OPENING STATEMENT OF COUNSEL TO THE INQUIRY

Arundel House, 2 February 2026

1. Thank you.

2. This is the Lampard Inquiry's sixth public hearing.

3. Chair, you have referred to the information recently provided by the Inquiry, including in your response to the submissions made by Core Participant lawyers in December, and in the Inquiry's updated Investigative Strategy (its "Statement of Approach on investigating illustrative cases of those who have died"). The Inquiry has also just published a disclosure update.

4. These documents are available on the Inquiry website. They are also hyperlinked in the written version of this Opening Statement, which will shortly go onto the website. Together, they provide an update on the progress of the Inquiry's work and information about its future timeline and plans. For that reason, this Opening Statement will be a short one in which I focus on the subject of this hearing, rather than repeating what you have said and matters that have been covered in those recent communications.

5. In July and October of last year, the Inquiry heard powerful evidence from the Families of those who died whilst receiving mental health care from Trusts in Essex. From that important evidence, there emerged a number of common themes and clear lines of enquiry, careful consideration of which is already well underway. This hearing is the last of three that will

be dedicated primarily to hearing evidence from the Family and Friends of those who have died.

6. Over the coming weeks, the Inquiry will hear oral evidence from thirteen further Families and Friends of those who have died. I want to reiterate, as I have done at each of these three Bereaved Family hearings, that the Inquiry is immensely grateful to each of those witnesses for their strength and courage in coming forward to share their accounts. As you have made clear, Chair, the unique experiences, recollections and observations shared by the Families and Friends of those have died form a fundamentally important part of the basis for the Inquiry's work; those Families and Friends, and those that each of them lost, remain at its core.

7. Chair, you have just mentioned that may be deeply distressing. For many of those following the Inquiry, the experiences of the Families we are about to hear from will resonate with the trauma and grief they too have suffered and continue to suffer, or of experiences of mental ill-health or mental health inpatient care.

Emotional Support

8. It is important for me to make clear to all those engaging with the Inquiry that emotional support is available for anyone who requires it. The wellbeing of those participating is extremely important to the Inquiry.

9. For those in the room, please know that you are welcome to leave at any point during these proceedings. Each day, present in the room will be two support staff from Hestia, an experienced provider of emotional support. The Hestia support staff can be identified by their orange lanyards and scarves. A private room where you can talk to Hestia support staff is available throughout this hearing. Or, if you would prefer, please speak to a member of the Inquiry Team so that we can make

arrangements for support from Hestia for you. We are wearing purple-coloured lanyards.

10. For those watching online, information about available emotional support can be found on the Lampard Inquiry website at **LampardInquiry.org.uk** and under the 'Support' tab near the top right-hand corner. You can also contact the Inquiry Team's mailbox on contact@lampardinquiry.org.uk for this information.

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

Legal Representation

12. I am assisted at this hearing by three members of the Counsel to the Inquiry Team: Rachel Troup, Priya Malhotra and Natasha Lloyd-Owen. We have been working closely with Bereaved Families and Friends and with their legal representatives to help to support and prepare them for their evidence.

13. As I have explained at previous hearings, my Counsel Team works closely with the Lampard Inquiry Solicitor Team, under Catherine Turtle, as well as with the Inquiry's Secretariat. Chair, as you have just mentioned, the Secretariat is under the new leadership of Helen Gibson.

14. My colleagues and I work for and are instructed by you, Chair, to assist you in your important task, and we do so independent from all other organisations and individuals.

15. I would also like once again to introduce the lawyers who are representing Core Participants. [Provided Separately]

The evidence

16. In this hearing, the Inquiry will hear about the following people who have died:

- **Georgina Sefton,** who died on 10 June 2006 aged 29. We will hear evidence this morning from her mother, Ann Sefton.

- **Daniel Lee Marcovitch,** who died on 11 January 2022 aged 44. We will hear evidence later today from his father, Simon Marcovitch.

- **Milan Radovanovic,** who died on 25 July 2018 aged 25. We will hear evidence from Milan's mother, Anastasija Fuller.

- **Terry Dicks**, who died on 16 April 2018 aged 46. We will hear evidence from Terry's mother, June Dicks.

- **Tillie-Anne King,** who died on 8 March 2020 aged 21. We will hear evidence from her mother, Lisa Bates.

- **Malgorzata Elzbieta Breczko-Nowak,** known as **Gosia**, who died on 27 June 2019 aged 41. We will hear evidence from her friend, Stuart Ringer.

- **Paula Parretti,** who died on 6 January 2002, aged 46. We will hear evidence from Paula's sister, Samantha Cook.

- **Marion Michel,** who died on 4 March 2022 aged 56. We will hear evidence from her sister, Karen Michel.

- **Benjamin Morris,** who died on 28 December 2008 aged 20. We will hear from Benjamin's mother, Lisa Morris.

- **Christopher Mark William Irwin,** [known to his Friends as **Teddy**], who died on 2 May 2023 aged 34. We will hear evidence from his mother, Sonia Edwards.

- **Glenn Holmes**, who died on 7 July 2012 aged 19. We will hear evidence from Glenn's sister, Amanda Cook.

- **Rocky Stenning**, who died on 19 July 2018 aged 26. We will hear evidence from Rocky's sister, Kristal Stenning.

- The Inquiry will also hear evidence in a private session from one further Family witness to whom you have granted a restriction order.

17. I referred a moment ago to common themes that have arisen. Chair, many of the issues raised by the Families and Friends we are about to hear from will, by now, be sadly familiar to those who have been following this Inquiry, echoing the voices of the Families we heard evidence from in both July and October. The issues that we will hear about include, but are not limited to:

    - Failures adequately to assess and admit, and failures to admit at all;
    - A lack of availability of beds in inpatient units;
    - Inadequate, inappropriate and in some cases non-existent communication and engagement with Families, at all stages of assessment, admission, inpatient treatment and discharge;

- Failures to plan and co-ordinate care, allocate staff to any co-ordination role, or to take any oversight;
- Inappropriate medication and over-medication, including on discharge in cases where overdose was a known risk;
- Wholesale failures for vulnerable young people at the crucial period of transition from Child and Adolescent Mental Health Services (or CAMHS) to adult mental health services;
- Failures in communication and co-ordination between service providers, including health services, social services, criminal justice system teams and prisons.
- Mismanagement of co-occurring physical health conditions and associated mental health difficulties;
- Failures in communication and co-ordination between physical and mental health services;
- Failures to prevent patients from absconding;
- Repeated failures to adhere to or even to activate missing persons protocols when alerted to patients having absconded or having failed to return from leave;
- Failures to consider or make appropriate safeguarding referrals, including in the context of sexual safety;
- Failures to refer for specialist treatment for eating disorders;
- Mismanagement in relation to all aspects of care for substance misuse;
- A lack of understanding about and a dismissive approach to addiction more generally, including in the case of self-harm and severe symptoms;
- Rudeness and a lack of care from staff;
- Clear deficiencies in the control of access to high-risk items, including knives;
- Inadequate and unfocused risk assessments;

- Disorganisation, understaffing and a lack of continuity in care; appointments that had been relied on cancelled at the very last minute, with no alternative support provided;
- Poor and inadequate investigations by Trusts;
- Trust defensiveness and an unwillingness to identify problems, still less learn from events.

Witness statements

18. In my Opening Statements for the July and October hearings, I explained that the witness statements provided by each witness giving evidence will stand in full as their evidence. That remains the case for this hearing. As before, each witness will be asked questions by the members of the counsel team I have named. Counsel will help each witness to expand on what they have written and to highlight their gravest concerns about the care and treatment of those they have lost.

19. Those witness statements will then be published on the Inquiry's website once each witness has given their evidence. May I say once again for the avoidance of doubt and for clarity, that copies of the statements that are published will be redacted in line with the Inquiry's published approach. That approach sets out three main categories where redactions may be applied:

    a. Staff Names – in order to ensure fairness, these names will be redacted on a temporary basis.
    b. Detailed evidence about methods of self-harm, injury or death, particularly where the details could be considered instructional – to minimise risk and to protect the public from potential harm.
    c. Information that is personal in nature where it is not considered by you, Chair, to be relevant or necessary to be made public.

Timing

20. I move now to the timetable for this hearing. In this week and next week, the Inquiry will sit on Monday, Tuesday and Wednesday. In the third week, the Inquiry will be sitting on Monday only (Monday 16 February). The timetable for the hearing can be viewed on the Inquiry website.

21. As a general rule, during this hearing, we will begin at 10am and finish before 4pm each day, though there may be days on which there is an earlier finish. There will be a short break in the mornings and in the afternoons in which teas and coffees will be provided for those who are attending. There will also be a one-hour break for lunch each day. Those timings will always be subject to change; the Inquiry works flexibly in order to support witnesses, and may therefore take additional breaks or make other arrangements wherever appropriate.

Livestream

22. As with all of the Inquiry's hearings, it is not necessary to attend in person in order to watch or follow the evidence. Arrangements have been made for Core Participants and their representatives, where not attending in person, to watch the hearing live on a secure weblink. For the wider public wishing to follow remotely, the hearing will be live-streamed on the Lampard Inquiry YouTube Channel. Please note that, as before, the footage on that channel will be streamed with a ten-minute time delay.

Conclusion

23. I am about to finish my opening remarks. I will then suggest we rise for 15 minutes before I hand over to my colleague Rachel Troup and we hear from our first witness. Ann Sefton's evidence and that of Simon Marcovitch later today will inevitably touch on troubling matters. I refer back to what I said at the start of this Statement, including about the

support that is available for those present here at Arundel House or watching remotely.

24. Chair, I conclude by reiterating that your Inquiry team remains wholly committed to doing whatever it takes to assist you in your scrutiny of the provision of mental health inpatient services in Essex and in formulating recommendations for real, long-term change.

NICHOLAS GRIFFIN KC

Counsel to the Lampard Inquiry