openness and transparency and to ensure their effective engagement. It will not be lost on you, Chair, that these are families who were shut out from the care of their loved ones and patients who were shut out from their own care, the families' experiences of their

inquests where they have been treated unfairly, especially in relation to the provider's control of documents and information. This Inquiry will not repeat those shortcomings.

We address the practicalities under two headings:

First, documents bearing on leadership, governance and oversight, including the overall management of the service at a macro level, and secondly, documents relevant to individual illustrative cases and importantly their context.

So, first, in relation to the macro level, a significant body of absolutely central documentation was clearly collated for the April hearings but has not yet been disclosed. Obvious examples include the exhibits to Paul Scott's and Ann Sheridan's witness statements. It is simply not understood at this stage why that material has not been provided.

To illustrate (audio breaks). There are also materials marshalled and generated by the prosecutions and by the independent investigation that preceded this Inquiry. None of those documents in those categories have been disclosed to date.

To illustrate the importance of those categories of documents being disclosed before the Inquiry embarks on the illustrative case studies work, we highlight the

circumstances relevant to the death of Ed Jackson.

You heard from Ed's brother, Ben Jackson, on 27th May. Ed's was the third of the 11 deaths addressed in the 2011 prosecution. We know that Maple ward, where Ed was an inpatient, was closed down in August 2013, and Ben spoke poignantly about his complicated feelings in relation to the information emerging of ongoing safety issues at Edward House at The Linden Centre.

The facility was named in his brother's honour, a facility that ought to have operated to exemplary standards of care and safety, a facility that ought to have reflected that lessons had been learned from the failures in Ed's care.

Self-evidently to contribute to Ed's illustrative casework, Ben will need full disclosure of the prosecution materials, of the Trust's internal response to Ed's death, including the shutting down of Maple ward, the strategy that was put in place for Edward House and documentation concerning the Trust's response to issues emerging at Edward House. In short, Ben must be in a position to place his brother's death in the context of previous and subsequent deaths and near misses raising similar issues. As matters stand, it is unclear whether it is intended that this should be achieved.

Staying with macro level disclosure, you will recall that when we addressed you in April we emphasised the importance of scrutinising the provider's evidence to coroner in relation to the operation of the systems to ensure patient safety and their responses to PFD reports and records of inquest. This body of material will be highly probative of the system issues and it is a matter of regret that this too has not been disclosed as yet.

This ongoing situation places our clients at a position of inequality in relation to the providers and their legal teams. At paragraph 7 of our written submissions, we address specifically the evidence of Ms Sheridan in the form of a witness statement dated 21st March 2025, which addresses adverse findings, including PFD reports and records of inquest. A number of her exhibits have not yet been disclosed.

Bereaved families ought not to be expected to engage with work in relation to their loved one's case, blind sighted in relation to relevant documents held by EPUT and/or your Inquiry.

Finally on this aspect, we highlight that there has not been any disclosure of the providers and oversight bodies' records save in relation to the Oxevision issue. This is a topic that has been discussed in some detail and apparently highly constructively in

counsel-to-counsel discussions. The categories include minutes, papers presented at board and committee level, emails, safety instructions and so on. But there has not yet been clarity as to the categories of documents that have been requested. Our clients' understandable concern is that these important categories of documents will come too late for them to engage meaningfully with them.

Secondly, we address you on the topic of disclosure in the context of individual illustrative cases. Timely disclosure here is also of vital importance and it cannot be confined to the particular families whose loved one's cases have been clustered together. That is an approach that will inevitably result in families not being able to place their loved one's experience in the context of the causative system failures and it would exclude lived experience Core Participants entirely. It would deprive your Inquiry of their assistance. The process must be capable of identifying disputes of fact based upon scrutiny of the relevant documents in context and, where necessary, your adjudication upon disputed facts.

This cannot be, to use Ms Misra KC's phrase, a paper exercise. And disclosure must not be asymmetrical. It would be invidious to afford the health care providers

an understanding of the full context in which a particular death occurred but to deprive the bereaved from that same understanding.

Our next topic concerns lived experience Core Participants. This category of Core Participants appears to be few in number and they are, as you have acknowledged, a precious resource.

The request not to take instructions from our client X4 was communicated on October 2024 and remained until the framework was circulated in July 2025. X4 experienced this as disempowering, exclusionary and it hampered his involvement with the Inquiry. And it had practical consequences during the April hearings, as his solicitors were not in a position to advise him as to the aspects of the evidence that were relevant to his experience because his full instructions had not been obtained at that stage.

The result was that X4 watched all of the evidence and he found that traumatising and it placed an emotional and practical burden on him. Regrettably, X4's experience has been one of feeling excluded from the Inquiry to date. We know this can and will be remedied.

Decisions made that concern him without consultation carry the very real risk of echoing X4's traumatic experience as a patient. X4's experience and that of

the other patients ought now to be brought into focus as a priority. It is of course vital that this important cohort are treated with demonstrable respect and not treated differently by reason of their status as patients, and our proposals are the following:

First, that a draft investigative strategy for those who offer evidence from their lived experience should be provided as soon as practicable.

Secondly, timetabling in relation to Rule 9 requests to this group and their evidential hearings.

Thirdly, a specific question and answer session should be convened for specifically those with lived experience.

And finally we invite you, Chair, to meet with this group.

Our next topic is the illustrative case studies Statement of Approach. May we emphasise that our observations are intended to be constructive. As your counsel has acknowledged, these must be rigorous investigations, they must be capable of resolving factual disputes and critically, in our submission, capable of resulting in evidence that will assist other strands of the Inquiry's investigative strategy.

It is for this reason that those we represent do not agree with EPUT's submission that this strand of the

Inquiry's work should be led by your assessors.

This is intended to be a forensic investigation, not a clinical review. It is clearly a project, as your counsel has acknowledged, that will benefit from expert clinical input in relevant disciplines, but it ought not to be led by it.

We invite the Inquiry to take a robust view in relation to expert evidence that has already been obtained and I'm referring here to paragraph 20 of EPUT's written submissions.

Where a civil claim has been resolved or liability admitted, there can be no good reason for the expert evidence that has been commissioned being kept from your Inquiry. This category of evidence in particular has the capability to save significant costs.

We have proposed chronological consideration of the illustrative case studies essentially because it will enable the Inquiry to place patterns in service delivery alongside the governance and oversight patterns and to thereby identify and consider the overall system failings and the providers' resistance to change.

Further, a chronological approach will minimise the risk of key illustrative facts being overlooked or the cumulative impact of multiple failings of the service delivery being missed, for example, in relation

to Bethany Lilley. You will recall the evidence of her brothers, Alexander and Paul Guille identifying the cumulative impact of the very many contributions to her tragic and avoidable death.

The placing of her illustrative case alongside other cases considering the approach to for example risk identification and management might appear sensible, but the risk is that other issues, for example in relation to poor use of the Mental Health Act sectioning, or dysfunction within the staffing teams, might not show up or show up adequately.

We agree with the submission of Mr Beer KC, on behalf of NHS England, that the purposes of this strand of the Inquiry's work should be identified. However, in our view, this strand will serve a number of purposes by:

First, identifying the extent to which care provision met or did not meet contemporary standards.

Secondly, by identifying causative contributions and achieving accountability.

Thirdly, by identifying the extent to which recommendations from previous investigations and reviews were taken into account and acted upon.

And fourthly, in the formulation of recommendations.

These are complementary purposes and the fruits of

this strand ought to assist with each of them. We have set out our proposals for systematic reporting from each case study to inform the work of the Inquiry's experts, the governance and data strands and scrutiny of the external oversight body. Relying on Ms Sikand's and Mr Beer's submissions that there ought to be greater clarity as to how the Inquiry will rely upon analytical methodology expertise.

As to case selection, we broadly support the approach proposed with the additional observations that: first, coronial views should be sought as to cases that are considered especially illustrative, given different coronial approaches to the relevant test for neglect, an observation also made by Ms Sikand and Ms Morris KC.

Secondly, the expertise of INQUEST ought to be relied upon in identifying illustrative cases from their caseload and our clients strongly support INQUEST being cited on documents.

Finally, particular care should be taken to identify illustrative cases of those whose death did not occur directly within an inpatient setting, given the broad definition of "inpatient death" that you rely upon.

As to the investigative strategy generally, you have our written submission, supported by a range of Core Participants that the Inquiry's various work strands, by

which we intend to include illustrative cases, the evidence of those with lived experience, benchmarking, governance, external oversight, data, the RIF process and so on, ought to be integrated with the illustrative cases and information provided as soon as practicable as to how each strand will be timetabled and brought together.

Our final topic is Oxevision. We are grateful to the Core Participants instructing Bindmans and Ms Campbell KC and Mr Stoate. Our clients entirely support their request for an urgent recommendation that EPUT safely halt the use of Oxevision in the circumstances they identify for the reasons they provide.

Unless, Chair, there is any other aspect of today's discussion that we can assist with, those are our submissions.

THE CHAIR: Thank you very much indeed for those submissions. Thank you.

MR GRIFFIN: Chair, we now hear from Ms Campbell KC.

Submissions by MS CAMPBELL

MS CAMPBELL: Chair, good afternoon. Together with Tom Stoate, and instructed by Rachel Harger and her experienced team at Bindmans Solicitors, we represent, as you know, the families of Christopher Nota, of Sophie

Alderman and Edwige Nsilu.

Chair, it was in November 2024 when I last addressed you on behalf of the families that we represent. In those opening submissions, we stressed to you that it was with a considerable degree of trepidation that families who had been so badly failed by EPUT look to your Inquiry to break the cycle of failures.

We pointed to enduring failures in diagnosis, in treatment, in overmedication, in the use of Oxevision in their loved ones' care, all of which contributed to their preventable death, and we stressed in particular the harmful impact of cultural defensiveness, of resistance to public scrutiny, reminding you then of the compounding trauma that comes from failing to treat Core Participant families with respect in responding transparently and effectively to post-death investigations with the deceased and their loved ones at the heart of the process.

It is a remarkable and perhaps unique feature of this Inquiry, as indeed Ms Sikand has already pointed out, that it is over one year on that I now have this next opportunity to address you directly in a public hearing on their behalf. Chair, we observe that that has not been for the want of trying.

In the year that has passed, Core Participants have

repeatedly sought opportunities to raise and seek solutions to ongoing procedural concerns.

A November 2024 proposal from INQUEST for a joint meeting between the Inquiry and Core Participant legal representatives to address procedural concerns and seek clarity was refused by letter of 4 December 2024.

And since then, Chair, independently, and jointly with other legal representatives, Bindmans have raised concerns about lack of communication, about an absence of updates from the Inquiry, about lack of transparency in this very public inquiry's work, about disclosure, Rule 10 processes, the absence of an investigation plan or roadmap for the completion of the Inquiry, all of which contribute to real difficulties on the part of the bereaved in planning their lives, in preparing for evidential phases and for their legal teams in planning and allocating their resources.

Chair, we have sought opportunities to address you before, during and after evidential hearings, but the message has repeatedly been that we might bide our time or have a discussion between counsel, or put it in a letter, or await a promised update or plan that does not arrive, and so grateful though we are for this opportunity, it is perhaps no surprise that the message today on behalf of the families who we represent is

that, far from assuaging their concerns and earning their confidence, our families' trepidation and anxiety about the future of this Inquiry is unfortunately increasing.

And worse still, the Inquiry is at risk of repeating the trauma which our families have endured in the past by being party to troubled investigative processes.

Chair, those are, I know, strong words and I recognise their strength. But they are representative of the strength of feeling that our families wish to convey today, not knowing when or if they will have the formal opportunity to do so again.

And Chair, in November 2024, I reminded you that the families we represent are motivated not only by justice and accountability for the death of their own children, but to prevent other children and young people from other families being failed in the same way.

They know only too well that there are many individuals and families across Essex who currently feel powerless. Those caring for children and young people with SEND or neurodivergent conditions continue, Chair, to experience daily struggles against a system that is still failing to safeguard children and their futures, battling to ensure not just access to basic systems of support, diagnosis and treatment to protect them as

children, but to ensure that they are in future able to lead full and content adult lives, unburdened by failures to treat or diagnose neurodivergent conditions or mental health needs.

That, Chair, is what motivates Julia Hopper on behalf of not only her son Christopher, but for all children and young people whose struggles continue to reflect Christopher's experience. In Julia's words, Chair, she said "I can't get Chris back, he was so precious and it's so hard to relive what happened to him via this Inquiry. The only point of doing so is so that it might stop happening. This Inquiry was such an important opportunity representing the hope that maybe we could get through to someone, to the Government, but I feel the carpet being pulled away and my heart is breaking".

Families like Julia's are still at the epicentre of this crisis day after day. They continue to support parents and families who turn to them desperately seeking access to services that should protect, support and enable their children to live, grow and flourish.

So, Julia's involvement and other families' involvement in this Inquiry is not only to right historic wrongs, it is personal, painful and rooted in unimaginable loss, but it is also their current

day-to-day lived experience.

So their participation comes at profound emotional cost and they want to know that the Inquiry truly understands why they are here. Because they know that these deaths were not inevitable. They know the same failures recur over decades. They know the urgency for robust and meaningful change is not abstract. It is a matter of every day life and death.

The internal resources of people like Julia and others who have battled for their own children are not limitless. They can do, Chair, without another battleground. Yet over the course of the last year their pain and distress is increasing as their fear mounts that this Inquiry is not going to deliver what it promises. Again Julia's words:

"It's heart breaking. I feel it every time I hear another story where a doctor won't treat a child or a parent or family is demonised for fighting for basic rights and support. This Inquiry is our last hope. It is like watching the Titanic go down."

Again, Chair, strong words.

But I stress, as I did a year ago, and undoubtedly I will in the future, that our families' Core Participant status in your Inquiry is borne out of a desire to make it work, with the success of this Inquiry

measured in both the process and the result.

They are not here as a kite mark of legitimacy. They are here because they are experts by experience, a phrase you have heard repeatedly. They can make a meaningful contribution. Given a chance not only to give evidence, but to properly consider and interrogate the evidence that you receive, they can help your Inquiry identify key failings and make impactful recommendations for change.

Yet for over a year, and with less than a year to go, there is a marked absence of proper processes, procedures, frameworks that are essential for an Inquiry of this magnitude to enable effective participation by its Core Participants.

Without clear procedures for disclosure, evidence handling, without two-way communication, in the absence of the opportunities to make submissions, whether at preliminary hearings or during evidence sessions, families cannot sufficiently contribute their expertise on these urgent matters of life and death.

Chair, when Mr Griffin KC referred, as he did in opening this morning, to concerns raised in writing before the October hearings and requests made to address you with that point, he reminded you that we were asked to wait, and we were with the promise of the publication

of the Inquiry's investigative strategy for the remainder of the Inquiry coming before any preliminary hearing.

That strategy, we were told, would set out not only how illustrative cases were to be addressed, but would address wider investigative issues. It would tell us about how the Inquiry would receive evidence from providers and enforcement agencies, regulators and other stakeholders. It would tell us of the Inquiry's approach to physical and sexual safety on wards, about how the Inquiry will address candour and accountability, about governance structures, ward to board evidence, expert evidence including neurodivergence, autism, ADHD and more.

Chair, in refusing on your behalf the opportunity for oral submissions back in October, we were told that the Chair had determined that holding a hearing after that investigative strategy has been shared with you would enable a more effective hearing to take place.

Reliant on that determination of yours, and the promise of a more effective hearing in December, our clients paused efforts to be heard sooner regarding their urgent concerns. And yet, Chair, November has come and gone, and the opportunity for a more effective hearing on the Inquiry's investigative strategy has

dissipated and we are, Chair, I'm afraid, none the wiser. Instead, we have received a single strand statement of a proposed approach to illustrative cases served on us as though passing it off as what we were promised.

Chair, it is not. And our clients, I'm afraid, have long had enough of promises of full disclosure and transparency only to receive something falling very far short. Chair, they ask: What is the plan? Where is the plan? And if there is no plan, why not?

It is important that I emphasise and I acknowledge, Chair, that you and your team are undoubtedly working around the clock and that the Terms of Reference of your Inquiry present unique challenges spanning, as they do, two decades, multiple providers, thousands of deaths and very sensitive personal records.

In part, it has been that very complexity of local arrangements with systemic failings leading to deaths obscured by differences of geographical location, time, age, diagnosis and ward that has meant the failings within EPUT prevailed for so long.

But what is already apparent from the evidence your Inquiry has heard from the bereaved is that, given the opportunity, they can help you draw together those systemic failings.

The evidence that you have heard from bereaved families has already drawn into sharp focus the consequences of untreated or undiagnosed conditions, often those which should have been identified in childhood or adolescent years. There is already an emerging pattern of substance misuse and undiagnosed or unmet needs due to failures in early intervention. The evidence has exposed that existing safeguarding pathways are wholly inadequate and urgent alternatives are required. Bereaved families concerns are met with defensiveness, dismissiveness, enforced isolation and sometimes even aggression.

The bereaved, Chair, know the systems, the institution, the cast of characters, they have navigated the smoke and mirrors and as such they are an enormous (audio breaks) and to date a wholly underused resource. We observe, Chair, that not only did the promised investigative strategy not come in November, the promise of rolling disclosure made back in July has also not materialised.

In Counsel to the Inquiry's opening back on 7th July, we were told that at the same time as Relativity becomes available for Core Participants, the Inquiry will provide its disclosure plan. This plan, we were told, would set out the Inquiry's proposal for the

disclosure of evidence for its hearings, along with 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, we were assured, will allow Core Participants to plan their work and resources in advance.

Chair, access to Relativity came in mid-August but no disclosure plan has ever been provided.

Chair, having acknowledged the inherent challenge within the Terms of Reference for your Inquiry, there are nonetheless practical procedural solutions that, if immediately actioned, would make an immediate and positive impact.

Our proposals have been echoed in some of the submissions you have already heard today, which is unsurprising given that they emerge from the basic tenets of good inquiry practice across a range of public inquiries, so they are neither new, nor do we submit are they a lot to ask.

I make them across ten points.

Firstly, a prompt, clear and achievable disclosure plan with timeframes and information about what is being

disclosed. Such a plan would include rolling disclosure so that lawyers can address their resources, consider and advise upon the material received enabling bereaved families to meaningfully consider the disclosure and engage within a reasonable time to do so. Such a plan would also ensure clarity and transparency on what avenues of disclosure is being sought, with updates on organisations and specific witnesses being sent Rule 9 requests allowing for an opportunity to make submissions in relation to the same.

We note, Chair, with concern, the submissions received for today's hearing from NELFT, asking the Inquiry for help in understanding what is expected of it and within what timeframe.

Those are basic and not unreasonable requests but, again, we wonder why they are necessary at this stage, and we observe that it would be wholly counterproductive for the Inquiry to find itself in a position where it is re-issuing or re-making Rule 9 requests because sufficient evidence wasn't sought in the first place, another reason we contend for prompt and full liaison with the Core Participants in relation to disclosure.

Secondly, Chair, we ask for monthly progress updates, having been repeatedly told that the Inquiry acknowledge the need for regular updates and are

committed to providing them. Such regular updates have not materialised, leaving Core Participants and the public without any proper insight into what the Inquiry has been doing or what progress is being made month by month.

We join with others in requesting a clear and comprehensive proposal for expert evidence. It is of particular concern that the Inquiry has not by this stage formally identified all the areas in which it intends to obtain expert evidence, let alone which experts it intends to instruct or within what scope, notwithstanding Core Participants' submissions.

Those we represent expect to fully participate in this process which is so important to assisting the Inquiry in reaching conclusions and making meaningful impactful recommendations.

Fourthly, Chair, we ask for two-way communication, in particular acknowledgement and response to written communications. All too often, including in the aftermath of the October hearings, detailed response on matters of real substance from legal representatives appears to have landed into a vacuum, apparently not meriting an acknowledgement, much less a substantive response.

Chair, we ask for preliminary hearings between

evidence phases at which we can address you on the issues that are of paramount concern to the bereaved.

We join also with others in asking for rulings where necessary, setting out, Chair, your written reasoned basis for the decision and generating confidence that the Inquiry is accountable for its decision-making and that decisions are part of a wider investigative strategy or plan.

Chair, we ask for modular evidence hearings with a clear focus on strategy, enabling the Core Participants and the public to know how the future hearings fit within the Inquiry's wider investigative strategy.

And we ask, Chair, for opening and closing submissions from Core Participants, enabling Core Participants to direct your attention to issues of particular consideration or concern in that phase of evidence and to draw together aspects of the evidence heard in conclusion.

That opportunity, Chair, would influence, or at least have the opportunity to influence, not just the Inquiry's interpretation and approach to the evidence, but also to impact public conversation and discourse. You know there is an ongoing public conversation about mental health treatment and care, but denying the

microphone to bereaved Core Participants or their representatives reduces their opportunity to be heard not only in Arundel House but also in the halls of Westminster.

We observe additionally that the Inquiry has proposed a recommendation and implementations forum to address both final and interim recommendations. How, we ask, are we to meaningfully and publicly identify an evidence-based need for interim recommendations if we are not to address you publicly and orally on the evidence in support of them?

Penultimately, Chair, we ask for a Rule 10 process that permits Core Participants to ask and follow up their own questions, not only enhancing the effective participation of bereaved Core Participants, but bringing to the Inquiry the collective wisdom of the bereaved, and indeed their legal teams, who have between them years of experience representing bereaved families in these inquests, including, specifically, Essex mental health cases.

Finally, Chair, we ask for what was promised in October: the publication of the Inquiry's investigative strategy, including a timetable for progress to allay Core Participants deep concerns about how much remains to be achieved in such a short time.

Chair, I turn now to the approach to illustrative cases and you have heard much on that today, and I won't repeat it in detail, but we observe that it really was into something of a void that your Statement of Approach to illustrative cases was received.

It was disseminated no doubt in an attempt to assuage mounting concerns, but you will understand from what you have read and what you have heard today that it has instead raised more questions than it answers. We echo what you have already read and heard on behalf of other bereaved Core Participants in their written and oral submissions.

We raise questions as to timing. Firstly, why only now is this work to commence? Surely this is a Statement of Approach that could properly have been determined a year ago and before many of the bereaved commenced giving their evidence.

We recall that in a disclosure update provided on 26th June 2025, CTI said that they had developed an investigation strategy for individual and illustrative cases and promised to share it shortly. Is this it, we ask?

And if it was developed in June, why are we receiving it in November?

We ask about the timeframe for this statement of

approach and how is it achievable within the lifespan of the Inquiry?

We ask, as others have, about how these 140 cases are to be or have been identified? What is the criteria, and therefore what consequences are there on the Inquiry's ability to properly cluster and ultimately draw meaningful conclusions?

We ask about disclosure, what documents will be considered, how will they be collated and analysed? What real opportunities exist for the bereaved to participate in that process?

And, relatedly, at what stage and in what circumstances will there be cross-disclosure among the Core Participants as surely there must be of the analysis of all of these 140 cases?

We ask about participation, how much of this process is to take place behind closed doors, away from scrutiny by the Core Participants or indeed the public, and how much will be revisited in any public forum or hearing?

And we ask what is the role of lived experience witnesses, whose experiences will be invaluable and yet who have no clear role in this or any other aspect of your Inquiry?

Chair, I want to turn before finishing firstly to recognise the impact of the evidence that you have

already heard from bereaved Core Participants and then to touch on the Oxevision evidence and the interim recommendation that it is we seek.

It is apparent that not only is the very existence of this Inquiry directly attributable to the determination of the bereaved and those with lived experience, but the progress that this Inquiry has been able to make to date has been also directly attributable to their courage and the clarity of their evidence. The evidence that the bereaved have provided the Inquiry has given it a very firm foundation for what your investigative strategy must include.

We have identified some of them at paragraph 9 of our written submissions, but for today's purposes they include the care and treatment of autistic people in the mental health system, including a rigorous examination of the interplay between mental ill-health and autism, how this should be managed and how patients should be safeguarded.

The evidence that you have heard addresses racism in mental health care, including a proper examination of its causes, its disproportionate outcomes and what needs to be done to address it.

Sexual safety and gender-based discrimination in mental healthcare.

It identifies concerns around the use and overuse of medication. It identifies concerns about the uncertain role of private medical health care providers, the role of regulatory bodies and the fundamental need for meaningful oversight. It identifies failures in co-operation between local government, local authorities and mental health care providers, including in particular in respect of ongoing safety concerns raised about the care of vulnerable individuals in Essex. It identifies trends of substance misuse and failures in diagnosis and of course it raises concerning evidence about surveillance and observation of patients on mental health wards.

This Inquiry, we submit, should harness both the experience and the courage of the bereaved and the lived experience witnesses in interrogating each of these things and more.

You will recall, Chair, in particular, that it was through the powerful evidence of Tammy Smith, the mother of Sophie Alderman, and of Hat Porter of Stop Oxevision that the Inquiry was in a position to understand and to challenge the weak and unsubstantiated evidence of any clinical basis for the use of surveillance technology and get an understanding of the extensive and ongoing harms to patients arising from placing surveillance

devices in their bedrooms. It was assisted by Stop Oxevision that concerns of privacy, consent and misuse of the system were exposed, as well as a deterioration in therapeutic engagement, alarm fatigue and overall reliance on alerts.

As a result, it was clear, we contend, that the cost and contractual commitments between EPUT and LIO or Oxehealth, which had rested primarily on the remote monitoring functionality of Oxevision and staff replacement cannot continue to be justified.

You will appreciate that the evidence given by both Tammy and Hat came at enormous personal cost, motivated by their deeply held, evidence-based concerns about the use and expansion of this invasive and harmful technology.

But in the absence of an opportunity to make oral closing submissions, it was on the basis of their evidence and the evidence received from EPUT and LIO that we wrote to the Inquiry contending that an interim recommendation should be issued requiring EPUT to take immediate steps to safely halt the use of Oxevision in inpatient bedrooms in all adult, older adult and children and young people wards within three months pending the final report and recommendation of this Inquiry.

Chair, we note that the proposed interim recommendation now finds considerable force in public statements by some Trusts, other than EPUT, that they have paused or will uninstall the use of Oxevision in their wards, concerned about a lack of evidence of its effectiveness or clinical justification, or because the use of Oxevision in private spaces such as bedrooms raises, which of course it does, significant human rights concerns, or because of profound concerns about data storage and retention.

What is clear as a result, Chair, is that in proposing this interim recommendation, we are not inviting this Inquiry to enter unchartered territory, but to join others in leading the move away from the blanket use of this intrusive technology with its unproven clinical justification.

As with other issues, Chair, we still await the Inquiry's response to our proposal, but we note that meanwhile, and quite remarkably, LIO have sought to publish on their website and social media the Lampard Inquiry evidence as promotional marketing material.

In a recent LinkedIn post, they write:

"In a newly published study, spanning six NHS mental health providers, a clear pattern emerged. Across different facilities, service types and outcomes" and

I stress "contactless monitoring was consistently linked to safer care, with fewer incidents of self-harm, falls and assaults, and reduced use of physical restraint (audio breaks) rapid tranquilisation."

That picture, they say on LinkedIn, is echoed in the evidence recently presented to the Lampard Inquiry:

"Over a 26-month period, one NHS Trust reported more than 1,700 incidents in which contactless monitoring enabled staff to identify risk earlier and step in before serious harm occurred."

"This impact", they say, "can be life changing".

It is, Chair, a staggering spin on the evidence that you heard. Not only using material from this Inquiry, but using it in such a way as to promote the use of a system, and in doing so ignoring the concerns raised in the Inquiry's evidence about how the system may exacerbate symptoms, particularly those experiencing paranoia, about a consequence of the use of Oxevision being measured in the reduction and removal of important one-to-one therapeutic contact, about the significant and ongoing concerns about patient consent and the suggestion that contactless monitoring was consistently linked with safer care, blatantly ignores Tammy Smith's evidence that the Oxevision alarm sounded as Sophie died but no one heard or responded.

The evidence that you heard, Chair, led CTI to observe in closing that it remains unclear from the evidence the extent to which Trusts, including EPUT, have considered how this relatively new technology should be applied in the provision of mental health care and the extent to which they have considered its benefits to patients.

It is plain, Chair, particularly in light of the way your evidence is being portrayed on social media, that a robust response from this Inquiry is called for, one element of which must be, we contend, the interim recommendation that we have identified.

There is no time for drift. Whilst more evidence may be forthcoming in relation to the use of this system, that which you have heard already is sufficient, and for all the reasons set out in our detailed correspondence, we invite you to act, because the consequences of failing to act are simply too grave.

Chair, it is plain from all you have heard that there is much to do and there is of course diminishing time to do it. I reiterate, as I have already, that our clients are participants in your Inquiry borne out of a desire to make it work because they need this Inquiry to succeed and it is in this spirit that these submissions are advanced. Thank you.

THE CHAIR: Thank you.

MR GRIFFIN: Chair, we now break for lunch and come back please at 1.45 pm. Thank you very much.

(12.45 pm)

(The short adjournment)

(1.45 pm)

MR GRIFFIN: Ms Lucas.

Submissions by MS LUCAS

MS LUCAS: I'm afraid it says "unable to start the video". It is disabled by the host. Thank you.

I am instructed by Bates Wells, representing Lydia Fraser-Ward. Lydia's sister, Pippa Whiteward, tragically died by suicide on 29th October 2016 after suffering from postpartum psychosis.

Chair, you heard from Lydia in July of this year. She said of her sister:

"I don't know what more Pippa could have done to ask for help. She is not a number. She is not a statistic. She was a person that people loved."

Lydia expressed her hope that this Inquiry will bring about lasting change. "If anything comes out of this," she said, "I ask for a more person-centric approach to care. You have to keep learning so that this all hasn't been in vain."

Lydia has repeatedly sought clarity from this

Inquiry about how it intends to give crucial issues such as perinatal care and the inappropriate use of out-of-area placements the attention and scrutiny they deserve.

Chair, we echo the concerns of the other bereaved families that, over a year into its work, fundamental questions about how this Inquiry intends to fulfil its Terms of Reference remain unanswered.

It is our view that the Inquiry is now at a critical juncture. If things continue to proceed as they have been, there is a very real risk that issues of profound importance to bereaved families will slip through the gaps. The opportunity for rigorous interrogation, as Lydia put it to keep learning, will be lost.

It is not too late for this Inquiry to deliver on its commitments. But the task ahead is ambitious. It requires a realistic cohesive and transparent plan for the next ten months.

To that end, Chair, Lydia wishes me to bring to your attention two issues arising from her sister's care which she hopes will serve as a call to action. I will then briefly address the Statement of Approach and procedural issues which have already been addressed in some detail on which I will seek to avoid repetition.

All I will go on to say is framed by Lydia's wish

for me to express at the very outset her appreciation to you and the Inquiry team for the work you have done so far. The enormity of the task embarked upon by this Inquiry reflects the scale of its potential to improve mental health care across the country. We hope to use this as an opportunity to help chart a course for this Inquiry to deliver meaningful and lasting change.

Turning first, then, to two illustrative issues arising in Pippa's case. We recognise that these represent a fraction of the issues, not only in Pippa's case, but amongst the bereaved family cohort as a whole. However, these two illustrative issues bring three points into sharp focus:

First, the gaps in the information provided to date about the substance of the Inquiry's investigative work.

Second, the reality that the Inquiry's core strands, its illustrative cases, data analysis, expert instructions and recommendations forum cannot be siloed. They must function as part of an integrated and cohesive investigation.

And, third, the sheer scale of the investigative work that is still required.

The first issue is perinatal care and risk assessments. Perinatal and mental illnesses have some distinctive features. They arise in a known high-risk

window. They can, with effective risk management, enable clinicians to predict vulnerability and offer preventative support. Care is also delivered through different treatment pathways involving maternity services and symptoms of course emerge at a time of unique change where a mother's health is inextricably tied to the welfare of her new baby.

The Inquiry must think critically about how it approaches evidence and makes recommendations in this context.

Perinatal care cuts across many of the issues this Inquiry will investigate and Lydia is anxious that the opportunities for learning raised by historic shortcomings in perinatal care are not treated as an afterthought in this Inquiry's work.

Chair, as you have heard, despite Pippa having previously suffered from postpartum depression, the opportunity for preventative intervention during her second pregnancy was missed. Despite signs of severe sleep deprivation, which is a well documented trigger of postpartum psychosis, no risk assessment was conducted and no consideration was given to the potential harm of separating Pippa from her newborn baby. During these delicate early months, Pippa became stuck in a cycle of discharge from and readmission to inpatient care, which

culminated in her being allowed on temporary home leave, despite numerous attempts at self-harm and suicide in the days prior. This occurred apparently without referral to community support services.

It is in this context that Lydia now wants to know how the Inquiry will investigate the joint working between mental health and maternity services.

Has the Inquiry received evidence from EPUT's perinatal mental health service and Mother and Baby Unit, for example, or from other Trusts nationally?

Does it intend to instruct an expert in perinatal care?

How will the Inquiry investigate staff training to recognise and act upon early signs of perinatal mental ill-health?

And how will it ensure that its recommendations are specifically implementable within the maternal care setting?

The Inquiry is yet to provide an indication, even in broad terms, as to how it intends to approach the issue of risk assessments across a wide range of clinical contexts.

Lydia wants to know when the Inquiry will share its proposal for expert evidence on this topic. Will this encompass so-called positive risk-taking in specific

context of new mothers?

How will the Inquiry examine the relationship between the timing of hospital discharge or leave following a self-harm or suicide attempt and a subsequent occurrence of suicide in the community?

Does the Inquiry intend to analyse readmission statistics, both before and after the introduction of the four-week discharge target?

The second issue is out-of-area placements. This Inquiry has committed to investigating the practical workings and reasons behind out-of-area placements.

When Pippa needed urgent support, she was informed that there was only one bed in the Mother and Baby Unit available in the entire country and it rejected her admission without explanation.

This is not an isolated issue. It is a national crisis. There are 19 Mother and Baby Units in England, many of which have fewer than ten beds. Some parts of the country have no Mother and Baby Units at all, meaning new mothers are disproportionately sent far away from their families and loved ones to receive the care they need.

This Inquiry is uniquely positioned to scrutinise this issue, but it must be done with the rigour and diligence that an issue of this importance requires. It

is only through piecing together evidence from EPUT to this Inquiry that Lydia has learned of the horrifying reality that, while in crisis, Pippa was likely taken from Essex to Nottingham where she was declined on arrival before being transferred to Staffordshire, and later Winchester.

As she said in her July evidence, if there are really so few beds in this country that mothers with young babies who are having a mental health crisis are being ferried around in ambulances hundreds of miles away, just to give them a bed, we are in dire circumstances. That is why Lydia wants and deserves to know how the Inquiry will assess the effect of out-of-area placements on patient recovery and which experts it will instruct on this issue.

What evidence will be obtained on out-of-area placement decisions, including admission criteria and timelines for placement and repatriation, and how will this evidence be tested and placed within a national context?

How will the Inquiry analyse Mother and Baby Unit bed availability across the relevant period.

How will the Inquiry assess the effectiveness of measures taken to reduce inappropriate out-of-area placements.

And how will the Inquiry interrogate the relationship between home Trusts and out-of-area Trusts, including oversight mechanisms, risk-sharing agreements, and home community teams, where patients are sent back into the community following an out-of-area placement.

Chair, this Inquiry has promised to leave no stone unturned. I have focused on just two issues but they serve to highlight that to make good that promise, the Inquiry must now engage carefully with Lydia's questions and provide clear, comprehensive answers.

Turning now to the Statement of Approach and procedural issues, we share the position of the other bereaved families that greater transparency is required for Core Participants to effectively participate with the Inquiry's work.

Through meetings with the Inquiry team, written correspondence and now the Statement of Approach, we have caught glimpses of the Inquiry's inner workings which we have tried to piece together to decipher an overarching strategy, but now is the time for clarity.

Lydia endorses the submissions you have heard already today that a roadmap is now essential. It must encompass all of the Inquiry's strands of work, explain how they integrate with one another and set out clear

timelines for each phrase.

I now intend to briefly touch upon some of these work streams.

First, the Inquiry's proposed cluster approach, as you have already heard, requires fuller explanation. Crucially, we do not know how the Inquiry intends to define its overarching themes or how Core Participants will be allocated to clusters.

It is essential that bereaved families are properly consulted on both the proposed themes and their allocation within them. Without this, there is a risk that issues such as perinatal care and out-of-area placements may fall through the gaps, where they cut across themes or cannot be neatly categorised.

Second, evidence-gathering. When Lydia gave evidence to this Inquiry in July, she did so without the benefit of evidence central to Pippa's care, including most of her medical records. She explained:

"It's very sad that I'm in a situation where I don't really know exactly what happened to her and I'm having to do detective work to try and work it out."

To this day, Lydia has only snapshots of Pippa's care. It is a source of considerable distress to Lydia that basic gaps in Pippa's care, such as how many hospitals her sister was passed between, are no closer

to being addressed. It is not lost on Lydia that just as being transferred miles away from home left Pippa effectively deserted by EPUT, there is a risk that her experience may now be overlooked in this Inquiry because so much of it took place outside Essex.

Lydia is determined that Essex Trusts do not shirk their responsibility for out-of-area patients and urges this Inquiry to be mindful of this in its pursuit of evidence, including from out-of-area Trusts.

The Statement of Approach confirms only that the Inquiry will consider whether further evidence is required. Chair, we ask you not to underestimate the weight of this uncertainty. Lydia looks forward to receiving clear answers about what evidence this Inquiry has already obtained and intends to obtain in relation to Pippa's care and the broader issues it represents.

Third, we wish to reinforce the importance of the early involvement of experts who can input not just as part of the case summaries, but across all the Inquiry's strands of work as outlined in our written submissions. Lydia is keen that the Inquiry benefit from expertise across a range of clinical contexts, from Trusts across the country and outside the NHS.

Fourth, disclosure. We ask that the Inquiry does not lose sight of the substantial time and emotional

energy required of bereaved families to participate in this Inquiry and the demands of their own lives alongside this.

In the absence of any clear roadmap, months of limbo have taken their toll and risk alienating Core Participants from the work they so keenly want to participate in.

Lydia very much looks forward to receiving a disclosure plan which will afford her adequate time to properly digest and engage with material.

And finally, Chair, we are acutely aware of the limited hearing time this Inquiry has scheduled for 2026. We echo the concerns that the illustrative casework must not become a replacement for the public ventilation and for rigorous scrutiny of witness evidence.

Lydia looks forward to receiving confirmation of provider witnesses well in advance of the 2026 hearings.

The Statement of Approach envisages further oral hearings for some illustrative cases and we look forward to receiving clarity on the selection criteria and how this dovetails with the existing hearing timetable.

Chair, this Inquiry has promised to leave no stone unturned from ward to board. Time is now of the essence to deliver on that promise. Lydia knows that there are

questions about Pippa's care to which she may never receive answers. But this Inquiry can offer Lydia some measure of comfort by ensuring that the past suffering of her sister drives meaningful lasting change for the future.

Chair, we urge you to be fearless in your investigation of these issues and to provide bereaved family members, including Lydia, with the clarity they need to meaningfully contribute to its work.

Thank you.

THE CHAIR: Thank you.

MR GRIFFIN: Chair, we now hear from Ms Morris KC.

Submissions by MS MORRIS

MS MORRIS: Chair, good afternoon. I appear alongside Lily Lewis instructed by Bhatt Murphy Solicitors and make these submissions on behalf of the charity INQUEST.

As the Inquiry has recognised, INQUEST provides advice and expertise to bereaved people in relation to state-related deaths. INQUEST has considerable experience of the deaths of those detained under the Mental Health Act in psychiatric settings and has worked on a large number of cases involving deaths in mental health settings in Essex.

INQUEST recognises that without the family's courage, persistence and determination, this Inquiry

would not have come into existence.

As Ms Campbell KC set out in her written submissions to the Inquiry in November of this year, in fighting for justice families repeatedly demonstrate courage over fear. Through its case work and campaigning, INQUEST bears witness to the significant personal cost to those families of exposing failure and pushing for future change.

Tragically the families are experts by experience of what happened to their loved ones, but it should not fall to bereaved families to hold state bodies or even public inquiries to account. They are not responsible for the deaths of their loved ones. They are not responsible for the investigations into their deaths, yet these families, through eloquent counsel who represent them today, have expressed in the clearest terms that they currently need reassurance that this Inquiry is able to lift that burden and to undertake the full and transparent investigation that is required and that they deserve.

Deborah Coles, the executive director of INQUEST, has given powerful evidence to this Inquiry in May and we have now provided three witness statements by Ms Coles on behalf of INQUEST. But beyond that, INQUEST continue to actively support the families involved in

this Inquiry and their legal team are actively engaged with both the Inquiry legal team and the legal teams representing the bereaved families and those with lived experience of inpatient treatment.

Sadly, INQUEST are experts as to how investigations and legal processes over the last 25 years can traumatise and impact on bereaved families. INQUEST has supported families during public inquiries since 2003, including the inquiry into the death of Rocky Bennett, a young black Caribbean inpatient who died after ward staff used excessive physical restraint against him.

INQUEST has also supported families bereaved by the 1989 Hillsborough disaster, the Grenfell Tower fire and the ongoing Sheku Bayoh Inquiry in Scotland.

We of course welcome the Inquiry seeking reviews of INQUEST on such core matters as procedural issues, the draft investigative strategy and the recommendation and implementation forum. But having walked alongside bereaved families and survivors for decades, INQUEST must now issue words of warning to this Inquiry at this critical juncture of its work:

Do not follow the tragic pattern that so many investigations have followed and failed to deliver on well-intentioned promises, failed to scratch the surface and failed to make robust and ambitious recommendations

for meaningful change.

We are concerned that the Inquiry is replicating the experiences that bereaved families have already had with previous investigations and Trust processes. INQUEST hears the families through the submissions made on their behalf today that they feel siloed, uncertain and are unsighted on core documents and are losing confidence in the Inquiry.

These are undoubtedly not words used lightly in the context of a public inquiry that they have fought so long and hard for, but without a radical change in the levels of transparency and engagement for bereaved families and other Core Participants, including INQUEST, this Inquiry does now run the risk of causing unnecessary suffering and risks not being able to achieve its admirable and ambitious aims.

So, Chair, I will use the time I have available to me to address you on seven key topics that we urge you to address immediately.

The first is transparency. We echo the calls by the families for a clear transparent and achievable route map. This is something that should have been identified from the opening of the Inquiry's hearings but the families and no doubt the public, for reasons highlighted by other counsel, feel that they are no

clearer today over a year later than they were at the beginning as to where the Inquiry is going and by when.

Core Participants need meaningful insight into the Inquiry's broadest investigative strategy, a clear roadmap and as all counsel have said before me in their oral submissions today, this must integrate the Inquiry's various work strands and identify how the evidence pertaining to each strand will be timetabled and brought together.

INQUEST also support the proposal by Ms Sikand KC and Ms Murphy KC that the Inquiry should follow a modular structure which brings the benefits of clarity and focus both to the investigations and to the family and public engagement.

We also make the further broader point which chimes with those made about the submissions going into the ether. Correspondence that INQUEST has sent to the Inquiry asking for clarity on key topics has likewise gone unanswered.

One key submission was made to you, Chair, in April 2025, highlighting to you the compelling case for an independent body to investigate mental health deaths which INQUEST has identified and campaigned for for over 20 years. In those submissions we asked you to look at making a specific and focused recommendation to give the

investigations into the death of mental health patients parity to other forms of state custody.

Also in helpful meetings with your counsel in July of this year, we underline that this could and should be done through an interim recommendation as the evidential basis has already been established by the Inquiry from the April and May hearings with the evidence of Mr Behrens and Ms Coles and the families themselves highlighting the lack of independence and scrutiny that the deaths of their loved ones had received.

These submissions have gone unanswered and therefore no interim recommendations have been made which means that the substantive work of government to respond to a recommendation and to put any such mechanism in place has not started.

Given the lack of timescale and clarity on other topics, including the recommendation and implementation forum, INQUEST is concerned that there will still be years lost before this important mechanism is implemented and further lives lost in the interim.

We also repeat the calls for the Inquiry as a matter of course to provide proper responses with formal rulings on key matters as an essential part of the transparent operation of the Inquiry's decision-making.

My second topic -- the draft investigative strategy.

Chair, we have made written submissions in response to the draft Statement of Approach and won't repeat all matters here. We welcome the Inquiry's recognition in the strategy that the Chair may re-examine matters where previous processes lacked system, scope or independence. We make the following observations:

In relation to where the Inquiry has provisionally identified categories of cases to form part of its sample, INQUEST asks why the Inquiry is only looking at cases where there was findings of neglect, which for coronial purposes requires there to be a gross failing to provide basic care as opposed to all cases where the coroner or jury have made findings that any act or omission by the provider or Trust has contributed to a death. In such cases, for example, there could have been findings of gross failures even if the test for neglect has not been met.

Given the Inquiry is looking here at inpatient deaths, all the deaths that were not natural should have had an inquest process that at least sought to comply with the Article 2 investigative duty and therefore should have been capable of identifying and recording critical findings that either probably or possibly contributed to the death.

INQUEST is concerned that if this category of deaths

are excluded from the investigation, then the Inquiry may miss illustrations of important causative themes that did not amount to neglect.

INQUEST understand there may be practical constraints in relation to obtaining and reviewing all the records of inquests of patient deaths across the time period for the Terms of Reference but would welcome further expansion of the Inquiry's rationale in relation to this category and can also engage with the Inquiry in relation to methods for the selection of relevant cases, including through requests to coroners or through INQUEST's own caseload.

INQUEST also ask the Inquiry to provide clarity as to when and how liaison with families and others will take place in order to ensure that the experiences of and expertise of families informs the investigations of relevant cases from an early stage and that importantly families understand when they will be contacted and will be given sufficient time to input meaningfully.

INQUEST's experience across decades of working with bereaved families is that this will be a very traumatic process for families and must be approached sensitively. The Inquiry must adopt a trauma-informed approach and appreciate that families are likely to be at risk of re-traumatisation, not only by the Inquiry examining

their own loved one's experiences, but also by having shared with them the experiences of others.

INQUEST's own experience through managing their caseload supporting bereaved families which seeks to bring together information about a death, including material from post-death investigations, family members and other sources is that it is an incredibly time-consuming and intricate task with a need for constant and sensitive communication with the families and other parties.

Given that the Inquiry's investigative strategy is currently only in draft, we are concerned as to how any evidence of any death relating to the illustrative cases could realistically be ready to be heard before the hearing windows in February or even April of next year.

The INQUEST welcomes the Inquiry's consideration of defensiveness and lack of candour and urges the Inquiry to make public findings in relation to these important topics.

The national profile and significance of this Inquiry means that other Trusts will be aware of its work and monitoring its findings, and if there is to be meaningful cultural change in Essex and nationally, then issues of transparency and candour should be identified at the earliest opportunity.

In terms of the details of how the proposals for the illustrative cases are selected and organised, INQUEST echoes the families' concerns about who is included and who is not and the impact and effectiveness of clusters. We also echo the families' concerns in relation to the methodology of identifying illustrative cases and what expert or statistical evidence has informed the selection.

Finally on this topic, it is submitted that INQUEST should be cited on case summaries, but that as a minimum where INQUEST had supported a bereaved family within any cluster, that with the permission of that family, INQUEST should be provided with a copy of the initial case summary in order to assist the Inquiry with any factual inaccuracies or areas of further exploration. In this way, INQUEST will be able to assist the Inquiry with its investigative obligations.

My third topic, Chair, the importance of a system level investigation.

We agree with the submissions made by Ms Murphy KC that the Inquiry must be able to identify the root causes of what she termed the "catastrophic systems collapse" that happened within Essex.

As the Inquiry has recognised in opening, forensic scrutiny must be applied ward to board. This is of

vital importance not only for this Inquiry to understand what happened in Essex and to ensure local learning, but the Inquiry is clearly also of national importance and failures of governance, regulation, oversight and learning will resonate loudly across other Trusts.

As INQUEST has already highlighted in Ms Coles' oral and written evidence, systems failures within mental health Trusts in Greater Manchester and Teesside have led to a significant number of inpatient deaths and have led bereaved families and survivors in those areas to call for a public inquiry and they will look to this Inquiry for findings and recommendations that will drive improvements at a Trust, a regional and a national systems level.

My fourth topic is the engagement of the bereaved families.

INQUEST hears the concerns raised by all the bereaved families groups, and in particular the concerns of those families who have already given such powerful evidence but without adequate disclosure or information.

The Inquiry's requests so far of those families appears to be to focus on their feelings and impressions in the absence of disclosure. They have asked today, not unreasonably, is this it? Is this the sum of their total expected input into their public hearings? At

this stage of the Inquiry, this question should be able to be answered with clarity.

In addition, there has been a lack of meaningful communication or regular updates from the Inquiry which has meant the families have only learnt what is happening for the first time in public hearings. The families of CPs have had no indication as to who has been asked for Rule 9 statements or what evidence has been gathered from them. There has been no opportunity for Core Participants to make submissions on further lines of investigation. This carries a significant risk not only of families not being at the heart of process, but also the Inquiry not achieving its aim within the timescale currently available.

My fifth topic, Chair, the lack of a proper disclosure plan.

INQUEST echoes the families' concerns about the broken promises when it comes to disclosure. Lack of proper disclosure prevents a lack of effective participation for families, a key aspect of the Article 2 compliant processes. As INQUEST pointed out in previous written submissions, the families in this Inquiry have had less access to disclosure and less right to question than they did when they were interested persons in their loved one's inquest.

This cannot be right. The Inquiry must now issue a disclosure roadmap that gives adequate time for all CPs to receive, assimilate and respond to that disclosure and particularly to the families and survivors in a trauma informed way.

Chair, being trauma informed isn't just about empathy, sensitivity and reasonable adjustments. It is about co-designing a process with those who have experienced trauma and a process which embodies respect, parity, clarity, transparency and engagement.

My sixth topic is on experts.

INQUEST reiterates the concerns raised by other CPs in respect of the Inquiry's approach to experts and despite multiple concerns raised about the expert reports of Dr Davidson and Maria Nelligan, those experts proceeded to give oral evidence, albeit in a curtailed format.

CPs have since raised further concerns about what further expert evidence the Inquiry proposes to hear. INQUEST, like other Core Participants, made detailed submissions in September regarding the instruction of experts in neurodiversity from the fields of psychiatry and psychology. No response has been received. Nor it seems has the Inquiry sought to instruct an expert on sexual discrimination and racism in the delivery of

mental health services in Essex, despite repeated requests made by both INQUEST and Bindmans.

We are still not aware if experts have been instructed and, if so, what they have been asked to address or when their reports will be provided. The Inquiry to date has not shared any letters of instruction for any expert within the investigation, and further to our submissions touching on the investigative strategy, it is not clear how and when further expert evidence fits into any future planning.

My final topic then, Chair, touching on the recommendations and implementations forum.

INQUEST will be making detailed written submissions in response to the recommendations and implementations forum in line with the Inquiry's deadlines but make the following short headline points:

First, in view of the lack of investigative roadmap, it is not clear how the recommendations and implementations forum fits alongside the wider investigations and within what timescales.

Second, INQUEST would press upon the Inquiry the need to be bold and ambitious in its approach to recommendations, not just recommend what it knows will be easy to resource and implement. This, we say, would entirely undermine and undervalue the role of the

Inquiry in striving for meaningful change. Many of the systemic failures of these Trusts and others are underpinned by years of austerity and cuts to public health funding to mental health services and to simply accept the current situation, not to demand better for patients, would be a failure of this process.

Third, INQUEST understands concerns families may have if the focus of the recommendation and implementation forum is to engage with Trusts and stakeholders to determine what is possible, not what is needed. Lawyers are not the only people that the Inquiry should be speaking to and the Inquiry should be mindful of the risk of over-legalising the process.

Fifth, INQUEST is supportive of a process of interim recommendations and has already highlighted in a previous submission and today the evidential basis for a number that you, Chair, could consider.

The first is an interim recommendation around the need for robust data based on Professor Donnelly's evidence to date.

The second, a recommendation INQUEST presses upon you around the need for an independent investigation mechanism into inpatient mental health deaths.

Thirdly, INQUEST supports the submission that Ms Campbell makes in relation to the interim

recommendation that the use of Oxevision technology in mental health settings should be safely halted.

Finally on this topic, INQUEST urges meaningful engagement with the families not just talking shops. Like with other parts of the Inquiry's process, there has to be clarity, planning and transparency in respect of the work of the recommendations and implementation forum.

In conclusion, Chair, within the current timetable INQUEST is deeply concerned that the Inquiry cannot deliver the breadth and magnitude of what remains to be explored in the hearing dates that have been allocated between now and the end of October 2026.

The families deserve more. Some of the Essex families lost loved ones 25 years ago. INQUEST encourages the Inquiry to reflect on the intergenerational suffering of these families and survivors who have also waited a generation to have the truth established of how their loved ones died and acknowledged publicly and for those responsible to be called to some level of account.

Sadly, INQUEST and the public know only too well from other scandals, such as the Horizon scandal and the Infected Blood scandal how delay and obfuscation by investigations only compound in injustice and trauma.

As Steve Kelly, who lost his brother Michael Kelly at Hillsborough, said just last week when reflecting on his family's fight for justice over the course of 36 years, said that no one should be beaten by the passage of time.

25 years after the beginning of the period within your Terms of Reference, Chair, time is passing without meaningful findings or recommendations that can manifest in meaningful change. There is no doubt that this will be taking its toll on the Essex families.

Chair, we don't doubt your ambitions or your intentions to deliver your terms of reference, but it will now take grit and grip to ensure that they can be delivered in an effective and timely way and with the families remaining where they should be, not at the sidelines, but at the heart of the process, and INQUEST endeavours to work with the Inquiry to achieve this. Thank you, Chair.

MR GRIFFIN: Chair, that is the last of today's oral submissions.

THE CHAIR: Thank you very much. Can I thank Ms Morris for her contributions too.

Can I also say that I want to thank everybody who has made submissions before me today and I can assure you that I am going to be giving them my deepest

consideration. Thank you.

(2.30 pm)

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