OPENING STATEMENT OF COUNSEL TO THE INQUIRY

Arundel House, 6 July 2026

INTRODUCTION

1. Thank you, Chair.

2. This is the Lampard Inquiry's seventh public hearing which marks a shift into a different phase evidentially. Having heard substantive accounts from Bereaved Families over the course of last three hearings, the Inquiry will now move on to hear evidence from some of those who were involved in the provision of mental health inpatient care in Essex. We will also explore topics of immediate concern.

3. Chair, on behalf of your Inquiry team, may I please add our thanks to all of the family members and to others who have provided witness statements to the Inquiry. We do not take for granted how difficult it is for those who have experienced significant trauma to share again the details of their family member's deaths. We thank them for their courage, and for their assistance, and we confirm again that their evidence has formed the foundation of our work.

4. Before I go any further, may I also stress that during this Opening Statement and throughout this three-week hearing, the Inquiry will once again be referring to, and hearing about, matters that will be distressing. We will be hearing evidence about individual deaths. We will also hear from witnesses who provide different perspectives about the care provided on mental inpatient units, including their views on where things went wrong. These details may be difficult and painful for many of those who are here today or watching online.

5. As we have done at previous hearings, at the start of each day, we will briefly summarise the evidence to be heard. This will give those attending, watching and listening, the opportunity to decide whether they wish to engage with that evidence. The timetable for this hearing is also available on the Inquiry website.

Emotional Support

6. I would like also to re-iterate that emotional support is available to anyone engaging with the Inquiry. The wellbeing of those participating is extremely important to the Inquiry.

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

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

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

Safeguarding

10. The role and remit of the Lampard Inquiry is to investigate mental health inpatient deaths. It is not the role of the Inquiry to intervene in clinical decisions for current patients or to act as a regulator or in the role of the police. We take safeguarding

very seriously, however. The Inquiry has a safeguarding policy, and we have team members who are specifically responsible for overseeing safeguarding matters. Where we receive any information which meets our safeguarding threshold, we will pass it on to the appropriate organisation.

Legal Representation

11. There will be a number of the Counsel to the Inquiry Team involved in this hearing, Chair. This afternoon you will hear from lead CTI Nicholas Griffin KC. You will also be assisted over the next three weeks by Rachel Troup, Priya Malhotra, Tom Coke-Smyth, Robert McAllister, Katie Sage, Teniola Onabanjo and Thomas Hayes. They have all been closely involved with the evidence to be explored at this hearing. They have each engaged with their respective witnesses to ensure those witnesses provide their best evidence as part of this inquisitorial process.

12. The Counsel to the Inquiry Team works closely with the Inquiry Solicitor Team, under the lead of the Solicitor to the Inquiry, Catherine Turtle. Together the legal team works with the Secretariat Team under the lead of Helen Gibson, to progress the Inquiry's work. Chair, the Inquiry Team works for you and as directed by you. We are independent from all other organisations and individuals with an interest in this Inquiry, and we must be very careful to ensure that we retain that independence.

13. Chair, you are also assisted by the Recognised Legal Representatives and Counsel teams of the Core Participants and others. A list of representation will be available on the website.

Engagement with Core Participants

14. Whilst the Inquiry must be careful to preserve its independence, it continues to engage directly wherever it can, with all Core Participants and their legal

representatives. Specifically assigned members of the Inquiry team meet regularly with the legal teams representing Bereaved Families and with those representing healthcare providers and other Core Participants. We also meet with many other stakeholders as required.

15. The Inquiry also continues, wherever appropriate, to provide Core Participants with opportunities to engage with its work. Current opportunities for engagement include the Inquiry's ongoing process of seeking Core Participant input in relation to its illustrative Case Summaries, and invitations to Core Participants to provide submissions in relation to proposed expert instructions.

16. We will continue to hold meetings with those representing Core Participants. We consider that these meetings provide a valuable additional opportunity to listen and discuss individual concerns. Whilst as an independent public inquiry, it is not possible to accept every proposal or submission, the discussions have often resulted in positive developments.

THE PROGRESS OF THE INQUIRY

17. The Lampard Inquiry has made very significant progress in 2026. Whilst the scale of the task remaining should not be underestimated Chair, you have a dedicated team, full of people to whom this work is of crucial importance, all of whom are committed to driving this process forward. At present, the majority of the Inquiry's work, much of which is in the investigative or preparation stage, is taking place away from public hearings. This Opening Statement will therefore provide an update on some of the Inquiry's progress, before I turn to the evidence to be explored during this hearing.

Evidence from Bereaved Families

18. The Inquiry continues to engage with the families and friends of those who died whilst under the care of Trusts in Essex, and to obtain evidence from all those who wish to provide it. As you have already stated Chair, the families and friends of those who died will always be at the very heart of the Inquiry's work. Whilst the hearings dedicated solely to family evidence have come to a close, you made quite clear in your Response published in January this year, that you will continue to receive witness statements from Bereaved Families, and you will invite further families to give oral evidence in circumstances where you consider that you will be assisted by that oral evidence. Further witness statements from Bereaved Families have been disclosed in advance of this hearing and will be published in due course. You have invited three further families to give oral evidence during the course of this hearing, and you have directed that a pre-recorded evidence session be arranged for a fourth.

April Evidence Sessions

19. Furthermore, in April this year, the Inquiry heard from 10 more families who provided their first-hand accounts during recorded evidence sessions. Chair, these are sessions where evidence is provided in a less formal setting, without the pressure of a public hearing. The Inquiry has been pleased to hear from those who have attended these sessions how helpful they have found them as a way in which to provide evidence to the Inquiry in a more flexible setting. For that process, other Core Participants were invited to engage with the evidence in the usual way by sending to the Inquiry any questions they had for those witnesses in advance. The evidence sessions took place over a period of three weeks, and the recordings will be published on the Inquiry's website. You have already confirmed today that you have watched all of those recorded sessions in full. Furthermore, the evidence provided in those sessions has already underpinned investigations undertaken by your team. The Inquiry is hugely grateful to all of those who took part in those

recorded evidence sessions. Once again, we do not underestimate how difficult those sessions were for the families involved.

Evidence from those with Lived Experience

20. The Inquiry continues to place significant value on evidence from those with lived experience of mental health inpatient care in Essex. Following consultation on the Inquiry's draft Statement of Approach to Lived Experience cases, submissions were received from a range of Core Participants and interested organisations. Those submissions have been carefully reviewed and are currently being considered as part of the process of finalising the Statement of Approach.

21. Alongside that work, the Inquiry has issued Rule 9 requests for evidence to 12 Lived Experience Core Participants and continues to adopt a flexible and trauma-informed approach to engagement, working closely with legal representatives and support services to ensure that appropriate support, reasonable adjustments and special measures are available where required.

22. To date, the Inquiry has received one witness statement from a Lived Experience Core Participant. As further evidence is received, it will be reviewed as part of the Inquiry's wider investigations. The Chair remains grateful to those who have engaged with this process and recognises the important contribution that lived experience evidence can make to the Inquiry's understanding of the systemic issues affecting mental health inpatient care in Essex.

Investigation of Illustrative Cases

23. A major part of the Inquiry's work in 2026 has involved the investigation of its illustrative cases. The Inquiry's Statement of Approach to Investigating Illustrative Cases was finalised in January 2026, having taken into account the submissions invited from Core Participants and their legal representatives. To date the Inquiry

has identified 147 illustrative cases, each of which reveals one or more of the systemic issues emerging through the Inquiry's work. Those issues have been divided into themes and are listed as clusters on the Inquiry's website. The Inquiry's dedicated Investigations Team is working tirelessly to obtain relevant material, and to examine carefully those emerging systemic issues and themes. The Inquiry has issued hundreds of requests for evidence in relation to the investigation of its illustrative cases. It has obtained important evidence using the arrangements we have in place for sharing information with other organisations, including those with HM Coroner, Essex Police and some of the Healthcare Regulators.

24. The Inquiry has now completed its initial evidence-gathering stage in relation to all 147 cases and is in the process of disclosing draft Case Summaries to those who are connected, as matter of fact, to each particular case, in order that they can provide their comments and views.

25. On your direction Chair, the Inquiry has identified two additional themes which you consider merit separate consideration, and which capture better the issues emerging in certain illustrative cases. These changes underline the need for a flexible approach during what is an iterative process. The Annex to the Statement of Approach has been updated accordingly:

    a. Firstly, there is now a separate cluster of cases which illustrate issues with 'post-admission/ongoing assessment' through which the Inquiry will focus on assessments that took place once a patient had been admitted to an inpatient unit;

    b. Secondly the Inquiry has divided its examination of 'older adult care' and 'co-occurring health conditions' into two, to ensure clearer focus on the issues in each.

26. Chair, you made reference in your Statement to the Summaries of the Inquiry's illustrative cases which are being prepared as part of the Inquiry's investigative

work. I would like to re-iterate, that the starting point for the investigation of every illustrative case is the first-hand account and oral evidence provided by the family or friend of those who died (where that evidence is available). The Investigations Team begins by looking carefully at that evidence in its entirety, and it is the *full* account that informs the Inquiry as to the further investigative steps required. The Case Summaries identify and set out clearly each family's concerns.

27. They are just that: Case Summaries. They are intended as a neutral but effective presentational tool by which the Inquiry can collate and disseminate large volumes of relevant material and facilitate the important engagement of those connected to the case in the process. Chair, you have indicated that you have found the Case Summaries helpful. They do not replace the evidence the Inquiry has obtained. They certainly do not replace the comprehensive and detailed witness statements and oral evidence provided to the Inquiry by Bereaved Families. That evidence is taken into account, in full, by you and your team, and forms a vital part of the Inquiry's evidential record.

28. Since February this year, the Inquiry has been inviting families and other organisations connected to each illustrative case to engage directly with the Inquiry's investigative process. So far, 94 Case Summaries and the associated documents on which they are based have been disclosed to the families and organisations involved in each case. Those who have received Case Summaries have been invited to provide input and comments. The Inquiry's Investigations Team is grateful to those who have responded and has been assisted by those who have engaged constructively in what we acknowledge to be a challenging process for many. 24 of those Case Summaries have been amended and updated as a result of this engagement exercise, and they formed part of the disclosure for this hearing. This work will continue over the summer and will ensure that the Inquiry captures all the systemic concerns that have been raised by families. We encourage Core Participants to work with us on this. I should also stress the Inquiry intends to keep all Case Summaries under review and will update them as appropriate should further evidence be received.

Experts

29. Another very important aspect of the Inquiry's ongoing work in 2026 is the identification and instruction of suitably qualified and experienced experts to provide specialist opinion. Chair, you have identified, quite properly, that there are systemic issues emerging from the illustrative cases and questions relating to the provision of mental health inpatient care more widely, where you require expert assistance to navigate the matters arising.

30. Last year, after liaison with Core Participants, the Inquiry published its Protocol on the Role and Instruction of Experts. The Inquiry has now instructed a number of experts in accordance with this protocol, which allows for effective engagement from Core Participants in respect of areas of expertise, proposed candidates, and the broad topics on which expert opinion should be obtained. The Inquiry has also invited suggestions for experts from its Core Participants. The Inquiry has made contact with over 100 potential expert witnesses and has interviewed a significant number of those contacted. There are now experts instructed and working in relation to a number of our thematic issues.

31. Furthermore, the Inquiry previously announced its intention to explore the issue of suicide preventability. As the Inquiry's work has progressed, and further illustrative cases have been investigated, the need for the Inquiry to tackle questions around suicide predictability and preventability has become all the more apparent. The Inquiry intends to instruct Dr Chloe Beale, Consultant Psychiatrist, to provide expert opinion on this topic. Chair, you have repeatedly stated that you wish to consider the range of available opinion in this area. Your team continues to explore ways in which that might be achieved.

32. Also at your direction Chair, the Inquiry intends to seek evidence from both a legal and clinical perspective in relation to the complex, and often controversial, question of 'capacity' in those requiring or receiving treatment for mental health.

Corporate and Other Evidence

33. Whilst the focus of recent public hearings and recorded sessions has been evidence from Bereaved Families, the Inquiry continues to send multiple requests for evidence to healthcare providers, enforcement agencies, regulators, charities, and a wide variety of other corporate organisations and stakeholders; all of whom have material relevant to our Terms of Reference. Given the broad remit of those Terms of Reference and the growing need for national comparison and analysis, the Inquiry's work includes not only the sending out of requests for evidence crucial to the investigation of our illustrative cases and to the exploration of the themes identified, but also includes sending out requests for the evidence required to understand more generally how mental health inpatient care has been, and continues to be provided in Essex, and beyond. We have already obtained evidence from the relevant government and arms-length bodies. As I say, the scale of the task should not be underestimated.

34. In summary Chair, the Inquiry has sent in excess of 500 Rule 9 requests seeking witness and documentary evidence to corporate organisations and stakeholders. Chair, you have also exercised your statutory powers to compel the provision of evidence where necessary and have issued 14 Section 21 notices requiring certain stakeholders to provide relevant material without delay.

35. Corporate work taking place alongside the Inquiry hearings preparation includes, but is not limited to: a review of previous Investigations, Reviews, Inquest findings and Prevent Future Death Reports to track recommendations; collation of evidence relating to IT systems and information sharing; and progress with the Inquiry's governance piece.

36. The Inquiry intends to scrutinise the overall governance structures of those who provided, and continue to provide, mental health inpatient care in Essex at one of its final hearings. This governance work, which will look "ward to board" at how services should be run, is now well underway. The Inquiry has already amassed extensive evidence from its providers and intends, where possible, to effect disclosure of that material later this year, to allow Core Participants the time required to review it.

Challenges to Obtaining Evidence

37. Given the broad remit of the Inquiry's Terms of Reference, and the length of the relevant period, the Inquiry continues to face considerable challenges in securing comprehensive and reliable evidence from healthcare providers and other corporate stakeholders in a timely matter. This has been the case with EPUT in particular, about which I will provide more detail later in this Opening Statement. These challenges and delays inevitably have a knock-on effect on the Inquiry's ability to progress its work including reviewing material, identifying follow up queries and/or other lines of enquiry, providing relevant material to experts, finalising a disclosure scheme, along with planning and preparing for hearings and so on.

38. Chair, it was partly owing to these challenges, that in April this year, you directed that this July hearing be re-focused, as the Inquiry was simply not confident that it would receive all of the important evidence it required in sufficient time. The Inquiry remains concerned about receiving evidence on time and is planning accordingly. I will provide information about future hearings at the conclusion of this Opening Statement.

39. The Inquiry remains committed to ensuring that its requests for evidence from corporate Core Participants and Material Providers are met with timely and

comprehensive responses, using its statutory powers when required. A great deal of the work required to achieve this necessarily takes place behind the scenes, by way of weekly meetings between legal teams, written correspondence and the issuing of the formal Section 21 notices to compel evidence, to which I have referred. It is of paramount importance that there is sufficient time for both the Inquiry team and the wider cohort of Core Participants to react, respond, and engage as fully as possible with any material disclosed.

Lists of Deceased and the Inquiry's Expert Health Statistician

40. In October last year, the Inquiry reported that following clarification to the Inquiry's definition of inpatient, we had invited the main healthcare providers within the scope of this Inquiry to revisit and re-submit their lists of those who died whilst under their care in the relevant period.

41. Unhappily Chair, there are still ongoing issues in obtaining the list from our main healthcare provider, EPUT. The Inquiry acknowledges that given the scope of our investigations, and the fact that EPUT's two predecessor trusts no longer exist, there are challenges in reviewing records to complete this exercise. What remains to be seen however is whether those challenges are insurmountable. The Inquiry will continue to work closely with EPUT to support this exercise. We have required a further iteration of EPUT's List of Deceased to be provided by the end of this month.

42. The Inquiry remains committed to doing all that we can to obtain, as far as possible, accurate and *definitive* Lists of Deceased. We are deeply troubled that we still cannot say with any certainty how many people died during the relevant period whilst under the care of Trusts in Essex, and we may never have a completely accurate figure. We will continue to work with EPUT to establish the position as best we can. We consider it our overwhelming responsibility to do so. In the meantime, Chair, our position remains that it would be wholly irresponsible

to publish any numbers until we are confident that they are at least close to being accurate.

43. The Inquiry's Expert Health Statistician, Professor Donnelly, remains engaged and ready to assist the Inquiry in understanding the Lists of Deceased and any patterns or themes that are revealed. She is currently awaiting the outstanding information from EPUT so that she can complete her work in this regard.

44. Notwithstanding the wait for EPUT's List of Deceased, the Inquiry has still made progress where it can. As a result of Professor Donnelly's advice in relation to further data of assistance, the Inquiry has reached the following agreements:

    a. With NHS England - to secure the Mental Health Services Data Set (MHSDS), which we understand will provide the best source of denominator data;
    b. With the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - to share anonymous aggregate data.

45. This denominator data relating to the population of patients who were admitted to the same wards during the same period will allow Professor Donnelly and her team to place the final Lists of Deceased into their proper context. Once we have completed our work to finalise the Lists of Deceased and have provided those lists to Professor Donnelly, we intend to return to the arrangements for our previously announced data discussion.

46. Professor Donnelly and her team have provided assistance to the Inquiry in other important ways, however. We will hear the views of Professor Donnelly and her team in relation to the evidence base for Oxevision and similar technologies, during the third week of this hearing.

Staff Evidence

47. Against the background of poor staff engagement with the Essex Mental Health Independent Inquiry, the Lampard Inquiry has worked very hard indeed to secure the co-operation of current and former staff members who worked in mental health inpatient units during the relevant period. There is, within the Inquiry team, a specific Staff Team dedicated solely to engaging with current and former members of staff.

48. A number of individuals have come forward of their own volition, and we are very grateful to them for their assistance and their candour, and for the fact that some have been willing to speak about their experiences, whilst they remain employed by EPUT. In addition, the Inquiry has identified many more potential staff witnesses. Our starting point for that exercise was the Terms of Reference followed by careful analysis of our illustrative cases and a wider review of other relevant evidence already held by the Inquiry. It is important to reiterate however, that this Inquiry is not tasked with relitigating previous inquests or other proceedings. It is also not our role or responsibility to scrutinise the actions of individual members of staff, save where it is necessary to do so to explore whether there are systemic issues at play.

49. Following careful review of material received, the Inquiry's Staff Team has identified and issued formal requests for evidence to more than 50 current and former members of staff so far. The Inquiry has received a number of finalised witness statements already, with many more anticipated in the coming weeks and months. The Inquiry intends to continue its staff engagement work.

50. The Inquiry is aware however, that there may still be many staff who we do not currently know about, and who have not come forward; not only because they fear work-place repercussions should they give evidence about colleagues and employers, but also because they fear professional repercussions should they now provide evidence that they could have provided before. We hope when they see

that their colleagues have assisted the Inquiry, they too will be encouraged to come forward.

51. Chair, this hearing marks the first occasion on which those who work, or have worked, in mental health inpatient units will be giving oral evidence to this Inquiry. You have already made clear that you consider evidence relating to staff experience, and their perspective of the issues the Inquiry is investigating, to be very important. You have indicated that you wish to hear from all those who can shed light on what went well, in addition to what went wrong.

THE JULY 2026 HEARING

52. Let me now move to say a few words about this hearing, which runs from today until Thursday 23 July 2026. Over the next 3 weeks, the Inquiry will hear evidence from a variety of witnesses. We will hear evidence from further Bereaved Families. We will hear evidence from healthcare professionals who are or were employed by EPUT and its predecessor organisations. We will hear evidence from the undercover reporter who featured in the Channel 4 Dispatches documentary, and we will explore issues relating to Resuscitation, and to Observations and the Use of Technology.

Evidence relating to EPUT's engagement with the Lampard Inquiry

53. Chair, this hearing will begin however, with evidence from senior representatives of EPUT who you have determined to call to account for EPUT's failure to engage effectively with the Inquiry over a sustained period of time. We will hear evidence this afternoon from Paul Scott, who was Chief Executive Officer of EPUT from October 2020 until the end of last month. The background to this is as follows.

54. Last year, the Inquiry became increasingly concerned about EPUT's ability to engage with the Inquiry. The Inquiry raised this concern repeatedly with EPUT querying firstly, the composition of EPUT's Inquiry Project Team and secondly, their capacity to meet the demands and obligations of a statutory inquiry.

55. On 19 September 2025, the Inquiry requested a Data Assurance Statement from EPUT. This request sought confirmation from EPUT, amongst other matters, that their Inquiry Project Team was appropriately resourced, and that in responding to the Inquiry's evidential requests, EPUT were using senior clinical and managerial input and oversight where appropriate. The Inquiry was also concerned that we did not have a clear picture as to EPUT's methodology or any limitations in responding to Rule 9 requests. EPUT's Data Assurance Statement was received by the Inquiry on 5 December 2025.

56. By way of example, on 18 August 2025, the Inquiry issued a Rule 9 request to EPUT seeking evidence relating to the monitoring and evaluation of services provided. That was, to a large extent, a request for further information following the evidence given by Dr Karale during the Inquiry's hearing in April 2025. It was an evidential request of which EPUT were on notice. After a lengthy period of repeated extension requests, partial compliance, and missed deadlines, including deadlines proposed by EPUT themselves, on 27 February this year, you determined Chair to issue a Section 21 notice to compel EPUT to provide the information first requested in August 2025.

57. The Inquiry remained concerned however, that EPUT were unable to meet the Inquiry's evidential requests, of which there have now been over 200 to EPUT. After protracted correspondence, and continued failures with compliance during February and March this year, Chair, you determined to request a Position Statement from EPUT which required them, amongst other matters, to account for their failures in engagement, to provide proper information as to their current capacity and ability to discharge their obligations to the Inquiry, and to explain arrangements for senior leadership transition, for reflections and learning.

58. Counsel to the Inquiry, Mr Griffin KC, will explore the contents of that Position Statement with Mr Scott this afternoon. We will hear admissions made by Mr Scott on behalf of EPUT, that there were failures in EPUT's engagement with the Inquiry which resulted in the Inquiry's loss of confidence in EPUT's ability to engage effectively, and about the impact this may have on Bereaved Families and other Core Participants. Mr Griffin KC will ask questions about why those failures occurred and seek assurances that EPUT has put in place appropriate measures such as to guarantee future compliance.

59. Tomorrow morning, the Inquiry will hear from Mr Loy Lobo who is currently the Acting Chair of EPUT's Board of Directors, following the sad death of Hattie Llewelyn-Davies in May this year.

60. Put shortly Chair, you were so concerned by EPUT's failures to date and the impact those failures have had on the Inquiry's work, that you determined it necessary not only to call EPUT to account, but also to seek public affirmation of EPUT's commitment to assisting the Inquiry going forward. The Inquiry acknowledges that over the past few months there has been a marked improvement in EPUT's compliance, however we consider that it is too soon to determine whether the recent changes represent sustainable long-term progress on the part of EPUT or enhanced short-term delivery under significantly reduced operational pressure.

Evidence from Bereaved Families

61. Chair, having reviewed witness statements recently received, you have invited three further families to provide oral evidence during this public hearing. You have also invited a fourth family witness to give evidence during a private session at the end of next week.

62. As for previous hearings, the Inquiry has invited the family witnesses to give evidence of their first-hand accounts, observations, recollections and concerns. We have also invited them to give their current views on what recommendations should be made for change. The Inquiry will not be seeking comments or analysis from the family witnesses on other documents that relate to their relative's care and treatment.

63. Over the course of this week and next, the Inquiry will hear evidence from the following three Bereaved Families:

- Tomorrow we will hear evidence from **Lisa Wolff**. Lisa will give evidence about her daughter, **Abbigail Smith**, who was born on 23 June 1995 and died on 16 February 2022, aged 26.
- On Monday next week, **Victoria Sebastian** will attend to give evidence about her daughter, **Elise Sebastian**, who was born on 24 May 2004 and who died on 19 April 2021, aged just 16.
- **Lynne Breaker-Rolfe** will give evidence next Tuesday about her husband, **Roy Breaker-Rolfe**, who was born on 19 April 1957 and died on 21 February 2021, aged 63.

64. Those Bereaved Families highlight their experiences of a number of failings that have become sadly familiar to this Inquiry and to those following it, including:

- Failures throughout to communicate with the families and support networks of patients, to listen to their concerns or to seek input from those who knew the patient best;
- Dismissive, defensive and hostile attitudes towards families who were attempting to provide input into the care and treatment of their relative, or to understand or question planned approaches to care and treatment;
- Inadequate assessments that failed to take proper account of a patient's history, background and risk factors, with reliance placed instead on

immediate presenting symptoms and assurances from the patient that all was well;

- Failures to plan appropriately for safe discharges, as well as wholly inadequate support and care following discharge;
- Medication errors;
- A lack of care, compassion and therapeutic intervention during inpatient stays, with allegations of inappropriate restraint, bullying and ill-treatment;
- Diagnostic confusion and overshadowing, with diagnoses being applied, withdrawn and re-applied without proper foundation or valid, robust assessment;
- Physical health issues ignored or overlooked;
- Clear failures in observations of patients and management of risk, including in relation to the use of Oxevision surveillance technology;
- In relation to resuscitation, delays and basic failures, with staff inadequately trained and unfamiliar with equipment or proper processes;
- Significant failures in record-keeping, including falsified observation records, and mixing the records of patients;
- Inadequate or non-existent training for staff on autism;
- Wholesale failures to identify, understand or plan appropriately for the needs of autistic patients or, at the most basic level, to take neurodiversity into account in any aspect of care and treatment.

Evidence from Current and Former Members of Staff

65. As I have already outlined, this hearing marks the first hearing at which we will hear evidence from which those who work, or have worked, in mental health inpatient units in Essex. The evidence those witnesses will give represents their own experiences and recollections and will ultimately be assessed by the Inquiry in conjunction with all other evidence in the round.

Stuart Ayris

66. The first staff witness from whom the Inquiry will hear on Wednesday this week, is Stuart Ayris, a retired registered mental health nurse. Mr Ayris will give evidence about what he saw and experienced whilst working within EPUT and its predecessor organisations over a period of almost 22 years. He worked in adult settings including the Christopher Unit and Finchingfield Ward at the Linden Centre, and Ardleigh Ward at the Lakes.

67. Mr Ayris raises concerns about the culture at EPUT and its predecessor trust; North Essex Partnership University NHS Foundation Trust ['NEPT']. He reports understaffing, over-use of medication, disjointed approach to physical health conditions, and deficient treatment of those with drug and alcohol dependency, dementia and learning disabilities, amongst other matters. He also expresses concerns about the environment of some wards. He reports issues with family engagement and shortcomings with IT systems. Mr Ayris' evidence touches upon the deaths of Diana Hammond, Ben Morris and Glenn Holmes.

Chloe Cawston

68. Chloe Cawston is currently employed by EPUT as a Service Manager covering the Linden Centre and the Crystal Centre in Chelmsford. She has been a Service Manager since 2020, initially covering the Basildon Mental Health Unit ['BMHU'] and the Linden Centre.

69. Ms Cawston will give evidence about her experience working within EPUT and its predecessors, NEPT and SEPT. She gives evidence, amongst other matters, about barriers to assessment, modification to the ward environment, shifts in treatment, high turnover in staff, and the impact of the national shortage of nurses on the provision of mental health care. She has witnessed compassion fatigue amongst staff and acknowledges the risk of desensitisation amongst those working on inpatient units. She will also speak to her experience of the use of Oxevision.

Ian Arthur

70. Ian Arthur is a registered mental health nurse. He completed his training in August 2000 and has worked for EPUT and its predecessor organisations since 2003. Mr Arthur is currently seconded to the Mid and South Essex NHS Foundation Trust ['MSEFT'] working as the Integrated Discharge Hub Mental Health Lead. His previous experience includes working at various managerial levels on older adult wards, dementia care wards and during various periods from 2018 to October 2023, he was also responsible for managing the Peter Bruff Unit, an assessment unit for North Essex based patients.

71. Mr Arthur will give evidence of his general experience, and of working with older adults with mental ill health. He will comment, amongst other matters, on ward environment, treatment, medication, and training. He also provides some insight into the use of Oxevision.

Zoe Bunting

72. Zoe Bunting has been a registered mental health nurse since 1997, holding a range of clinical and managerial roles in that time for NEPT and then EPUT for around 29 years. She worked as Ward Manager of the Ruby Ward at the Crystal Centre, Chelmsford, an older adult inpatient mental health ward between 2016 and 2020, and thereafter as Ward Manager and Acting Matron at the Peter Bruff Assessment Unit until 2024. She is currently a Professional Nurse Educator at EPUT.

73. Chair, you have allowed Special Measures to enable Ms Bunting to give evidence in the most effective way to assist you with your Inquiry. She will provide her evidence outside of the hearing in a pre-recorded session, which the Inquiry intends to play next week.

74. Ms Bunting will give evidence about her experience working in NEPT and EPUT. She will provide her views on the assessment process. She will describe how

admission decisions were often heavily influenced by bed capacity constraints and systemic pressures, rather than being driven by purely clinical need.

75. Ms Bunting's evidence will touch upon the assessment of falls, a key issue arising from the death of Doris Smith. She will also explain how she was asked to complete the Patient Safety Incident Response Framework ['PSIRF'] investigation into the death of Christopher Nichols without having received training, and how she found that extremely challenging.

76. Ms Bunting will provide evidence about various ward environments expressing her view that the Peter Bruff Unit was not *"fit for purpose"*. She will touch upon her experience of training around Oxevision, which was not immediately available to her on joining the Peter Bruff Unit with little by way of guidance.

Brian O' Donnell

77. Brian O'Donnell is currently employed by EPUT as the Clinical Lead for Compliance and Assurance. He was previously the Clinical Lead for the St Aubyn's Centre, a Child and Adolescent Mental Health Service ['CAMHS'] Unit in Colchester. Mr O'Donnell has worked in CAMHS throughout his career. He initially began working as a Healthcare Assistant in 2003 working mostly on Longview Ward (NEPT) before qualifying as a registered mental health nurse in 2009. He returned to Longview Ward as a registered nurse. In 2014 he became the Ward Manager of Larkwood Ward, a CAMHS Psychiatric Intensive Care Unit ['PICU']. In 2020, he moved back to the Longview Ward as a Ward Manager.

78. Mr O'Donnell will give evidence about the working conditions for staff on CAMHS wards including training, internal recruitment, staffing levels, admission decisions, patient observations and the use of Oxevision. He will also give evidence of his experience on adult wards, and his views on culture and leadership at the Trust. Mr O'Donnell's evidence touches upon the deaths of Rebecca Watkins, Charlotte

Cobbold, Madison Naylor, Molly-Ann Sargeant, Antonia Trapani and Elise Sebastian.

Stuart McGough

79. Stuart McGough is also a retired registered mental health nurse. He worked in mental health settings in Essex between August 1999 and December 2008.

80. Mr McGough will give evidence about his experience of mental health inpatient care in Essex, and, in particular, his experience of working at the Linden Centre where he held the role of Clinical Manager and oversaw Galleywood and Finchingfield wards. He will speak to ward environment and refer to staffing and the reliance placed on agency and bank staff. He will give evidence about the management support in place for staff, including when they were undertaking investigations.

81. Mr McGough has also been granted Special Measures and will give his evidence as a virtual pre-recorded session next week when the Inquiry is not sitting. The Inquiry intends to play his evidence the following day.

Louise Borton

82. Louise Borton is a registered mental health nurse. Her first role as a Staff Nurse was in October 2016 on the Cedar Ward at Rochford Hospital. She has worked in Ward Manager and Matron roles at Basildon Mental Health Unit since 2018. She will give evidence of her experience of working within EPUT and its predecessor, SEPT.

83. Ms Borton's evidence will touch upon risk assessments and the lack of access to appropriate services for those with co-morbidities, including drug and alcohol dependency. She will describe how physical changes to the ward environment (in particular the move from dormitory to single rooms) has led to improvements in privacy, dignity, safety and respect for personal space better supporting recovery. Her evidence will touch on the barriers to treating those living with Emotionally

Unstable Personality Disorder ['EUPD'] and obstacles in the process of transferring patients, which, in her experience, persisted after the recommendations arising from the death of Bethany Lilley. She will speak about the difficulties in updating patient records and how in practice care plans were often treated as an administrative requirement rather than a dynamic clinical tool. She will give evidence about her experience of the use of the Oxevision system which she states "*negatively impacted inpatient mental health care*", and about ward culture, which she states was *"not consistently positive"*.

Beverley Switzer

84. Beverley Switzer is a healthcare assistant with over ten years' experience. She will also provide her evidence by way of a pre-recorded session. Ms Switzer has worked within EPUT Community Dementia Services since 2022. Prior to this, she worked on the Peter Bruff Unit from August 2020. Ms Switzer will give evidence about her experience of working within EPUT, touching on ward environment and facilities, observations and the use of Oxevision, staffing, training, and her experience of serious incidents and the response to those incidents.

Dispatches Undercover Reporter

85. Chair, you will recall that on the first day of the Inquiry's hearing in April 2025, the Inquiry played the Channel 4 Dispatches documentary 'Hospital Undercover: Are Our Wards Safe?' That documentary shed light on practices across four wards within EPUT. Dawn Low was the undercover reporter who appeared in that documentary.

86. As part of her deployment undercover, Ms Low worked as a Healthcare Assistant during a two-month period from 5 April 2022 to 8 June 2022. She undertook shifts in the Willow Ward, Rochford Hospital, the Mental Health Urgent Care Department in Basildon Hospital, Cherrydown Ward in Basildon Mental Health

Unit and Galleywood Ward in the Linden Centre. She will give an account of her experience whilst working undercover which includes evidence of:

a. Repeated ligature attempts and self-harm incidents;
b. Reductions in observation levels, where she did not see the rationale or risk assessment process underpinning the decision;
c. Staffing shortages affecting patient safety decisions;
d. Agency staff sleeping during observations, failing to react to ligature attempts and using mobile phones whilst supervising high-risk patients;
e. The induction, briefing and training of agency staff;
f. Lack of access to patient risk information;
g. Inconsistent approaches between wards regarding environmental safety and supervision;
h. Poor communication between staff;
i. Absence of effective management visibility and oversight;
j. Unsafe access to ligature and self-harm materials;
k. Inaccurate or copy-and-pasted patient records;
l. Concerns regarding whistleblowing culture;
m. Allegation of sexual assault by staff at another EPUT site;
n. Concerns regarding staff exhaustion and morale;
o. Examples of potentially stigmatising or clinically inappropriate staff comments;
p. Concerns regarding absconsion procedures and post-incident review;
q. Concerns regarding whether observations were actually completed despite entries stating they were;
r. Comparative observations about different wards.

87. Chair, Ms Low will give evidence to the Inquiry in person on Thursday this week, however you have directed that her evidence be live-streamed and broadcast via YouTube in audio-only format.

Resuscitation and Emergency Response

88. Chair, in March of this year, having heard a number of accounts given by Bereaved Families, and having considered concerns raised by Core Participants in submissions, you directed your team to look closely at issues relating to the resuscitation of patients and emergency response on mental health inpatient units, and to do so without delay.

89. Some of the evidence the Inquiry has already heard gives rise to serious questions about clinical response, emergency decision-making, and the adequacy of resuscitation practices and procedures, past and present, within mental health inpatient settings. You determined that this was an emerging area of investigation with potential implications for the safety of current patients. You considered that it was important to begin exploring these issues straight away and that is what your team has done. Given that you were concerned about the risk of harm to current patients, you directed that the Inquiry focus on current and recent practices in order to help you identify quickly whether there is need for more immediate change in this area.

90. On Monday 20 July 2026, as timetabled, the Inquiry will provide a more detailed update on the work it has done on this standalone topic. The Inquiry has already disclosed a significant quantity of material, including some of the Case Summaries of the illustrative cases which reflect these issues. We will also provide an overview of our proposed next steps during that update.

91. The Inquiry will also hear evidence on Monday 20 July from Adam Benson-Clarke who is the Director of Clinical and Service Development at the Resuscitation Council UK ("RCUK"). RCUK issue resuscitation practice standards and guidance for the healthcare sector in the UK, including specific standards and guidance for mental health inpatient units. Mr Benson-Clarke will explain what cardiac arrest is and give an overview of how it is treated, including cardiopulmonary resuscitation

['CPR'] and the use of automatic external defibrillators. He will explain the development and application of RCUK's Quality Standards for CPR, training, equipment, and drugs on mental health inpatient wards, covering what RCUK consider to be obligatory, normal and best practice.

Observations and the Use of Technology (including Oxevision)

92. Chair, The Inquiry's investigation into practices surrounding observations and the use of technology continues. This builds upon the evidence we heard last October.

93. At the hearing last October, the Inquiry heard evidence which raised material concerns about the use of Oxevision. These included:

    (i) whether Oxevision's stated purpose aligns with its actual use at EPUT;
    (ii) the adequacy of consent and capacity processes;
    (iii) the risks of harm arising from the use of the system, including escalation of self-harm;
    (iv) the adequacy and operability of EPUT's governance, training and Standard Operating Procedures ['SOPs'];
    (v) whether Oxevision is being used covertly or informally as a substitute for required staffing or in-person observations; and
    (vi) whether its use complies with the relevant data protection legislation.

94. More broadly, the Inquiry has continued to investigate the role of observations and therapeutic engagement in the care of mental health inpatients in Essex, as well as providers' deployment of technology intended to assist in the delivery of that care.

95. As part of our investigations, the Inquiry has sought to understand how Oxevision has been used at trusts outside Essex so as to provide important context to the evidence we have heard. The Inquiry has therefore obtained evidence from a number of other NHS trusts who use Oxevision in order to assist us in our

assessment of how the system has been implemented, governed and used in practice across different settings. The comparator evidence is intended to assist the Inquiry in assessing whether issues arising from the evidence concerning EPUT are trust-specific or whether they are reflected more widely in the implementation and use of Oxevision elsewhere. It also helps us understand whether other trusts have taken a different approach to that in Essex.

96. The comparator trusts were selected on the basis that they were capable of assisting that exercise. We will hear from two of those trusts. One, Tees, Esk and Wear Valleys NHS Foundation Trust ['TEWV'], have deployed Oxevision widely on their inpatient mental health wards. The second, Leicestershire Partnership NHS Trust, trialled Oxevision but declined to roll out the system thereafter. In the third week of this hearing, the Inquiry will hear evidence about those trusts' particular experiences.

97. In addition, in the last two days of this hearing, the Inquiry will hear evidence from two expert witnesses. Firstly, Jill Archibald will provide evidence as to expected practices in respect of observations and therapeutic engagement, and also the role technology can play in patient care. Secondly, Professor Donnolly and Ms Maria Christodoulou will provide expert evidence looking at the strength of the academic literature supporting the use of Oxevision, as well as providing important context about the design of medical studies, and the limits on their interpretation.

98. Chair, this is a second area where you have indicated that you wish to explore whether there is need for more immediate review and/or change. You have therefore directed your team to focus on obtaining the evidence required on this topic to ensure you are fully informed.

Witness Statements

99. As with previous hearings, the witness statements and expert reports provided for this hearing by those attending to give oral evidence, will stand in full as their evidence. Statements will not be read out during the course of the hearing - rather the witnesses will be asked careful and focussed questions about what they have written and about topics they can assist with.

Publication

100. 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. There are three main categories where redactions may be applied:

    a. Staff Names - staff names, including those of junior staff, will generally be disclosed in the course of the Inquiry. Individuals can apply for their names to be withheld however, in line with relevant law and the Inquiry's Protocol on Restriction Orders. Each application for a Restriction Order is considered individually by you, Chair. Some staff may need time to decide whether to apply for anonymity and to seek legal advice. While they are given this time, their names will be redacted temporarily. This ensures fairness. To be clear, in many cases, those redactions are likely to be temporary only.

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

    c. There is other information which may fall under the Inquiry's Privacy Information Protocol - this will be information which is personal in

nature and which you, Chair, do not consider relevant and necessary to be made public. This would include details such as someone's address, or other personal sensitive information.

Achieving Best Evidence and Inquiry's Protocols

101. Finally, can I also remind those following and engaging with the Inquiry that we have in place various further protocols. This is with the aim of assisting those who wish to engage with the Inquiry in providing the best possible evidence, in a way that also ensures they are supported throughout the process. All documents are accessible on the Inquiry's website and kept under review. Chair, you have a wide discretion to put in place measures to support witnesses giving evidence. I have already referred to the Special Measures that have been granted to various witnesses at this hearing. The Inquiry will continue to work with witnesses and their legal representatives to take an individualised approach as far as is reasonably possible.

Timing

102. I move now to the timetable. The Inquiry will sit on Monday to Thursday for all 3 weeks.

103. For this hearing, we will generally start at 10am and finish around 4.30pm, although sometimes it may be necessary to finish later. There will be a short break in the morning and in the afternoon in which teas and coffees will be provided for those who are attending. There will be a one-hour break for lunch each day. This is all subject to the need for the Inquiry to proceed flexibly and take more breaks or make other arrangements as required to support witnesses.

Livestream

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

THE NATIONAL PICTURE

105. As the work of the Lampard Inquiry progresses Chair, the size of our task continues to grow exponentially. This is because, as you have already stated, it is becoming increasingly clear that the serious concerns and systemic issues we are investigating are unlikely to be individual to Essex, and the work of the Lampard Inquiry will be of national importance. It is for this reason that the Inquiry is increasingly looking to achieve meaningful comparisons with other trusts across the UK. Whilst the Inquiry must apply serious scrutiny to practices in Essex, how do those practices really differ to what goes on elsewhere?

106. The Lampard Inquiry awaits news of the statutory inquiry into the Tees, Esk and Wear Valleys NHS Foundation Trust ['TEWV'] to which you have referred, with particular interest. The Inquiry notes from the material available, that the serious concerns and systemic issues to be investigated in relation to those who died under the care of TEWV, are likely to mirror very closely those we are already examining in relation to those who died under the care of Trusts in Essex. They are clearly national concerns and issues. As previously outlined, the Lampard Inquiry will hear evidence from the Director of Nursing and Quality at TEWV in the third week of this hearing.

107. Furthermore, the Lampard Inquiry has been following closely the evidence given at the Nottingham Inquiry. The Nottingham Inquiry is seeking to understand the events, acts and omissions that led to Valdo Calocane brutally killing three individuals and seriously injuring three others. Prior to those attacks, Valdo

Calocane interacted with mental health services. The serious concerns and systemic issues that appear to have given rise to the tragic events in Nottingham, particularly those relating to poor care planning, treatment and management of those with serious mental illness, echo the concerns and issues emerging in the Lampard Inquiry. We also note that there has been similar criticism about the way in which the Trust in Nottingham responded to concerns raised. We note that Sir Rob Behrens provided markedly similar evidence to the Nottingham Inquiry as that which he provided to the Lampard Inquiry; referencing lack of candour and defensiveness on the part of NHS trusts.

108. Furthermore, the Lampard Inquiry has reviewed with care the recently published Report of the Muckamore Abbey Hospital Inquiry. Whilst, as you say Chair, the Recommendations of the Muckamore Inquiry are limited to Northern Ireland, it is striking once again to read that a significant number of the systemic failures identified by that Inquiry are the same alleged systemic failures that we are investigating within Trusts in Essex.

109. Systemic issues in inpatient mental health care are very evidently a national problem. Recommendations made by the Lampard Inquiry will inevitably include national recommendations. Against this background Chair, we do not underestimate the importance of our work, nor our responsibility to bring about lasting change.

110. And it is clear Chair, that change is still very much needed. As part of its work for example, the Inquiry will hear evidence, amongst other matters, about historic issues on Ardleigh Ward at the Lakes in Colchester. It was with real disquiet therefore that the Inquiry learned of very recent CQC concerns relating to Ardleigh Ward following an unannounced inspection in January this year.

Future Hearings and Beyond

111. Chair, as previously outlined, you have directed your team to examine issues relating to resuscitation, and issues relating to observations and the use of technology, without delay. You have also determined that you wish to conclude your investigation into these topics in 2026, after which you will determine whether the evidence you have heard requires you to consider making interim recommendations.

112. As a consequence, you have directed that the hearing in Chelmsford listed for October this year be re-framed as the Interim Recommendations Hearing. Arrangements for that hearing, including proposed opportunities for Core Participant engagement will be circulated after this hearing.

113. The Inquiry will therefore commence its substantive hearing programme examining thematic issues in January 2027. A revised timetable will be circulated as soon as it is available. This revision to the Inquiry's hearings plan will provide an opportunity to EPUT and other material providers to demonstrate consistent and timely compliance with evidential requests. The revision will also allow the Inquiry to develop further its system of disclosure outside of hearings, enabling Core Participants to review material for hearings next year in slower time.

CONCLUSION

114. Chair, the aim of this Inquiry is to bring about the long-awaited and greatly needed improvements to impatient mental healthcare both in Essex, and beyond. As I said at the outset of this statement Chair, your team remains committed absolutely to assisting you with this task and will continue to work without let up towards that aim.

115. Whilst the mental health landscape is changing in the UK, there is a considerable way to go. This Inquiry welcomes all work being undertaken locally or nationally towards positive change. We were pleased last month for example, to read the

Interim Report of the Independent review into mental health conditions, ADHD and autism, which whilst not yet reaching conclusions, provides an update what they have learned so far and their plans for the next phase of that review. The evidence being explored by that Review dovetails with the important issues that we are investigating; issues which will feature again during the course of this hearing.

116. Chair, the purpose of this Inquiry is to make recommendations for that long-term change, and for this we remain committed to our Recommendations and Implementation Forum. This Inquiry is focused not only on making meaningful recommendations but also on achieving their implementation going forward.

117. A written version of this Opening Statement will shortly be available on the website.

REBECCA HARRIS KC

Deputy Counsel to the Lampard Inquiry