Monday, 6 July 2026

(10.00 am)

(Proceedings delayed)

(10.03 am)

Opening remarks by THE CHAIR

THE CHAIR: Good morning.

Good morning, and welcome to this July hearing, to all those who are following these proceedings virtually, and to everyone joining us here in person at Arundel House in London.

This hearing, which begins today, will finish in three weeks' time on 23 July.

To the bereaved families and to all those affected by the issues which I'm investigating, I wish to reassure you that you remain at the very heart of this Inquiry's work. The evidence you have given is central to the Inquiry's understanding of the key issues and concerns within the scope of our work, and I am grateful to all, for the moving accounts, and for all your time and considerable efforts in engaging with the Inquiry.

During April and May, my team recorded further oral evidence sessions with more families. In addition, since our last public hearing, I've received further written statements from other families. I've read all the statements that were provided to the Inquiry, and

I have watched all recorded evidence sessions carefully, and in full.

Having reviewed the family witness statements provided earlier this year, I have invited further family witnesses to give evidence at this hearing. I consider I will be assisted by hearing about their experiences and recollections of the mental health inpatient care received by their family member.

I am very grateful to them for their time and for their courage in sharing their accounts.

Family evidence is the starting point for the case summaries that are being produced by my team. These case summaries set out, in summary form, what the Inquiry understands happened in each of our illustrative cases and identify the issues emerging and family concerns, where those are known.

I would like to stress that these case summaries do not in any way replace the statements or oral evidence provided to this Inquiry by bereaved families. As I say, every family account is read very carefully and reviewed in its full form by me and my team. Those full accounts are the evidence that will form the record of this Inquiry, and provide the basis for our further investigations.

The case summaries are neutral, and are useful

documents because they help me and the wider Inquiry team to focus on the key issues raised in each case in a proportionate and focused way. I've found the case summaries very helpful. They're intended as a proportionate and effective method by which to investigate systemic issues. They provide a way for my team to distil large quantities of very complex information relating to individual cases into a format from which we can progress our work.

I will now briefly outline the evidence to be covered at this hearing, although we will shortly hear an opening statement from Deputy Counsel to the Inquiry, Rebecca Harris KC, who will speak in more detail about the evidence for this hearing.

In April this year, I announced that there would be a change of focus for this hearing.

Having read all of the family witness statements received to date, and having listened to many family accounts, I reflected on the urgent concerns raised by some Core Participants and their legal representatives about the use of technology on inpatient wards, and current practices around resuscitation, and I directed my team to explore those issues in detail without delay.

As things currently stand, I share some of those concerns, and therefore directed that as far as

possible, evidence in respect of those themes should be heard during this July hearing.

On the practice of observation and the use of technology on inpatient mental health wards, this Inquiry has already received extremely informative evidence at previous hearings. In the last week of this hearing, we will build further on our understanding of the use of technology on mental health inpatient units, exploring the topic through an evidence-led examination of the issues, including the continued use of Oxevision.

We will also start hearing evidence in relation to emergency response and resuscitation practices on mental health inpatient wards.

A number of the accounts that we've heard from families and illustrative cases being investigated by my team involve issues relating to resuscitation. I am concerned that current practices and procedures in relation to resuscitation may give rise to ongoing patient safety issues, and they therefore require urgent consideration.

I have directed that evidence on these topics be heard during the next three weeks, and that the Inquiry return to them again during our October hearing.

I will then consider in detail the evidence heard during this hearing and the hearing in October, along

with any other relevant evidence to inform my decision on whether I may consider making interim recommendations on these areas of concern.

I'll be assisted by submissions from Core Participants on these topics, and I intend to invite those in due course.

From Wednesday this week, we will also begin hearing evidence from members of staff who have worked within organisations providing mental health inpatient care in Essex. This will be the first time that the Inquiry has heard evidence from staff witnesses. Considering the challenges experienced by my predecessor in securing staff engagement during the Inquiry's non-statutory phase, I'm very grateful to the staff witnesses who have come forward to assist the Inquiry.

Giving evidence to a public inquiry can be a challenging experience, especially when talking candidly in public about difficult and challenging situations. Staff experience of the issues the Inquiry is investigating is very important. As an independent Inquiry, it's crucial that we gather a wide range of views and perspectives, listening to all those who can shed light on what went wrong as well as what went well, and from those who can tell us what happens currently in inpatient care.

In order for the Inquiry to obtain the best information and evidence possible, every witness must be given the opportunity to be heard and everyone attending or engaged in these hearings must be afforded respect throughout.

I therefore ask that those attending listen quietly to the evidence we will hear over the next three weeks. There are to be no disruptions or disturbances of any kind. Mobile phones must be switched off within the hearing room, and no recording or filming devices of any kind may be used. I thank everyone in advance for their cooperation with this.

The Inquiry is dealing with the most sensitive of subjects which are understandably distressing to many. I encourage us all to remember this and ask that we treat everyone involved in this Inquiry with courtesy at all times, whatever their role.

The Inquiry places the wellbeing of all those engaging with it at the centre of its work. I wish to remind everybody that emotional support services are available. Anyone who needs assistance during the hearing should please contact my Inquiry Team who will help them access this support.

I wish to talk briefly about participants' cooperation and engagement with the Inquiry and some of

the very significant challenges that we've been facing on this front. The Inquiry's Terms of Reference require me and my Inquiry Team to undertake a thorough investigation of the systemic issues and failings relating to the deaths of mental health inpatients in Essex between the years 2000 and 2023, a period of 24 years. I recognise that the scale of this Inquiry's task and the extensive remit of our Terms of Reference mean that we're asking for a great deal of information from relevant material providers.

Some of the providers we've sought information from, including the main NHS trust in Essex, EPUT, have struggled with answering our requests for information for a number of reasons and have requested extensions of time by which to comply. This is partly owing to the breadth of the issues we're investigating and the 24-year time period over which we're seeking the information.

So far I've issued 14 formal legal orders, known as Section 21 Notices, to corporate stakeholders. These notices compel the relevant organisation to provide evidence and documents to the Inquiry.

Deputy Counsel to the Inquiry, Rebecca Harris KC, will shortly provide more detail about those challenges and how they will be further explored during this

hearing.

The Inquiry aims to work closely and constructively with all those who provide evidence to us. This includes establishing an effective working relationship with all relevant trusts, providers, and other stakeholders, and in particular with the main provider, EPUT and its Senior Leadership Team.

The Inquiry has worked hard over many months to establish that working relationship. The aim is always to progress the important work of this Inquiry.

I was very saddened to hear of the very recent death of Hattie Llewelyn-Davies, Chair of the EPUT board. I wish to express my condolences to her family, all those who worked with her, and others who were touched by her death.

I also wish to mention, for anyone who may have missed the EPUT announcement earlier this year, the departure of previous Chief Executive Officer Paul Scott. We understand that Mr Scott will now take over as CEO at East Suffolk and North Essex NHS Foundation Trust this month. We're seeking assurances from EPUT that their cooperation and engagement with this Inquiry will be unaffected as we will continue our important work with Mr Scott's replacement.

I anticipate that we will hear more about this in

evidence from the witnesses this afternoon and tomorrow morning. Furthermore, I will not hesitate to ask Mr Scott to return to give evidence at future hearings, should I consider such evidence to be necessary.

The size of this Inquiry reflects the complexity, importance, and relevance of the systemic issues we're investigating.

I am waiting until I hear all the evidence before drawing any firm conclusions, but from the evidence that that's been presented to me so far, it appears that issues arising are not confined to Essex.

Whilst our investigations quite rightly centre on Essex and the mental health inpatient care provided there from the year 2000 to the end of 2023, it's highly likely that many of the systemic issues identified will be pertinent to our current healthcare system more widely and that my findings and recommendations will be of national relevance, applying to mental health inpatient care in all areas of the country.

My view that these are likely to be national issues is supported by the fact that systemic failings in mental health inpatient care are being identified in other parts of the country too.

Failings in mental health inpatient units have been reported widely around the country, including

Northampton, Sheffield, Nottingham and Manchester, to name just a few.

The Government has established other locally focused investigations relevant to mental health inpatient care, including the Southport Inquiry and the Nottingham Inquiry. In addition, the Health Secretary announced in December a statutory Inquiry into the mental health services at Tees, Esk and Wear Valleys NHS Foundation Trust, and just last month, the final report was published by the Muckamore Abbey Hospital Inquiry, which investigated the abuse by staff of patients with learning disabilities, autism, and mental ill health at the largest hospital in Northern Ireland.

To me, this demonstrates that there's a need to improve mental health care not just in Essex but across the UK.

I am mindful of the need to learn what we can from other relevant inquiries and investigations. I'm keenly interested in the very recent report from the Muckamore Abbey Hospital Inquiry. Although its recommendations are limited to Northern Ireland, the systemic issues raised in that report are similar in nature to the issues we're discovering through our investigations in Essex.

I've asked my team to consider what we may learn

from the findings and recommendations made in other reviews and inquiries into mental health care and their potential relevance to our work.

In the same manner I anticipate that the findings and recommendations from the Lampard Inquiry will have direct relevance to, and be taken account of, by inquiries and reviews that follow us, such as the Tees, Esk and Wear Valleys Inquiry.

The recommendations are also likely to be applicable not just in Essex, which was our key focus, but also to mental health providers right across the country. For this reason, it's important, wherever possible, that my recommendations are national as well as local in scope. By understanding what happened, I can make recommendations to help ensure that the same failings do not happen again in Essex or in the rest of the country.

I will now hand over to Deputy Counsel to the Inquiry, Rebecca Harris KC. Before doing so, I wish once again to thank all those who will be giving evidence to this hearing, and all those who gave evidence via recordings during April and May. I am grateful for their participation, their time and their candour.

Ms Harris.

Opening submissions by MS HARRIS KC

MS HARRIS: Thank you, Chair.

Chair, 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 the 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, and we will also explore topics of immediate concern.

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 members' 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.

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 -- mental health 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 who are watching online.

As we've 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, listening, the opportunity to decide whether they wish to engage with that evidence. And the timetable for this hearing is also on the Inquiry's website.

I'd like to reiterate, as you did, Chair, that emotional support is available to anyone engaging with the Inquiry. The wellbeing of those participating is extremely important to the Inquiry.

Anyone in this hearing room is welcome to leave at any point. We have two support staff here from Hestia, an experienced provider of emotional support services. They're here today and for each day of this hearing. There's a private room where you can talk to Hestia support staff if you require emotional support at all throughout the 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'll put you in touch with them. We are all wearing purple-coloured lanyards.

If you're 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.

We want all of those engaging with this Inquiry to feel safe and supported.

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.

Chair, there will be a number of the Counsel to the Inquiry team involved in this hearing. This afternoon you will hear from lead Counsel to the Inquiry, Nicholas Griffin King's Counsel. 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.

The Counsel to the Inquiry team works closely with the Inquiry Team 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.

Chair, you are also assisted by the recognised legal representatives and counsel teams for the Core Participants and others. A list of that representation will be available on the Inquiry's website.

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 team's representing bereaved families and those representing healthcare providers and other Core Participants. We also meet with many other stakeholders as required.

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.

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

Chair, the Lampard Inquiry has made very significant progress in 2026. And whilst the scale of the task remaining should not be underestimated, 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.

The opening statement or this opening statement will therefore provide an update on some of the Inquiry's progress before I will turn to the evidence to be explored during this hearing.

The Inquiry continues to engage with the families and the 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. And 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, and have done so again today, 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 recorded evidence session be arranged for a fourth.

Furthermore, in April this year, the Inquiry heard from ten more families who provided their firsthand 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 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've already confirmed today that you've watched all of those recorded sessions in full, and 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 because once again,

we do not underestimate how difficult those sessions were for those families involved.

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 that statement of approach.

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, closely working with legal representatives and support services to ensure that appropriate support, reasonable adjustments, and special measures are available where required.

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.

Chair, you remain grateful to all those who have engaged with this process and recognise the important contribution that lived experience can make to the

Inquiry's understanding of the systemic issues affecting mental health inpatient care in Essex.

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 this year 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, such as those with His Majesty's Coroner, Essex Police, and some of the healthcare regulators.

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 a matter of fact to each particular case in order that they can provide their comments and views.

On your direction, Chair, the Inquiry has identified two additional themes which you consider merit separate consideration, and which capture better the emerging issues in certain illustrative cases. And these changes underline the need for the Inquiry's flexible approach during what is an iterative process. The annex to the statement of approach has been updated accordingly.

Firstly, there is 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 has been admitted to an inpatient unit.

And 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.

Chair, you made reference in your opening statement to the summaries of the Inquiry's illustrative cases which are being prepared as part of the Inquiry's investigative work and I would like to reiterate that the starting point for the investigation of every

illustrative case is the firsthand account and the 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 then identify and set out clearly each family's concerns.

And 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've 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 it forms a vital part of the Inquiry's evidential record.

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 the 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.

Twenty-four 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 of 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.

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 changes and questions relating to the provision of mental health inpatient care more widely, where you require expert assistance to navigate the matters arising.

Last year, after liaison with Core Participants, the Inquiry published its protocol on the role and instructions 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 thematic issues. 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 intents to instruct Dr Chloe Beale, consultant psychiatrist, to provide expert opinion on this topic.

Chair, you've repeatedly stated that you wish to consider the range of available opinion in this area and your team continues to explore ways in which that might be achieved.

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.

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 sending out of requests for evidential -- evidence crucial to the investigation of our illustrative cases and to the exploration of 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 arm's-length bodies and as I say, the scale of the task should not be underestimated.

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 already exercised your statutory powers to compel the provision of evidence where necessary and, as you have already stated, have issued 14 Section 21 Notices requiring certain stakeholders to provide relevant material without delay.

Corporate work, taking place alongside the hearing's preparation includes, but is not limited to, review of previous investigations, reviews, inquest findings and Prevent Future Deaths Report to track recommendations, collation of evidence relating to IT systems and information sharing and progress with the Inquiry's governance piece.

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 under way. 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.

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 manner.

This has been the case with EPUT in particular, about which I'll provide more detail later in this opening statement. But 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 inquiry, providing relevant material to experts, finalising a disclosure scheme, along with planning and preparing for hearings and so on.

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 and I will also provide information about future hearings at the conclusion of this statement.

But the Inquiry remains committed to ensuring that its request 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 you and I have already 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.

Chair, in October of last year, the Inquiry reported that following clarification to its definition of "inpatient", we had invite the main healthcare providers within the scope of this Inquiry to revisit and resubmit

their lists of those who had died whilst under their care in the relevant period.

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 the 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 to us by the end of this month.

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. But 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.

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 have been revealed. She is currently awaiting the outstanding information from EPUT so that she can complete her work in this regard.

But notwithstanding the wait for the Lists of Deceased, the Inquiry still has made progress where it can. On Professor Donnelly's advice in relation to further data that could be of assistance the Inquiry has reached the following agreements: with NHS England to secure the Mental Health Services Dataset, which we understand will provide the best source of denominator data, and with the National Confidential Inquiry into Suicide and Safety in Mental Health, NCISH, to share anonymous aggregate data.

And 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 provided those lists

to Professor Donnelly, we intend to return to the arrangements for our previously announced data discussion.

Professor Donnelly and her team have provided assistance to the Inquiry in other important ways in the meantime, however, and 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.

Chair, 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 cooperation 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.

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 of them 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 the 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's necessary to do so to explore whether there are systemic issues at play.

Following the 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 more anticipated in the coming weeks and months, and the Inquiry intends to continue with this staff engagement work.

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 workplace repercussion should they give evidence about colleagues and employers, but also because they fear professional repercussions should they now provide evidence that could have been provided before. We hope that when they see that their colleagues have assisted

the Inquiry, they too will be encouraged to come forward.

Chair, as you have already alluded to, this hearing marks the first occasion on which those who work or who 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. And 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.

Let me move now, please, to say a few words about this hearing, which runs from today until Thursday, 23 July.

Over the next three 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 who 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 in the use of technology.

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: 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.

On 19 September last year, the Inquiry requested a Data Assurance Statement from EPUT and this request sought confirmation from EPUT, amongst other matters, that their Inquiry Project Team was appropriately resourced, 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 didn't 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.

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. This was, to a large extent, a request for further information following the evidence given by Dr Karale during the Inquiry's hearing in April last year. 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 the 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.

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 and for reflections and learning.

Counsel to the Inquiry, Mr Griffin King's Counsel, 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 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. 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 of this year.

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.

Chair, as you have said, 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.

As for previous hearings, the Inquiry has invited the family witnesses to give evidence of their firsthand accounts, observations, recollections and concerns. And we've 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.

Over the course of this week and next, the Inquiry will hear 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 April 2021 aged 63.

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 -- 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 recordkeeping, including falsified observation records, and the mixing of records of patients; inadequate or non-existing training for staff on autism; and 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.

Chair, I note we've been going for just over an hour and there is a little way to go. Would that be a convenient moment for a break?

THE CHAIR: If that suits you.

Ten minutes?

MS HARRIS: I think to return at 11.30. Thank you.

THE CHAIR: We'll return at 11.30.

(11.02 am)

(A short break)

(11.33 am)

THE CHAIR: Ms Harris.

MS HARRIS: Thank you again, Chair.

Chair, as you and I leave already outlined, this hearing marks the first hearing at which we will hear evidence from 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.

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.

Mr Ayris raises concerns about the culture at EPUT

and its predecessor trust, North Essex Partnership University NHS Foundation Trust, NEPT. He reports understaffing, overuse of medication, disjointed approach to physical 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's evidence also touches upon the deaths of Diana Hammond, Ben Morris, and Glenn Holmes.

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 and the Linden Centre.

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 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.

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

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.

Chair, you have allowed special measures to enable Ms Bunting to give evidence in the most effective way to assist you with the Inquiry, and she will provide her evidence outside of the hearing in a pre-recorded session which the Inquiry then intends to play next week.

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.

Ms Bunting's evidence will also touch upon the assessment of falls, which is 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 investigation into the death of Christopher Nichols without having received training and how she found that extremely challenging.

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 is currently employed by EPUT as the Clinical Lead for Compliance and Assurance. He was previously the Clinical Lead at the St Aubyn's Centre, a Child and Adolescent Mental Health Service, a 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, which is 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, and in 2020 he moved back to the Longview Ward as a Ward Manager.

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 is also a retired Registered Mental Health Nurse. He worked in mental health settings in Essex between August 1999 and December 2008. 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.

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

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 also give evidence of her

experience of working within EPUT and its predecessor, SEPT. Ms Borton's evidence will touch upon risk assessments and the lack of access to appropriate services for those with comorbidities, 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 upon the barriers to treating those living with emotionally unstable personality disorder, EUPD, and the 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 her experience -- sorry, her evidence about her experience of the use of Oxevision, which she states "negatively impacted inpatient mental health care" and about ward culture, which she states was "not consistently positive".

Beverley Switzer is a Healthcare Assistant with over

10 years' experience. She will also provide her evidence by way of a pre-recorded session to be played thereafter. 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 in the use of Oxevision, staffing, training, and her experience of serious incidents and the response to those incidents.

Chair, you will recall that on the first day of the Inquiry's hearing in April 2005, 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.

As part of her deployment under cover, 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 under cover, which includes

evidence of: repeated ligature attempts and self-harm incidents; reductions in observation levels where she did not see the rationale or risk assessment process underpinning the decision; staffing shortages affecting patient safety decisions; agency staff sleeping during observations, failing to react to ligature attempts, and using mobile phones whilst supervising high-risk patients.

She will give evidence of: the induction, briefing, and training of agency staff; about the lack of access to patient risk information; the inconsistent approaches between wards regarding environmental safety and supervision; poor communication between staff; absence of effective management visibility and oversight; unsafe access to ligature and self-harm materials; inaccurate or copy-and-pasted patient records; concerns regarding whistleblowing culture; an allegation of sexual assault by staff at another EPUT site; concerns regarding staff exhaustion and morale; examples of potentially stigmatising or clinically inappropriate staff comments; concerns regarding absconsion procedures and post-incident review; concerns regarding whether observations were actually completed despite entries saying that they were; and comparative observations about different wards.

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.

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.

Some of the evidence that 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 a need for a more immediate

change in this area.

On Monday, 20 July, 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 on Monday, 20 July.

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 for short. RCUK issues resuscitation 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.

The Inquiry's investigation into practices

surrounding observations and the use of technology continues. This builds upon the evidence we heard last October.

At the hearing last October, the Inquiry heard evidence which raised material concerns about the use of Oxevision and these included: whether Oxevision's stated purpose aligns with its actual use at EPUT; the adequacy of consent and capacity processes; the risks of harm arising from the use of the system, including escalation of self-harm; the adequacy and operability of EPUT's governance, training and operating procedures; whether Oxevision is being used covertly or informally as a substitute for required staffing or in-person observations; and whether its use complies with the relevant data protection legislation.

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.

As part of our investigations, the Inquiry has sought to understand how Oxevision has been used at Trusts outside of Essex, so as to provide important context to the evidence that 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 the 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.

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

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. And secondly, Professor Donnelly and Dr Maria Christodoulou will provide expert evidence looking at the strength of the academic literature supporting the use of Oxevision as well as providing important contexts about the design of medical studies and the limits on their interpretation.

Chair, this is a second area, as you have already indicated, where you wish to explore whether there is a need for more immediate review or change.

You have, therefore, directed your team to focus on obtaining the evidence required on this topic to ensure you are fully informed.

As with our previous hearings, the witness statements and the expert reports provided for this hearing by those attending to give oral evidence will also 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 focused questions about what they've written and topics they can assist with.

Those witness statements will then be published on the Inquiry's website once each witness has given their evidence. And may I say once again for the avoidance of doubt and for clarity, that the copies of the statements

that are published will be redacted in line with the Inquiry's published approach, and there are three main categories where redactions may be applied and I'll set them out again for the record.

Firstly, 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, and some staff may need time to decide whether to apply for anonymity and to seek legal advice and while they're given this time, their names will be redacted temporarily. This ensures fairness. And to be clear, in many cases, those redactions are likely to be temporary only.

Secondly, methods of self-harm 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.

Thirdly, 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 somebody's address or other personal, sensitive information.

And finally, in terms of giving evidence, can I 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 ensures they are also supported throughout the process.

All documents are accessible on the Inquiry's website, and kept under review, and, Chair, you have a wide discretion to put in place measures to support witnesses giving evidence. I've already referred to the special measures that have been granted to various witnesses at this hearing and the Inquiry will continue to work with witnesses and their legal representatives to take an individualised approach as far as is reasonably possible.

Moving, then, to timetable, the Inquiry will sit on Monday to Thursday for all of the next three weeks. For this hearing we will generally start at 10.00 am and finish around 4.30 although sometimes it may be necessary to finish a little later.

There will be a short break in the morning, and in the afternoon, in which tea and coffee will be provided for those attending. There will be a one-hour break for lunch each day.

This is, of course, all subject to the need for the Inquiry to proceed flexibly, take more breaks, or make other arrangements as required to support witnesses.

It is, of course, 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 ten minutes.

Chair, as the work of the Lampard Inquiry progresses, 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 these practices really differ to what goes on elsewhere?

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, and 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.

Furthermore, the Lampard Inquiry has been following closely the evidence being given at the Nottingham Inquiry. The Nottingham Inquiry is seeking to understand the events, acts and omissions that led 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 issues 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.

Furthermore, the Lampard Inquiry has reviewed with care the recently published report of the Muckamore Abbey Hospital Inquiry to which you've already referred. 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.

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. And it is clear, Chair, that change is very much needed still. 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 learnt of very recent CQC concerns relating to Ardleigh Ward following an unannounced inspection in January this year.

Chair, as previously outlined by you, 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.

As a consequence, Chair, you have directed that the hearing in Chelmsford listed for October this year be reframed as the Interim Recommendations Hearing. Arrangements for that hearing, including proposed opportunities for Core Participant engagement to which you've already referred, will be circulated after this hearing.

The Inquiry will therefore commence its substantive

hearing programme examining its thematic issues in January 2027 and a revised timetable will be circulated as soon as it's available.

This revision to the Inquiry's hearings plan will provide an opportunity to EPUT and to the 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.

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

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.

Chair, a written version of this opening statement will be available shortly on the website, and that being the conclusion, that brings us to the end of this morning's session, and I understand, and would invite you to sit again at 1.30, please.

THE CHAIR: Until 1.30. Thank you.

(12.06 pm)

(The Short Adjournment)

(1.33 pm)

THE CHAIR: Mr Griffin.

PAUL SCOTT (affirmed)

Questioned by MR GRIFFIN KC

MR GRIFFIN: Would you provide your full name, please.

A. Paul Michael Scott.

Q. Mr Scott, were you, until the end of last month, Chief Executive Officer, or CEO of Essex Partnership University NHS Foundation Trust, EPUT?

A. Yes.

Q. Are you here today to give evidence in relation to a Position Statement provided to the Inquiry?

A. Yes.

Q. And is it correct that the Position Statement addresses concerns raised by the Inquiry about EPUT's failures to provide timely disclosure of documents and information requested by the Inquiry?

A. Yes, it is, yeah.

Q. Mr Scott, in relation to the Position Statement, did EPUT -- can you confirm this: did EPUT receive from the Chair a notice under Section 21 of the Inquiries Act 2005, and did it -- that notice was on 22 April of this year. Did it require EPUT to supply certain specified information in the Position Statement, and to do that by 26 May 2026?

A. Yes, it did.

Q. Thank you.

I'm going to ask for a document to be put up on our screen, please. Could you put up the first page of the appendix to the Section 21 Notice. This is INQY023625, thank you, and could you expand paragraph 2.

Here we see part, as I said, of the appendix that accompanied the Section 21 Notice. I just want to read this out by way of background:

"The Chair remains concerned that EPUT is not able to discharge its professional obligations to assist the Inquiry, and provide the evidence and information requested within deadlines set, including those deadlines proposed by EPUT itself. The Chair therefore requires EPUT to provide a Position Statement to explain, and to provide assurances in relation to:

"a. The failures to meet deadlines to date;

"b. The reasons for these failures, including the adequacy of resources dedicated by EPUT to meet the Inquiry's requests; and

"c. The steps that have been taken to mitigate these issues, identify ongoing risks and ensure that the future needs of the Inquiry will be met in time and with sufficient detail."

And can you confirm, Mr Scott, that over the 13 pages of the appendix, the Chair required EPUT address certain specific matters and concerns, namely

the lack of confidence in the assurances provided to date, the lack of effective search software, the use of technology and automated tools, delays in correspondence to Next of Kin of those who'd died, pre-merger limitations, resources dedicated to the Inquiry, extension requests and missed deadlines and late applications, senior leadership transition, and evidential continuity and, finally, reflections.

Can you confirm those are all amongst the areas to be covered in the Position Statement?

A. That's correct.

Q. Thank you. Could that go down, please.

And did you indeed provide a Position Statement dated 26 May this year aiming to address these points?

A. Yes, we did.

Q. Can I ask you this: did you write the Position Statement yourself in your capacity as CEO?

A. I didn't draft it myself; I contributed to the contents.

Q. So was it a combination of people assisting in producing the statement and you were one of them?

A. Yes.

Q. So did you have any additional role to that? Have you reviewed it very carefully?

A. Yes.

Q. Do you have it in front of you?

A. Yes.

Q. Is it 31 pages long?

A. Yes.

Q. Is there a Statement of Truth on the last page?

A. Yes.

Q. I'm going to ask that that's put up on our screens, as well, please. Could you put up page 31 of the Position Statement. Could you expand up to and including (d), please.

Now the Statement of Truth, does it say this:

"I Paul Scott, Chief Executive Officer of ... EPUT, make this witness statement on behalf of EPUT in response to the Section 21(5) Notice issued by the Chair of the Lampard Inquiry on 22 April 2026."

And does it go on to say that:

"I confirm that:

"(a) All reasonable steps have been taken to ensure that the information provided in this statement is complete and not misleading, in accordance with EPUT's duty of candour ...

"... Any limitations in the evidence provided have been clearly identified and explained within this statement;

"(c) EPUT understands that the position set out in this statement may be relied upon by the Inquiry and

tested in oral evidence; and

"(d) EPUT adopts the contents of this statement as its formal position in response to the matters identified, subject only to any expressly identified limitations."

Now, we'll come back in a moment to the fact that you've actually left EPUT, but have you signed the Position Statement?

A. I have, yes.

Q. And do you again today confirm the matters that we see on our screens from (a) to (d) in the Statement of Truth?

A. Yes.

Q. Overall, is the Position Statement true to the best of your knowledge and belief?

A. Yes.

Q. Please, if you have it in front of you, please refer to it as you need to. Generally speaking, I will put paragraphs or extracts on the screen if I need to, or I'll tell you a paragraph that I want to ask you about.

That can go down, please. Thank you.

As you're aware, Mr Scott, the Position Statement stands as part of your evidence and what that means is that I won't be asking you about every facet of it.

This isn't the first time you've come to give

evidence on the basis of the Position Statement, is it?

A. No.

Q. You provided a Position Statement dated 27 March 2025 on behalf of EPUT and came to give evidence at our hearing on 15 May last year.

A. Yes, I did.

Q. On that occasion did the Position Statement address, in very general terms, EPUT's involvement in the care of mental health inpatients during the period being considered by the Inquiry?

A. Yes.

Q. When you gave evidence last year, you informed the Chair that you became CEO of EPUT in October 2020. You left that role at the end of last month. Was it 30 June, the date that you --

A. The 30th, yes.

Q. Does that mean, though, that overall you were EPUT's CEO for about five and a half years?

A. Yes.

Q. Did you officially take up your new role at the start of this month, July?

A. I'm employed by the organisation, in my new role, but I am taking some leave and I won't start there until 21 July.

Q. And where is that, what is the new role and where is it?

A. It's CEO at East Suffolk and North East Essex Foundation Trust.

Q. Mr Scott, your leaving EPUT during the currency of this Inquiry is reported to have caused concern amongst some of the bereaved families. Were you aware of that?

A. I did see some of the reports in the press, yes.

Q. Did you understand why they might feel it concerning that the CEO of a trust, in the middle of scrutiny by a statutory public inquiry, should decide to move on?

A. I can see that, and I'm really sorry for the impact that might have had on families. As you say, I have been in post nearly six years and have joined EPUT in a, I think a very difficult period, when we were facing Covid, we were delivering Covid vaccination, we were facing HSE prosecution and then independent -- subsequently a statutory inquiry and it's time, I think, for me to have a fresh challenge and for fresh leadership at EPUT. But I will -- I mean, I'm here today. I just want to assure people that I'm not running from anything; I'm here to -- available to be accountable for my time in EPUT.

Q. Thank you. We'll come on to that in a moment.

THE CHAIR: Your new Trust is based where, in Ipswich, is it?

A. Ipswich and Colchester.

THE CHAIR: And your offices will be where?

A. There's two headquarters.

THE CHAIR: Thank you.

MR GRIFFIN: Was the move connected to criticism the Trust has received during the currency of this Inquiry, and as a result of other processes?

A. No.

Q. Has anyone in a senior role at EPUT suggested that you should leave the organisation?

A. No.

Q. Have you moved on because you feel it's job done, that the various issues that have been identified have now been addressed?

A. Well, I think I made clear last year that there's still more to do. I think -- I hope I leave the organisation in a better position than I joined it and I've steered the organisation through some difficulty.

Q. Do you think leaving now might actually be premature and it should have waited until the end of this Inquiry?

A. I wouldn't say so. I think, you know, six years is a long time to lead an organisation as complex as EPUT and I think, you know, we've also got, you know, I do recognise the needs of the Inquiry. We've also got to recognise the needs to make sure we've got the right energy and focus in the leadership.

Q. You refer in this statement to the transfer of

responsibility from you on your departure from EPUT to the two people who were previously your deputy CEOs. I'm not going to ask you about that, but the acting Chair of the Trust, Mr Lobo, is coming tomorrow to give evidence so I may ask him some questions about that area.

At paragraph 100 of the Position Statement, that's page 24, says that:

"Arrangements are in place with Paul Scott to ensure he remains available to the Trust."

Now, this is the point I think you've just started to touch on:

"... responding to Rule 9 Requests and/or to provide evidence to the Inquiry in relating to matters arising during his tenure."

Now, do you confirm that those arrangements are in place?

A. Yes.

Q. And that you will remain available to the Trust and to the Inquiry?

A. Yes, and I hope the Inquiry and families is, you know, my presence here today hopefully gives confidence in that.

Q. Before we move on, I want to refer to EPUT's Chair, Hattie Llewelyn-Davies. The Inquiry is aware she died

recently.

Chair, I know that you've said that that news was met with sadness. It was met with sadness by the Inquiry team as well.

Mr Scott, I understand there's something you would like to say now.

A. Yes, and thank you, Chair, for affording me the time to recognise Hattie and her sudden death at the end of May affected lots of people. Hattie had devoted her career to public service, leading and supporting organisations across the NHS and beyond and those who worked with her knew her as an exceptional leader of great wisdom, kindness and compassion and Hattie was committed to openness, learning and improving care for the communities we all serve and those values continue to guide the Trust's work and she cared deeply about people, particularly those who were least often heard, and she brought this care to everything she did, and finally, although I worked with Hattie for only a relatively short time, I benefited greatly from her support and wise counsel. On behalf of everyone at EPUT I would like to express our sincere condolences to her family, friends and colleagues and she will be greatly missed. Thank you.

THE CHAIR: Thank you for that.

MR GRIFFIN: The approach that I'd like to take with you, Mr Scott, is to address the matters that you've addressed yourself in the Position Statement in this way. I'd like to start with some of the admissions and reflections that you've made in the statement and ask you about those. And then I'd like to come on to ask about the issue of deadlines and extensions, concerning the response of EPUT to requests for information and documentation. And then I'd like to come on to ask you about EPUT's search capabilities.

Finally, to ask you about EPUT's resourcing of and governance in relation to its engagement with the Inquiry, and the disclosure of material in particular.

So that's the route that I would like to take with you this afternoon.

Before we do that, can we first deal with some relevant background, please.

We covered some of this when you gave evidence before but it's probably helpful briefly to remind ourselves of it now. Was EPUT the Trust formed on 1 April 2017?

A. Yes.

Q. And was that as a result of the merger between two Trusts, South Essex Partnership University Foundation Trust, or SEPT, and the North Essex Partnership

University Foundation Trust, or NEPT?

A. Yes.

Q. We might refer to them as the predecessor trusts as we go along. This Inquiry is looking at events over a 24-year period from the start of 2000 to the end of 2023, and that clearly means, doesn't it, that we'll be looking at events within the predecessor trusts as well as at EPUT?

A. Yes.

Q. Have you come to learn, in the exercise of your role at EPUT, how statutory inquiries such as the Lampard Inquiry, seek and obtain evidence from organisations such as EPUT?

A. Yes.

Q. Has one method by which this Inquiry asked for information and documentation been to issue what's known as a Rule 9 Request in writing under the Inquiry Rules 2006?

A. Yes.

Q. Has EPUT in fact received multiple Rule 9 Requests? And for ease of reference are they often referred to as Rule 9(1), Rule 9(2), so they're labelled sequentially in that way?

A. That's correct, yes.

Q. As we've just seen, this Position Statement was provided

in response to the requirements of a Section 21 Notice. The Inquiry has issued Section 21 Notices for other information and material held by EPUT too. Are you now aware, Mr Scott, that Section 21 of the Inquiries Act 2005 empowers the Chair, by notice, to require a person or an organisation to give evidence and to produce documents and materials to the Inquiry?

A. Yes.

Q. And do you understand the difference between the Rule 9 process, which is voluntary, and the Section 21 process, which is mandatory, with criminal sanctions sometimes for failure to comply?

A. Yes.

Q. Thank you. So that brings us on to the first area that I'd like to address with you arising from your Position Statement, and that's admissions, reflections, and lessons learned.

In the Position Statement you've made a number of admissions concerning failures in EPUT's engagement with the Inquiry. And may we start by looking at a couple of those. We don't need to put these on the screen but I'm just going to read out paragraphs 4 and 5 at page 2 of your statement.

So this is what you say:

"The Trust recognises that aspects of its engagement

with the Inquiry have not consistently met the standards expected by either the Inquiry or the Trust itself. Where shortcomings have occurred, the Trust recognises the impact these may have had on the Inquiry, Core Participants and bereaved families, and offers its sincere apology."

And paragraph 5:

"The Trust has sought to reflect on those shortcomings, understand the factors contributing to them and implement substantive changes to strengthen its response arrangements."

So in those two paragraphs, Mr Scott, have you both accepted shortcomings in EPUT's engagement with the Inquiry, and suggest -- do you suggest an improved response more recently to the Inquiry's requests?

A. Yes, I do, and I'd just like to verbalise the apology in the Position Statement. We do really regret the impact on the Inquiry and the families and I'm really sorry.

Q. But do those two paragraphs in a way encapsulate your evidence today: on the one hand, an admission that things have gone wrong, but on the other, a suggestion that you've taken steps as a Trust to put them right?

A. Yes.

Q. So -- and that, in essence, is what we'll be investigating for the rest of the afternoon.

What I would like to do is to look at another part of the statement, please. I'd like this up on our screens. It's Position Statement page 26 and it's paragraph 107.

Yes, could you expand 107, thank you.

I just want to work through this with you and ask you some questions about it, please. Paragraph 107 starts in this way:

"EPUT reflects that it underestimated at the outset, the scale and complexity of what would be required of it as the primary Core Participant. That underestimation was not in bad faith, but rather an error of planning and resourcing in not appreciating the wide focus which would be put on the delivery of services by it and predecessor trusts."

So just dealing with that first.

Do you, on behalf of EPUT, recognise that this was always going to be a significant and wide-ranging Inquiry?

A. I think yes, I mean I think that's without doubt, yes.

Q. As you've, I think, accepted elsewhere in the Position Statement, it was clear that EPUT would be the primary corporate Core Participant with disclosure requirements to match?

A. Yes.

Q. We can see on the screen there, on the top line, that you say that "EPUT underestimated at the outset". Could you just explain what you mean there by "outset"?

A. Well, I think -- at the outset, I guess the start of the Inquiry, we resourced what we thought was appropriate for the Inquiry, and for many months, that was suitable for certainly the Inquiry. We didn't appreciate or didn't estimate -- underestimated, I think, the increase and intensity of the evidence required by the Inquiry as we came into the latter half of last year.

THE CHAIR: So that was the statutory Inquiry?

A. The statutory Inquiry, yeah.

MR GRIFFIN: Would you agree that this should have been clear from the Terms of Reference of the original non-statutory Inquiry, which was established in September 2021? They required it to review the circumstances and practices surrounding the deaths of mental health inpatients over a 21-year period, that was up until the end of 2020, and to draw conclusions both on a local Essex and national basis?

A. Look, I think we accept responsibility. We did underestimate the level of resource that was going to be needed to serve the Inquiry, and I think we say in our Position Statement, EPUT or any NHS organisation is not -- this is, you know, new to all of us, actually,

how this works. And we underestimated resources and we've had a very difficult few months trying to serve that demand and have put the right resources in now, we believe.

Q. At what point does EPUT now consider it ought reasonably to have recognised that additional programme management, governance, IT capability and so on were required to meet its obligations to the Inquiry?

A. Well, I mean as you might imagine, Chair, I've been reflecting on this a lot and there's no clear point to me where we should have said, "This is where we step up" or no point where we could have anticipated the increase. We could have had more baseline resources put in earlier and I think making sure we had programme management and more legal support in the team from the outset, may have been something we should have done.

Q. Because I mean, we've just spoken about the non-statutory Inquiry established in September 2021, then there were the Terms of Reference of the statutory Inquiry from April 2024, and then of course there was an 18-page list of issues from early 2025. So these are all massive signposts, aren't they, Mr Scott, making clear the nature and extent of EPUT's proper involvement in this Inquiry?

A. I, you know, I accept our responsibility for making

sure, you know, it's our job and our job alone to make sure we can serve the Inquiry. It's only as a way of -- it's not, you know, and we should have done that, you know.

Q. Throughout the lifetime of this Inquiry so far, in relation to setting up systems for compliance with the Inquiry's deadlines, to what extent has EPUT sought specialist assistance from external consultants or trusts with a track record of complying with Inquiry requests?

A. Sorry, can you just repeat that?

Q. Yes. As part of your response to this Inquiry, has EPUT gone to specialist consultants or indeed other hospital trusts that have had to go through the same process, to learn from them?

A. Well, we've spoken to a number of NHS organisations. Clearly this is, I think, the first statutory inquiry for some time in the NHS. So there's not a lot of experience there, but we have sought advice from -- I can't remember the organisations, I'm really sorry. We can confirm that -- from others, yes.

Q. In terms of NHS Trusts that have been involved or organisations that have been involved in major public inquiries recently, the NHS Trusts and haemophilia centres were involved in the infected blood which

completed its work this year. There were NHS Trusts which were participating in the Covid-19 Inquiry which has been ongoing for a number of years. The Countess of Chester Hospital NHS Foundation Trust was involved in the Thirwall Inquiry, which has been ongoing, and that's the Inquiry that involved allegations concerning Lucy Letby.

So there were, in fact, a number of NHS organisations that had relevant and recent experience. Are you aware whether you've liaised with any of those?

A. Yes, we liaised with the Countess of Chester and with Nottingham as well, the Mental Health Trust in Nottingham.

Q. Coming back to the screen, please, you go on to say this in paragraph 107, "This", that's underestimating the scale and complexity of what would be required:

"... had real consequences: it generated delay, eroded the Inquiry's confidence, and in the case of the Next of Kin letters, directly affected bereaved families."

We'll come back to the Next of Kin letters shortly. But can we deal now with the issue of delay, please.

To be clear, this is delay to the work of the Lampard Inquiry.

A. Yes.

Q. You also refer elsewhere in your statement to aspects of EPUT's engagement with the Inquiry not consistently meeting the standard required, and this contributing to delays. So, just for reference, that's paragraph 116.

Do you accept that these delays have interfered with the Inquiry's plans for its work, including for its hearings?

A. Yes.

Q. And that they have resulted in delay to the -- delay in the hearing of significant issues, as the EPUT documentation that underpinned them wasn't ready?

A. Yes.

Q. Do you accept that EPUT's manner of engaging with the Inquiry, including the delays, can compound, exacerbate, and prolong the grief of the bereaved families and others?

A. I understand the impact of delays on the bereaved families and delaying the answers and truth that they want.

Q. Moving to the last part of the paragraph on the screen:

"The complexity and scale of the Inquiry's requirements demanded a level of programme management discipline, specialist IT capability, and senior governance not initially in place. EPUT reflects that investing in those capabilities earlier may have

prevented many of the difficulties described in the statement but has sought to ensure that the correct infrastructure is now in place to continue its work."

Does that bring us back to the point that we've touched on already, namely that you suggest that EPUT has put in place necessary steps to improve its engagement with the Inquiry?

A. Yes, it does. I mean, you know, also I'd add, and it's probably something about wider learning, actually, around how NHS organisations are prepared and resourced for a statutory Inquiry, you've made the point, I think, Mr Griffin, that, you know, we could have -- we checked in with other organisations to see how that should work. We are also, based upon our -- the track record in terms of what work we'd done, and we have had no -- you know, this is our responsibility, not the responsibility of the Inquiry, but we had no additional funding to support the Inquiry so we were balancing that off.

Q. We'll come to the issue of funding a little later on.

You say elsewhere in the Position Statement, it's paragraph 26 at page 6, that the Trust remains committed to ensuring that lessons identified continued to inform both Inquiry arrangements and, as you put it, wider organisational governance.

So this is picking up on the point you just made.

So you talk about learning lessons not just in relation to engaging with the Inquiry but also to wider organisational governance. Could you just expand on what you meant by that?

A. Sorry, can you just --

Q. Yes, it's paragraph 26 on page 6. Can you see at the bottom there?

A. Sorry, what paragraph was it?

Q. Paragraph 26 at the bottom of page 6.

A. Yes, okay.

Q. So what that says -- shall I just read it again?

A. Yes.

Q. "The Trust remains committed to engaging openly, transparently and constructively with the Inquiry, and to ensuring that lessons identified continue to inform both Inquiry arrangements and wider organisational governance."

Now, you were just talking about wider learning a moment ago so I just want to pick up on that and what you've said here in the Position Statement. And my question was this: what in particular did you mean by "wider organisational governance"?

A. I'll probably have -- I don't know, if I'm honest.

Q. Thank you.

Might it mean learning lessons from the way in which

EPUT has engaged with this Inquiry that could assist it in the wider management of the Trust?

A. It could. I mean, there's a -- I think, um, I think the lessons that we've learnt about how we manage the information, I think, and there's definitely benefits from the wider -- to the wider Trust, I think, of some of the technology we put in, the knowledge we now have of how to manage our data.

Q. And we'll come on to this because it's relevant particularly to the search capabilities, isn't it?

A. Yeah.

Q. I'm just going to pause for a moment just to make sure everyone can hear what you're saying. Yes. Thank you.

I'm going to move on to the issue of deadlines and extensions, please, Mr Scott.

So these are deadlines and extensions in relation primarily but not exclusively to the Inquiry's requests for information. I'm going to ask you about paragraph 27 at page 7. We don't need to have it on our screens. But you say this, in part of that paragraph:

"Over a period of time, EPUT failed to meet deadlines on multiple occasions, reflecting a combination of structural, technical and resource-related challenges. EPUT does not seek to excuse this pattern; it takes responsibility for it."

My question, Mr Scott, is what does it mean? What do you mean by taking responsibility for it?

A. It was our responsibility to ensure the Inquiry had the information that it asked for. We failed to do that in a timely fashion consistently over the last few months and it was our responsibility to fix it and correct that and make sure that is in place.

Q. Thank you. I want to ask you in this section about three matters, all revolving around February 2026. And they might provide examples of what we were just talking about, and paragraph 27 that I just read from.

Having a look at the first example, this was a request for evidence that led to a series of delays in complying and ultimately led to the Chair issuing a Section 21 Notice on EPUT. So this relates to Inquiry Rule 9, number 26, so Rule 9(26), which was issued on 18 August 2025, and that was for a witness statement from EPUT, and supporting material, in respect of the issue of monitoring and evaluation.

This sought a systemic and comprehensive explanation of how practice in the delivery of inpatient mental health treatment and care was monitored and evaluated throughout of the relevant period and specified matters to do with that.

Do you accept that EPUT's approach to monitoring and

evaluation was and is clearly a relevant topic for this Inquiry, given its scope?

A. Yes.

Q. Thank you.

Now, there was a letter that accompanied the Section 21 Notice and it included a timeline tracing the Inquiry's attempts over a six-month period to secure that evidence from EPUT. What I want to do is to put the letter up on the screen and just look at aspects of it and then I'll ask you some questions. Thank you.

Could you expand from Rule 9(26) down? Perfect. So here is the body of the letter on the first page.

As I've said, I'm not going to read the whole letter because there are a couple more pages that we'll go through but just look at aspects of it. It starts in this way:

"This letter is sent further to the Inquiry's Rule 9(26) request and accompanies a Notice issued by the Chair in respect of the same ..."

And that was issued under section 21 of the Inquiries Act, and it goes on to say this:

"This letter sets out the procedural history of Rule 9(26), the extensive engagement between the Inquiry's Legal Team and EPUT, the multiple extensions granted at EPUT's request and the Chair's reasons for

exercising her powers pursuant to Section 21 of the 2005 Act."

Then we see a number of numbered paragraphs underneath. The first one says:

"The Inquiry issued the Rule 9(26) request on 18 August 2025 with a 4-week deadline ..."

And we can see in the third paragraph, and we'll see this, actually, throughout the rest of the letter, references to weekly meetings.

Now, Mr Scott, can you confirm that there have for some time been weekly meetings between the EPUT legal team and the Inquiry's legal team covering a range of matters but very much also covering disclosure?

A. Yes.

Q. Thank you. So we can see here reference to one of them on 26 August 2025, and we can see in the middle of paragraph 3 that the Inquiry Legal Team acknowledged that Rule 9(26) was a weighty request.

So this was a big request from the Inquiry to EPUT.

Can we go over the page, please, and can you put up page 2, thank you very much.

Again, I'm not going to look at all of this but just couple of paragraphs to get the flavour of what was taking place. Looking at paragraph 6:

"During a weekly meeting between legal teams on

16 September 2025, EPUT's legal representatives indicated that they had started work on the response to Rule 9(26) but were not in a position to set down a timeline for completion yet."

Dropping down to paragraph 8:

"During a weekly meeting between legal teams on 30 September 2025, EPUT's legal representatives indicated that good progress was being made in relation to the Rule 9(26) response and requested an extension of time to mid-December. The Inquiry indicated that EPUT should make this request in writing but that it would likely be accepted."

Now, can you confirm, Mr Scott, that during the weekly meetings and in correspondence, there would be discussion about disclosure deadlines and the type of request that was coming up?

A. Yes.

Q. Can we see that in action here: a request for a deadline is signposted by EPUT and an indication that it will probably be granted but it would need to be sought formally?

A. (No audible answer given).

Q. Thank you. And just dropping down to paragraph 10:

"During a weekly meeting between legal representatives on 18 November 2025, the Inquiry noted

EPUT's difficulties in relation to obtaining a sign-off for the response to Rule 9(27) ..."

So that was a different request.

"... and [this] Rule 9(26) due to the signatory having a family wedding aboard. The Inquiry made clear that the receipt of both responses by 31 December 2025 was essential, as the Inquiry's work in relation to governance and oversight was materially dependent upon these responses and cannot effectively progress in their absence. Further delay would risk prejudicing the Inquiry's timetable and its ability to fulfil its Terms of Reference."

And then if we turn over the page, please, we can see at paragraph 14 the Inquiry chasing EPUT for its response. At paragraph 15, the Inquiry indicated that a chaser email was sent the previous day and the Rule 9(26) response is due. EPUT's legal representatives indicated that progress had been made on every section, but no section was quite complete.

But:

"EPUT were confident that the full response would be sent to the Inquiry by the end of January."

And if we drop down we can see that on 3 February the Inquiry sent a letter to EPUT stating that the final draft must be uploaded by 10 AM on 9 February.

At 10.04 on 9 February after the deadline expired, EPUT's legal representative informed the Inquiry that the deadline would not be met.

Paragraph 19:

"EPUT's legal representatives responded by way of email on 10 February ... stating that the 'Inquiry submission will be made on 27 February ...'"

Then just the last paragraph there, paragraph 22, thank you:

"The Chair has carefully considered the full chronology of this request, the repeated extensions granted, the assurances provided but not met, and the subsequent failures to comply with revised deadlines including those proposed by EPUT. In light of that history, the Chair is satisfied that there is a real and substantial risk that a complete and compliant response will not be provided even by 27 February 2026 absent the exercise of statutory powers."

So that's all I want to read from that letter. But can we see there, and we've traced through, haven't we, a series of extensions being requested by EPUT with new proposed deadlines coming from EPUT; yes?

A. Yes.

Q. And then those extended deadlines being missed with, as we saw on the second page, a potential knock-on effect

on the ability of the Inquiry to do its work in a timely manner and indeed a threat to what we wanted to tackle in its -- our hearings.

So that's all understood by you, is it?

A. Yes.

Q. And by you and also by EPUT the organisation?

A. Yes.

Q. And do you agree that this pattern that we've just traced through here is a pattern that has been repeated regularly in relation to other requests and responses?

A. I think -- I mean, clearly, you know, these are very serious matters and we really didn't want to have this impact on the Inquiry. I think this one in particular, just as a bit of an explanation, rather -- this is -- we take responsibility for it, was an enormous, I think you've described it, the description is "weighty", the sort of Rule 9 Request, and clearly of huge importance to the Inquiry. It covered a 24-year period. I think there was 29 lines of inquiry within it and effectively, and it did the reconstruction of mental health clinical governance for the last 24 years which I can really see how important that is, it did present us with a number of very difficult challenges and it was frustrating because we couldn't get to a point where we could have a timeline, and we discovered new things as we went

through it.

The work that we've done, actually, and I appreciate -- again, apologise for the fact that it took so long. It took over six months or more. We have learnt a lot about the data we've got now. It is all identified on our IT systems and we should be in a much better position now to deal with these complex requests going forward.

Q. Thank you. But I hear all of that, but do you accept that the repeated pattern of extension requests followed by breach of deadlines that we've just seen and that has been reflected elsewhere, is just completely unacceptable?

A. I -- well, yes. Yes.

Q. Can we take that down, please.

Just moving on to another example in relation to deadlines and extensions. And this is the February 2026 assurance, which you cover at part three -- Section 3, part B of your statement from paragraph 29 on page 8. When I talk about the February assurance, do you know what I'm talking about?

A. Yes.

Q. Thank you. The starting point is a letter written by the Inquiry to EPUT's legal representatives on 3 February this year, concerning -- the title was

"Rule 9 prioritisation". Are you aware of that letter?

A. Yes.

Q. And have you read it recently?

A. Yes.

Q. Can you confirm that it provided EPUT with a list of Rule 9 Requests from the Inquiry that were sitting with EPUT and that it should prioritise?

A. Yes.

Q. And that the letter expressed that providing the prioritised requests was "critical to the Inquiry's ability to prepare and deliver the content for the July hearings", so this hearing, "and to achieve the wider hearing timetable that's been published." Can you confirm that the letter included that?

A. Yes.

Q. And finally that in the letter the Inquiry sought assurance from EPUT that it's able to meet the Inquiry's request for evidence to the deadlines stated or, where this assurance can't be provided, a clear explanation of what action EPUT is taking to ensure that it's able to do so, for example securing additional resources? Does the letter cover that as well?

A. Yes.

Q. And in fact does it also say that any, "any assurances provided must be grounded in realistic and achievable

plans. The Inquiry cannot rely on assurances which are not subsequently met"? Can you confirm that the letter included that?

A. Yes.

Q. We can pick this up in the Position Statement at paragraph 31, that's page 9, where you say that:

"The situation -- forgive me. You say that:

"The situation led to the Inquiry requiring the delivery of eight Rule 9 Requests by 16 February ..."

And you go on to say, paragraph 33:

"EPUT accepts it provided assurances to the Inquiry that all eight would be delivered on time and that it failed to do so".

Now, in fact, some of those eight were delivered on time, weren't they?

A. Yes, I think four were. Three followed a day after the deadline. One sometime after.

Q. So, yes, the four that were late, the latest of them was provided ten days after the deadline notwithstanding the assurance that had been given.

Do you understand that how what happened there has undermined the Chair's confidence in assurances provided by EPUT?

A. I completely understand that, yes.

Q. And do you accept that the issue of a Rule 9 Request by

the Inquiry brings with it the expectation that a response will be provided by the stipulated deadline unless for very good reason more time is required?

A. Yes.

Q. You say in the statement, I can take you to it if you need to see it, but you say that EPUT provides an open commitment that deadlines will not expire without prior written engagement?

A. Yes.

Q. Do you know what you meant by the word "engagement"?

A. I think it's the process of agreed deadline extensions through the legal to legal meetings.

Q. So that deadlines won't be breached without the prior agreement of the Inquiry?

A. Yes.

Q. Thank you. And then the final matter from February 2026 that I want to look at with you, please, is also in relation to delay but not concerning disclosure responses. We've touched on it already.

Could you put up, please, Position Statement page 25 and expand paragraph 105. So we've talked about Next of Kin letters and I've said I'll come back to them. This is what you've said at paragraph 105 of the Position Statement:

"The failure to forward 30 Next of Kin letters

provided by the Inquiry on 5 February 2026 by the given deadline was admitted to be a serious failure directly impacting bereaved families. EPUT apologises unreservedly for that failure. EPUT had legitimate concerns about validating last known addresses before dispatching such sensitive correspondence to potentially unvalidated addresses, but it accepts that those factors led to unacceptable delay."

Now, Mr Scott, those were letters to Next of Kin to inform them of Inquiry process and other matters; is that right?

A. Yes.

Q. You've accepted that EPUT's failure in respect of the Next of Kin letters directly affected bereaved families, we can see that in 105 there and you make the same point later on in the Position Statement. What specific steps have been implemented to ensure that correspondence relating to bereaved families can't be delayed in a similar manner in the future?

A. Well, we have, I think so part of -- and again, unreserved apologies in writing, I just want to reiterate that from me personally, the issues that we were facing in February we can pinpoint direct actions to it, but I think if you're looking at system learning, these are symptoms of the period leading up to it that

was a very intense period for I think both the Inquiry and for us, and we hadn't resourced for that intensity, as we've talked about already. So we are in recovery mode and these mistakes and errors that were made and failures, as you put them, Mr Griffin, were largely as a result of those things. So making sure we have the right resources in place, there's good communication between the teams, good escalation, it means we're in a much better position now to make sure those kind of failures don't happen again.

Q. And I'm going to come back towards the end of my questioning to ask you about exactly that area of the Position Statement.

Mr Scott, elsewhere in the statement -- and I'm looking at paragraph 92(b) so that's page 22, we don't need to -- well, I can see it up on the screen as well. Paragraph 92(b), you refer to EPUT identifying issues internally, at an earlier point than communicated to the Inquiry. What were you talking about there, please?

A. Well, this is as we look back on the production of Rule 9s, there was a number of people who were expressing concerns that we won't meet deadlines, but not escalating them, and they were the kind of things we were talking about there, where people in the organisation knew there was a problem but they weren't

escalated.

Q. So internally, part of the organisation knew there was a problem, but that wasn't passed on to other members of the organisation and therefore not to the Inquiry?

A. Yes.

Q. Can you explain why these issues were not escalated and explained to the Inquiry more promptly?

A. I hope they were, as they were covered.

Q. No, but why has it taken so long for that issue to be identified and rectified?

A. I think, as -- well, I think as part of our reflection and looking through what happened, in this very intense period, you know, these are the kind of -- these are kind of the things that come to light, I think.

Q. You say, this is still in paragraph 92(b), that:

"This reflects the failure of escalation and transparency, and is inconsistent with EPUT's stated commitment to candid engagement."

Can you just expand on that, please.

A. Well, I think EPUT have declared and set an intention to serve the Inquiry in a candid, transparent, and open way, and there is elements in what we're disclosing in this Position Statement where we haven't met those standards.

Q. What changes have been made to improve the culture

within the EPUT Inquiry Project Team and particularly, have any steps been taken to ensure the importance of the duty of candour and proactive communication of fully understood within the team?

A. So we have increased the governance and we've increased the oversight. We've got a new programme director, a new Senior Responsible Officer and we have completely reset the team with -- at a programme management and more legal support. I haven't got a specific example where we've talked to the team about those particular things.

Q. So the issue of candour and transparency, we'll come on to the governance and additional structures that have been put in place to respond to the Inquiry's requirements, but this question is focusing particularly on transparency with the Inquiry and the duty of candour. You can't at the moment point to anything specific that has been done to address that on a cultural level within the project team?

A. I'm confident that the team would have had those conversations. I can't point to particular evidence, and maybe we can provide it --

THE CHAIR: Can I understand this a bit better: this reflects a failure of escalation and transparency. What do you understand is the cause of that? Why are things

not being escalated? Why are people not being transparent? Have you understood what the problem is?

A. I think it's people under a lot of pressure that we didn't recognise, and they want to do a good job and they don't want to confront the fact that they're not going to be able to meet it and we've got to help people disclose that earlier with good faith.

THE CHAIR: So they're frightened of saying they can't cope?

A. I think "frightened" wouldn't be the word I'd choose.

THE CHAIR: What -- (overspeaking) --

A. I'd say they're -- and there's no sense that anyone is going to -- there's no consequences for them, you know, if they do disclose things, but I think there's just a genuine desire to deliver what was being asked for and acknowledging that is difficult for people when they're going to fail, I think. That's what we talked through with people.

THE CHAIR: Have you had those conversations with people?

A. I have spoken to people but I haven't personally talked about that level of detail, no. That's -- sorry, do you mind asking that question again, Chair?

THE CHAIR: I just wonder what you have done to enable people to feel that they can say they're not coping.

A. I hope that people feel -- so we've had conversations within -- and I have spoken to members of the team.

There is a reflection that they want to -- we want to know if there's issues earlier and we've made that very clear, I think, and we've supported that with some governance and programme management that will give people more tools to be able to tell us.

MR GRIFFIN: Is there a cultural issue, at least in the Inquiry project team at EPUT that still needs to be addressed in relation to transparency?

A. I don't believe so. I think there's very, very dedicated people who are working with the Inquiry team who understand the importance of it. As I've said, the elements of the February, you know, it was a crisis for us, it was a very, very intense period of time, led to some unusual behaviours I guess, for people. And what we're being clear about now is: we've got the capacity, we've got the oversight, we are dedicated to making sure we provide this information and we need to know early if that's not going to be the case but we've got much more support in place for people now, as well.

Q. Thank you. We're going to move on to a new topic, and that is searches, but I may pick up on this transparency issue in that context as well.

So these EPUT's search capabilities, and this topic was prompted, as you say, at paragraph 35 -- you don't need to bring it up -- by the fact that -- sorry, could

you take down what's on the screen, thank you.

This topic was prompted by the fact that the Chair was -- and this is what you say in paragraph 35 -- "unclear on what EPUT's electronic search capabilities and limitations are", and that she wished to know whether there is an ability to search the body of a document contained within EPUT systems rather than just the document title.

So that's just to give background, Mr Scott, about the topic that we're going to embark on now.

Inevitably some of this is going to become a little bit technical. Mr Scott, I know -- as I understand it, you're not a specialist in conducting searches of documents and the like so you'll have to tell me if we go beyond your own level of knowledge, but I think I'm going to try and keep my questions at a higher level to do more with approach. And I'm hoping that you'll be able to engage with those, but say if there's something that's beyond your technical knowledge, please.

Can we set the scene, first. Would you agree that medical institutions such as hospital trusts may hold a large amount of important but sensitive information within their records?

A. Yes.

Q. And that the records they hold will cover a wide range

of information?

A. Yes.

Q. And most obviously, possibly, medical records, but will there be a large amount of further information, including, for example, corporate, administrative and governance records?

A. Yes.

Q. To what extent would records generally have been held on paper during the early period covered by this Inquiry? So we start at the start of 2000.

A. Yes, I don't know exactly, but a wide extent in the early 2000s, absolutely.

Q. And later on within the period that we cover, so going up until the end of 2023, was there a change to holding documents and material and information electronically?

A. Yes, there's been an adoption of electronic tools and systems over the period.

Q. Would you agree that for a medical institution such as a hospital trust to function properly, it will need to have control over the information it holds, and the ability to access it effectively and efficiently?

A. I think that's quite a big question that might go beyond my expertise, because there's -- we're getting into the realms of the policies around retention of records and you're getting into quite a complex area, I'd say there.

Q. Subject to retention requirements, which are set out by policy and there are particular requirements in the NHS, putting that to one side and understanding that there are details and technical aspects to that, as a general concept, would you agree that a hospital trust, if it's to function properly, will need to have access -- well, control over the information it holds and the ability to access it effectively and efficiently?

A. I think to function as an organisation delivering healthcare it needs to have the contemporaneous information, so where patients are still being treated or if employment records need to be accessed for the last previous while. I wouldn't say, in my experience, that -- running an NHS organisation, that I need access to information from 15 to 20 years ago.

Q. So you would say that there's a difference between the older material and the newer material, and you've said around -- what did you say, sorry, 15 years?

A. I mean, that was just indicative, and it would be depending on the type of information, clearly.

Q. So is -- the general answer is yes, you need to have control and access for more recent documents and information?

A. Yes.

Q. In a nutshell, is that what you're saying?

A. Yes.

Q. You've explained in the statement that there are a number of issues at EPUT that mean that accessing information for the Inquiry isn't straightforward.

A. Yes.

Q. Let's look at what you've said. You refer in the statement to the fact that no single system contains all potentially relevant information.

First of all, does EPUT hold its information across a number of different electronic systems?

A. Yes, and -- yes they do.

Q. Do those systems include, for example, a number of different patient record systems? You've named them: Mobius, Paris, SystemOne. So even different patient record systems; correct?

A. Yes, I mean, there's a huge range of systems I think I've detailed in the annexes that, you know, so that that's some of them, but there's plenty more.

Q. Just so people are clear, you've provided in annex four to the Position Statement, a list of all of the different electronic --

A. Yeah.

Q. -- databases and the like that you're aware of; is that right?

A. Yes.

Q. So I just didn't want to have to go through all of that, but just in terms of general categories. So we've talked about patient record systems. Then there's Datix in relation to incident logging and connected matters. That would be another example, would it?

A. Yes.

Q. Then there are a range of shared drives, SharePoint and Teams, to store documents, policies in the like. Does that give us a flavour of the different kinds of electronic systems that are in play at EPUT?

A. I think so, yes.

Q. I want to talk now about legacy systems, because this is something that you've raised in your statement. When you use the term "legacy systems", what do you mean?

A. Systems that were in place before the current systems we use.

Q. So that wouldn't necessarily be confined to systems that were used by the predecessor trusts; it might be EPUT systems that are no longer used, as well?

A. I think so, but I think the intention of that was to say legacy was prior to EPUT.

Q. All right. So for present purposes, although this may not be a strictly correct use of terminology, when we, or if we refer to legacy systems, for the purposes of this afternoon, we're referring to those systems that

were used by the predecessor trusts?

A. Yes.

Q. Yes? Thank you.

So in short, when responding to requests for information from the Inquiry, might EPUT need to access records across a number of different systems including those that were used by predecessor trusts?

A. Yes.

Q. When you gave evidence last year, we spoke about EPUT's plans with a neighbouring acute trust to move towards an electronic patient record, or EPR, across acute mental health and community services, and the suggestion was that that would be implemented 2026, 2027.

A. **(Witness nodded)**.

Q. What is the current position with the EPR?

A. That's still scheduled to go live in 2027.

Q. What does "EPUT would hope to have" -- so that's later in 2027?

A. Yes.

Q. Will the new EPR system improve the interoperability between NHS data systems?

A. Yes, it will, substantially, yeah.

Q. Is it asking too much to ask you how that will happen?

A. Well, so we'll be consolidating seven electronic patient records or patient record systems within EPUT. The

acute hospitals will be consolidating four main ones but many, many more ancillary ones, and with the right safeguards in place to make sure only relevant records are seen, there will be one single record available for clinicians treating patients.

Q. Do you know when in 2027 that will come online?

A. It will be a staggered process in -- with the acute hospital going first and we'll follow in the summer, the late summer.

Q. Do you know to what extent the EPR might overcome some of the issues we've discussed, and we're going to go on to discuss?

A. I think it will -- it won't solve the legacy issues or the historical issues. It will create a -- data will be imported, but it will be summary data, and recreated in the new EPR and I think the real benefit is going forward.

Q. Do you know how far back the data that will be imported into the EPR will go?

A. I don't, I'm sorry.

Q. Do you know what Single Patient Record is?

A. Sorry?

Q. The Single Patient Record, it's a digital record that brings together a patient's health information in one secure place. That's the NHS England description of it.

A. Right, okay.

Q. Is a Single Patient Record something you're aware of?

A. Yes, yes.

Q. And as I understand it it's currently in development?

A. Well, there's a range of different ways of bringing records together. So the electronic patient record we'll be putting in is a huge benefit, because acute mental health and community care will have one record, but it won't cover all of the healthcare records and it won't cover any other records from social care, or other places.

So there's still -- and patients will come from different areas, as well, and so they will be treated by different acute hospitals, that may not be in the electronic patient record. So there remains a need, I think, for an overarching Single Patient Record which is done by synthesizing that, putting front end on lots of different patient records, so there is a summary record available by logging into a different system.

Q. Do you know when that Single Patient Record will become available?

A. No.

Q. Do you know whether it will solve any of the problems we've been talking about or we're going to go on to talk about?

A. It won't solve the historical but it will solve some of the issues about having multiple systems for patients and their treatment.

MR GRIFFIN: Chair, we've been going for a little while now. May we take a break?

THE CHAIR: Yes.

MR GRIFFIN: Can I say until 3 pm, please.

THE CHAIR: Yes.

MR GRIFFIN: Thank you very much.

(2.44 pm)

(A short break)

(3.03 pm)

MR GRIFFIN: Thank you, Chair.

Mr Scott, we were talking about EPUT's search capabilities and we'll just continue with that, please. I want to look at something again on our screens.

Could you put up, please, the Position Statement, page 10 and expand paragraph 39, please.

So this is referring to the Trust's search capabilities before 2025 and what you say here is this:

"It should also be noted that prior to 2025, the Trust's electronic search capability was significantly more limited. Searches were largely dependent upon document titles, file naming conventions and the correct spelling of names or identifiers. This created obvious

limitations in identifying relevant material, particularly across historic records and legacy systems."

So are you saying there that before 2025, the Trust's search capability was really very basic?

A. It depends how you define basic. We were able to search our systems but it was more limited than it is now with the additional software we have.

Q. But just picking up on one of the points we can see on the screen, was EPUT having to rely on a document title to identify what was actually within the body and the text of that document?

A. Yes.

Q. That's pretty basic, isn't it?

A. If that's the definition of basic, yes.

Q. Does this relate to the legacy systems only, so to information from the predecessor trusts, or does it also extend to information held by EPUT?

A. This is where we're getting quite -- because there's a different -- it gets quite complex to answer that question, if I'm honest, because there's a whole range of different systems and different access to them. We have good understanding and information of the EPUT information database.

Q. So this is, at the least, it's more of a pronounced

issue in relation to the information from predecessors?
A. Yes.
Q. But if I've understood your evidence correctly, you're not entirely sure about the extent to which it might affect EPUT information?
A. I am confident in the EPUT information, but the change in search capability, I don't know what impact that would have had but I'm sure we'll come to --
Q. Let's see how far we get as we work through what you've said.

This issue that we've got up on the screen, are you aware that the Inquiry only found out about it in September last year?
A. Yes.
Q. Do you know why EPUT didn't notify the Inquiry about this issue earlier on?
A. The issue, sorry?
Q. So this issue here, these limitations in relation to search capability prior to 2025, the Inquiry heard from EPUT about these limitations only very late -- in September 2025. Do you know why it took so long for EPUT to notify the Inquiry of this particular limitation?
A. I don't, I'm sorry.
Q. We're going to come on to two software platforms that

EPUT has procured. I'm going to keep my questions at quite a high level but as I've said before, please let me know if there are issues in providing technical details. Did EPUT procure two platforms during the course of 2025 to increase its search capability?

A. Yes. Sorry, I need to qualify that in the sense that the procurement started earlier than 2025.

Q. That's my mistake. Did two platforms come online --

A. Yes.

Q. -- and started to be used by the Trust in 2025?

A. Yes.

Q. Thank you. And was the purpose of procuring them to increase EPUT's search capabilities?

A. It was primarily I think, yes, and also to increase the productivity of searching, as well.

Q. Thank you.

A. It was very labour intensive.

Q. Did EPUT -- so I'm looking at paragraph 41 to 43 of your statement just so that you have it in front of you if you want it. But did EPUT introduce Relativity in April 2025 and something called Netwrix, that's N-E-T-W-R-I-X, on a pilot basis in August 2025?

A. Yes.

Q. Is Relativity a document review platform to which the Trust can identify and then upload documents that can

then be subjected to more sophisticated searching?
A. Yes.
Q. Is the plan to continue to upload documents to Relativity to benefit from its functionality?
A. My understanding is that Relativity is used for a document management system and search capability for documents that have been used to disclose Rule 9 information so we'll continue to update that as we supply Rule 9 -- (overspeaking) --
Q. But the limitation of Relativity, if that's the correct term, is that a document has already to have been identified and uploaded --
A. Yes.
Q. -- to the system before that search functionality can be used; is that correct?
A. Yes.
Q. Thank you. You say at paragraph 42 that the database continues to be updated with material and currently contains a repository of some 167,000 documents?
A. Yes.
Q. Moving on to Netwrix, which you refer to in paragraph 43 as a "data classification and search tool" that allows EPUT more thoroughly to search its shared drives, you say that Netwrix searches all text within documents using key search terms across document titles, and

within the body of the document. But there is a limitation to Netwrix, or one of them is that it can only search single words; is that right? It can't search for phrases? This is paragraph 43.

A. Yes.

Q. You refer to Netwrix being piloted in August 2025. Did EPUT then go on to continue to use it after the conclusion of the pilot?

A. Yes.

Q. Are you still using it now?

A. Yes.

Q. Thank you. Has it been possible for EPUT to find software that does permit searches of phrases rather than single keywords?

A. It's not my understanding that we have.

Q. Okay. Could that be taken down, please.

Can you explain this: why is it only in 2025 that this additional functionality was procured and brought into use?

A. The process, I think it started in 2023. It's quite a long process of implementing this, for reasons of procurement, time frames of building the servers and the capability and then building cybersecurity, because it's got access to all of the, you know, very importantly it's got -- we've got to put cyber security in, it's got

access to all of EPUT's data, and then the size of the database actually meant that we had to continue to build server capacity after that, as well.

THE CHAIR: At what point did you become aware that the demands of the Inquiry could not be met by the systems that you had?

A. I -- well, it was, as I said in the documents, it was an emerging understanding I think, but I think probably in November last year we were really clear that we needed to do something very different.

THE CHAIR: But you'd already started to procure separate systems, at which you've said were designed to meet the needs of --

A. Yes, that started -- the process of that started in 2023, as I said and, you know, we were constantly trying to enhance the team so we'd brought associate directors of -- for the project team in. We brought a project director who had much more experience of dealing with these kind of -- this kind of work. So it was a constant evolution but the absolute, "We've got to fundamentally change", was November.

THE CHAIR: And did you have discussion with anybody at that stage about informing us that there was an issue?

A. I understand there was conversations going on about our ability to serve the Inquiry at that point.

THE CHAIR: Thank you.

MR GRIFFIN: You refer in the Position Statement to important limitations in relation to EPUT's search capabilities and you list a number of them, and what I want to do is put up on screen the relevant paragraph and ask you about them.

This is Position Statement page 11, expanding paragraph 44, please.

This is dealing with Relativity and Netwrix. You say:

"Whilst these systems have materially improved the Trust's search capability ..."

Just pausing there; is that correct?

A. Yes.

Q. There's been a material improvement. They've made a difference?

A. I think so, yes. So I've been told that and it's really helped the teams find data and information quicker.

Q. But you go on to say this:

"... important limitations remain."

In particular, I -- we've touched on some of that already but what I want to ask you about is what we see there at paragraph (c):

"Some legacy systems are not fully accessible through current search tools."

Can you expand on that, please?

A. Yes. So there is a number of now defunct software systems that have not been able to be -- we can't load them onto our servers, they're not readable. This is where I'm right on the edge of what I understand, but --

Q. Understood.

A. But I understand that they're not readable on our servers and the only way to access that information is to log into that software itself. So therefore the Netwrix capability is not available to those systems, and then furthermore, there's paper records, we've got 40,000 boxes of paper records which aren't available to Netwrix, as well.

Q. In terms of -- understood, thank you. Can we go over the page, please. We see more limitations listed here and I don't want to read them all out but I do want to look at a couple. You say this at (f):

"... some historic records may no longer exist due to historic retention and destruction practices which pre-dated the Inquiry."

And you say at (i):

"the destruction of records, both as a result of policy and the SEPT asbestos issue."

We'll come back to that asbestos issue in a moment, but can you confirm that what you're referring to there

is the destruction of documents in accordance with policy, but before the Inquiry moratorium on destruction was put in place?

A. Yes.

Q. So to be clear, this was expected destruction in accordance with pre-existing policy?

A. Yes.

Q. And it wasn't destruction of documents after moratoriums were put in place because of the existence of the Inquiry?

A. No.

Q. Thank you.

Now, the SEPT asbestos issue, could you just explain what that is, please?

A. My understanding is that as historic records were held in accommodation in SEPT, and due to asbestos contamination -- and this was before EPUT was formed, I think, because asbestos contamination had to be destroyed.

Q. Were these paper records?

A. Yes.

Q. Do you know what categories of records were lost as a result of that?

A. We don't.

Q. What assessment has EPUT undertaken of the impact of

that loss of documentation on the Inquiry's investigations?

A. We're unable to make an assessment at the moment.

Q. Can you take that down, please.

You refer in the Position Statement to pre-merger evidence limitations being particularly significant. And I think this picks up on points we've already covered. But what I want to do is just come on to discuss what you mean by that in a little bit more detail.

We're going to look at another part of the Position Statement.

Could you put up page 17 and expand paragraph 66, please.

So again, I'm not going to read all of this, but this is you saying at 66 that the Trust -- and if we drop down to the bottom half of that paragraph:

"The Trust cannot provide unqualified assurance that all potentially relevant material relating to predecessor organisations has been identified or remains available. This reflects a number of structural and historic limitations ..."

Then you go on to list them, don't you? And we'll come back to that in a moment. But for those reasons, are you making clear here that there are obstacles that

mean some relevant pre-merger material may not be located, and provided to the Inquiry?

A. I think so and I think just, you know, it's a 24-year period of data with legacy systems, as we've talked about, so I'd say that would be the case, yes.

Q. Are you able to identify the categories of records or documents in respect of which EPUT has encountered data gaps or has been unable to verify whether records exist or previously existed?

A. I can't here today, no.

Q. Has EPUT identified any instances in which missing or incomplete records have affected its ability to respond fully to Rule 9 Requests?

A. I don't know.

Q. Has EPUT undertaken any assessment of the extent to which relevant historic material may not have been identified or disclosed overall?

A. I don't know. I'm really sorry, I don't know the answer to those questions today.

Q. Just dealing with that list that we can see on the screen, you refer at (b), can you see that, to "incomplete or inconsistent historic data migration."

Can you explain what that refers to, please?

A. So every time, as you know, there's multiple organisations that pre-date EPUT and NEPT and SEPT, so

each time a new organisation is created, data is migrated into the new organisation. And that's what the new organisation relies on. That migration may have errors in it occasionally. Historically.

Q. You say this, it's paragraph 68 of the statement:

"In relation to NEPT the Trust identified, during the course of the Inquiry, that the historic migration of records from the legacy Carebase system was incomplete. Access to an archive dataset identified additional cases which had not transferred into the later Paris system."

We've spoken or I've mentioned the Paris system but is that a patient record system?

A. Yes.

Q. So do you know whether patient records were affected by this incomplete or inconsistent data migration?

A. So there was -- this is quite historical, I think, and discovered I think three or four years ago, I think. So the information -- sorry, the question is about the patient record, is it --

Q. I'm just trying to ascertain, to the extent you're able to assist us, what kind of material hasn't copied across from the predecessor Trust to EPUT, and we spoke about the Paris system being one of, as I understood it, the patient record systems?

A. Yes.

Q. So I was asking you whether in fact the data that hasn't copied across here is likely to be patient records or included in them.

A. Well, that data is now available to us now.

Q. Oh really?

A. Yes.

Q. Can you explain how that's come about?

A. So there was -- three or four years ago we were looking for all of the records of deaths that were relevant to the then independent Inquiry, and we were seeing, I think just through the analysis, there were some obvious gaps, I think, and we didn't know why. And through a bit of research we found a repository of this data was elsewhere in a server that hadn't been known to us. I mean, I'm really simplifying --

Q. Understood.

A. The -- so that -- we accessed -- so that was discovered and corrected.

Q. But that sounds like -- when you say here at 66(b) that we can see on our scene "incomplete or inconsistent historic data migration", is that what you were referring to --

A. Yes.

Q. -- or were you referring to or were you referring to

something else?

A. That's an example of that, I'd say.

Q. So there may be more examples as well?

A. I'm not aware of any more.

Q. But in terms of the example we've just been talking about, that's one that's been rectified?

A. Yes.

Q. Thank you.

Can you take that down, please.

How much corporate knowledge does the Trust's Senior Leadership have of the pre-merger period?

A. When you mean Senior Leadership, do you mean executive level, or board level?

Q. So this is what you say at paragraph 74:

"The Trust's current senior leadership team has limited direct corporate knowledge of the pre-merger period."

A. Yes.

Q. So perhaps you can answer your own question.

A. Yes.

Q. What were you referring to there?

A. I was referring to the Executive Team and the board and yes, there is limited knowledge.

Q. Is the Trust therefore often reliant on the pre-merger records, where an understanding of events before

April 2017 is needed?

A. Yes.

Q. In the Position Statement you previously provided to the Inquiry -- so this is the one from March last year -- and in answer to questions from me in May last year, you referred to attempting to learn from the past. Do you remember that?

A. Yes.

Q. You confirmed that in order to effect meaningful and lasting change at EPUT you personally, and the Trust leadership more generally, needed a good understanding of what had gone wrong in the predecessor trusts; do you remember that?

A. Yes.

Q. How has it been possible to learn and change when your historic records are in such a poor shape and there is limited senior personnel that you can talk to?

A. I think ... there's lots of ways of doing that, I guess. The majority of the work I've done, actually, in looking at data is looking at reports of investigations or, you know, the HSE prosecution was a really big, as we talked about last time, learning exercise for me. So there's ways and I think if you look back in all healthcare and NHS data, there's going to be problems as you go back in time in terms of its completeness and how relevant it is

to today as well. So the work of synthesising that and understanding what had meant and what that impacted on patients and staff is how that learning comes forward, I would say.

Q. But the learning is inherently limited, isn't it, because of the types of things we've just been discussing?

A. I think, if you rely solely on information and data, I think, then learning will always be limited, actually, and I think these stories and the testimonies of people from that period of time are as important and I think also that that investigative work and understanding the context and synthesis.

Q. I thought that what you were saying was that people, at least from a senior level, from that period, there aren't that many of them around?

A. I'm thinking about the HSE prosecution which got testimonies from people that was collected at the time.

Q. I understand. But apart from scenarios where there are witness statements and there's been an investigation and there's some documentation that you can refer to, how are you able to effect learning?

A. So I think there's been quite -- you know, there's been quite a lot of historic investigation already. So I would rely on, you know, the HSE prosecution, CQC

reports, whatever it might be, to look at thematic things that have come up. I'm -- I am sort of hesitating a bit because there are very big things that are very clear, and I have taken forward in the learning of the Trust but I think to get forensic on that data now, looking back, there's more, I think more impact about making sure we've got the current data, we're looking at our information, the signals coming out of that to make sure we're learning properly and speaking to patients and to families and to staff more and more to make sure we're gathering our learning.

Q. You say, sorry, just going back to paragraph 74:

"The Trust's current senior leadership team has limited direct corporate knowledge of the pre-merger period. Much of the Trust's understanding of events ... is therefore dependent upon the records [of events] that remain available ..."

Are those the records you've just been describing?

A. I understand. Sorry. So yes, we do rely on -- there's data and records and reports and synthesis of that data have been a part of those records.

Q. What I'm trying to ascertain, perhaps not very well, is the extent to which you feel there is a pool of data from the pre-merger period that does allow you to learn lessons and to understand in a profound way what has

happened and what has gone wrong?

A. I'm not entirely sure how to answer that question, I'm afraid. I think the -- there is aspects of that data and information that can be used to learn from the past, but it's not fully complete and it's not contextualised with the corporate knowledge and the staff. But there is reports and reflections that have been done on that data in the past that are actually very useful to that learning.

Q. Thank you. You also address in the Position Statement EPUT's approach to determining which systems, records and the like should be searched in response to a Rule 9 Request from the Inquiry. And in the context of that you explain, this is paragraph 53 at page 14, that:

"EPUT does not maintain a record of decisions not to search particular categories of material."

So there's no record of the categories of material that have not been searched in response to a particular Rule 9 Request; correct?

A. That was correct at the time of writing this, yes.

Q. And has that changed?

A. Yes, we have. That's part of the improvements we put in place. So it was -- historically it was a positive identification of the data that was searched rather than a list of all the areas that were excluded, and now

where we make decisions not to include some searches, and they're for fairly obvious reasons like they pre-date the age of the patient. That would be recorded as well.

Q. But does that mean that there are -- most of the searches to date have not recorded databases and the like that have not been searched?

A. Well, they list, I think, the positive searches that they made, so therefore whilst they don't name them all, you can conclude what hasn't been searched, I would say.

Q. Do you know why EPUT decided not to maintain a record of decisions not to search particular systems or categories of material up until recently?

A. I don't.

Q. You say at paragraph 38 -- this is page 10 -- that the Trust aims to make sources of data transparent and to set out the methodology applied to each Rule 9 response within the response itself. But you say this too:

"It is accepted that the aim to include this information has not been consistently met."

Would you agree that the failure to include information of that type undermines the transparency of the approach adopted by EPUT and makes it harder, actually, for the Inquiry objectively to review the information provided?

A. Well, I think I would say that not including the databases that weren't searched leads, I think, the Inquiry to have to do more work to understand what was excluded and why it was excluded, and I think we can definitely have enhanced that with the current arrangements.

Q. So that's another area that's changed?

A. Yeah.

Q. You say -- this is paragraph 112(d) at page 27 -- that the impacts of the limitations of the Trust's search system were not communicated to the Inquiry clearly or promptly.

What did you mean by that?

A. Sorry, which paragraph are we on?

Q. Yes, of course. It's 112(d), it's page 27.

A. I'm sorry, I can't recall what that was referring to -- (overspeaking) -- speculating.

Q. So that's not a question that you can answer at the moment?

A. No.

Q. Do you accept that the failure to inform the Inquiry of the effect of limitations, whatever they may be, is a transparency issue?

A. Yeah, I think we should have told you earlier and across a wide range of things and, you know, around the

disclosures here, and we often fell short, I think of the standards we set.

THE CHAIR: What would you think was the reason for that? I mean, you've said you didn't know until about November but others must have known they were having difficulty. What was the reason for that?

A. Well, I think it is an emergent piece. So people started to struggle, you know, and we were clear that people were struggling and, you know, volumes had gone up. We started to miss deadlines in November, so that was the early signal now. Could we have had a better forecasting system to see where issues might arise? And it really got very intense from there, and we were effectively in crisis management for three months to try to recover it.

THE CHAIR: When was the three-month crisis management?

A. So we're talking about the delivery of Rule 9s here, are we, Chair? Yeah. So it was November, December, January into February. So four months sorry.

THE CHAIR: Okay. Do you think others in your senior team were aware that this was a problem?

A. Yes. Prior to November?

THE CHAIR: Yes.

A. I think people were under stress. I don't know if they knew that we were going to continue to get the level of

demand we had, and that we were going to get to a point where we were not meeting deadlines.

THE CHAIR: And do you think that they were aware that the system in place and the electronic systems you had were not meeting -- were not able to meet the requirements of the Inquiry?

A. Which electronic systems are you referring to?

THE CHAIR: Well, you've just explained to us how the systems were not fit for doing the job that is needed in terms of responding to the Rule 9s. Do you think others in your team were aware that that was an issue prior to November?

A. I think the -- sorry, I just want to make sure I'm really clear what we're talking about. Are we talking about Netwrix and Relativity or ...?

THE CHAIR: Well, you started to commission new systems.

A. Yeah.

THE CHAIR: The existing systems were unable to cope with what was required.

A. Oh, right. I'm sorry, Chair, I was getting confused between IT systems and systems and processes.

THE CHAIR: I'm sorry, I meant the IT systems. Yes.

A. So Relativity and Netwrix were in place from April '25 and August '25 so that enhanced our search capability, ahead of this difficulty over the autumn and

winter --

THE CHAIR: But by November, you said it was clear that you weren't going to be able to manage --

A. Yes.

THE CHAIR: -- even so.

A. Yes.

THE CHAIR: So had others in your team become aware of that? When did the others in your team ...?

A. So I'm trying to think how to answer how this developed for us, I guess, isn't it? How did this develop and emerge as a system?

THE CHAIR: And how did you find out?

A. So the volumes went up in August, September and continued into the winter and autumn, and historically, we'd managed to deal with the spikes and increases in demand by flexing our resource. And that was working, up until November. Now, so in November that was very clearly becoming an issue that we were missing deadlines. People were signalling the pressure on the system but they weren't signalling that we were not going to sustainably going to meet deadlines.

And the continued sort of Rule 9 Requests meant we hit an issue in November, and we had a significant shortfall between capacity and demand that rolled into -- and our work then, that was escalated quite seriously

at that point -- our work then was to make sure we got as much resource as possible to recover those lack of capacity and to recover the backlog and to get back on track. That was the work. In doing that -- and we've explored a few examples of that today, about our systems and governance were exposed to not being robust enough under that level of pressure, and so that's why we've put in place lots of changes since, but our focus was to get back on top of the Rule 9s and then to build a more sustainable structure and resource level so that we can be more confident going forward that we can meet the needs of the Inquiry.

Does that answer your question, Chair?

THE CHAIR: It does, thank you.

MR GRIFFIN: Just picking up on that, you sit, or as CEO of EPUT, you sat as an executive member of the board; is that correct?

A. Yes.

Q. What kind of board oversight has there been over this period previously and now of the manner in which EPUT engages with the Inquiry, provides disclosure to it, and the concerns and problems that have been experienced and that you've been explaining?

A. So the board meets eight times a year formally, and on other occasions informally uses committees to inform its

work, as well. So there's a regular report that details volumes of Rule 9s and areas, and also other business from the Inquiry as well, that would be of interest to the board.

Q. So the board is sighted on some information in relation specifically to EPUT's disclosure to the Inquiry as well as wider matters relating to the Inquiry?

A. Yes.

Q. Were the board aware of the difficulties that EPUT was experiencing?

A. Yes.

Q. The ones that you've just been covering with the Chair?

A. Yes, I mean -- now, I think the board obviously meets in -- less frequently than an operational executive team would, but there is a number of reports that went forward, and also I've pointed out what we're trying to do to recover it, as well.

Q. Thank you. You add, and this is paragraph 112(e), so that's page 27 which you may already have in front of you, you add that:

"The limitations of EPUT's knowledge and documentation of the pre-merger period cannot be overcome."

And you say:

"EPUT accepts that it has been more forthcoming

about these limitations than it has been about the precise nature and implications of them on the work of the Inquiry."

What did you mean by that?

A. I'm sorry, Chair, it's only when you get this scrutiny of the exact words that it becomes less clear what we were saying and I can't -- I'd be speculating if I tried to sort of retrospectively put that in there.

Q. Does it mean that whilst in general terms EPUT may have been informing the Inquiry about issues concerning pre-merger evidence, it wasn't actually providing the kind of detailed information about the effect of those limitations to the Inquiry?

A. I think that -- yeah, I mean it's quite a complicated sentence, isn't it? But I guess what I would say to that is our understanding, my understanding, this will need to be checked -- is that we were disclosing the limitations for each Rule 9. What we didn't understand, I think it was only when we -- and this is hopefully of interest to the Inquiry because it's as you get into the information and data and you try and understand it and use it, and I think Rule 9(26) is a really good example of this -- you start to understand the limitations because you're looking at quite complex data, you bring it back and you say, okay, there are some gaps, what are

the gaps? So our learning and understanding of those limitations has developed over time and I think -- yeah, I think ...

Q. So the statement suggests that where neither former staff nor documentation from the relevant time exist, there is little scope for mitigation, but has EPUT identified any matters within the Inquiry's scope where neither documentary evidence nor relevant former staff are available? So have you had that double whammy in trying to respond to an Inquiry request where you haven't been able to find information in written form and there is no person that you can talk to from that period to assist you?

A. I'm not aware of any specific, but I'd be very surprised if there isn't an occasion. Especially if you get back to the early 2000s.

Q. You may not be able to answer this question but if it's happened, do you know if you've informed the Inquiry about it?

A. I don't know, I'm sorry.

Q. You've told us about the platforms introduced in 2025, so Relativity and Netwrix. Have the searches conducted prior to their introduction been rerun in order to benefit from the greater functionality that they afford?

A. So my understanding -- again, I'll try my best to answer

this -- is that Relativity has got all of the documents that have been used to provide the Rule 9s in it, and no more, so there's nothing more to be gained from further searches, is my understanding.

Q. Sorry, just pausing there, Relativity has a search functionality that you didn't previously have. So before those documents were loaded on to Relativity, you wouldn't have been able to search them in the same way. So surely Relativity does afford an additional functionality that the Inquiry could benefit from?

A. That's probably worth exploring, I'm at the limit of my knowledge on that now.

Q. Understood.

A. Then when it comes to Netwrix, that's been used since August '25 and I think all but 20 or 22 Rule 9 Requests after the use of Netwrix and then many of them have been revisited and therefore benefited from -- so the earlier ones before Netwrix was implemented, many of them have been revisited on supplementary requests or clarifications from the Inquiry. So my understanding is that nearly all Rule 9 Requests have benefited from Netwrix.

Q. Given that search capabilities were materially improved by Relativity and Netwrix, what assessment has been undertaken to satisfy EPUT that relevant material is

unlikely to have been missed in the earlier responses, given everything you've just said?

A. Yeah, I think that's the -- that's my answer in the sense that I think that all of them have benefited from Netwrix apart from a handful prior to August '25.

Q. Well, this is something that we may have to take up further with your legal representatives.

A. Okay.

Q. But Netwrix would be used specifically in relation to a Rule 9 Request to search for issues, documents, relevant to that specific request. So subsequent use of Netwrix on new Rule 9 Requests, how would that benefit and identify documents that were relevant to prior Rule 9 Requests?

A. Yeah, that probably needs exploring more outside of here, but yeah.

Q. I understand. But on the basis of your current understanding you think that the fact that Netwrix has been used quite widely means that many of these issues would have been caught?

A. Well, so working on the premise that -- on the hypothesis that Netwrix and previous searches will give different results and how do you mitigate against that, then I would say that 90 per cent plus of Rule 9s have used Netwrix and therefore it's a very small issue.

Q. Okay, thank you.

What I want to do now is to turn to your current search methodology. You deal with this at paragraph 47. That's page 13, but we'll put it up on the screen, please. Page 13, paragraph 47, thank you.

So you say this:

"The Trust recognises that no search methodology applied across multiple historic systems and records, can provide absolute assurance that every potentially relevant document has been identified. The Trust has therefore adopted an approach focused on reasonableness, proportionality, and layered validation ..."

Then you go on to say what that includes.

How long has this approach been in place?

A. I think a version of this approach has been in place since the work began., is my understanding.

Q. You say this at (c). You say:

"The Trust has therefore adopted an approach focused on reasonableness, proportionality and layered validation and this includes ..."

And we can see at (c):

"Involvement of subject matter experts familiar with the relevant services, systems, and historic practices."

In relation to that, how does EPUT satisfy itself that sufficient expertise remains available to identify

relevant documents, and understand historic practices where former SEPT and NEPT personnel are no longer employed by the Trust?

A. I'm afraid -- I mean, I can't answer that question today. I'm sorry.

Q. So at the top of 47 we can see at the top of our screen there's reference there to multiple historic systems and records.

Can EPUT provide the Inquiry with assurance that all documents created after the merger, and potentially relevant to specific Rule 9 Requests, have been identified in EPUT's responses to our requests for information?

A. I think, if there's any data or information, I don't think there's a hundred per cent guarantee of anything but I can be very confident or much more confident that the data has got -- we have access to the right data and information from EPUT records.

Q. So what level of confidence would you have in relation to the EPUT documentation as opposed to the pre-merger documentation?

A. I can't, I can't put a figure on that, I'm sorry.

Q. You refer at the end of this paragraph -- the top paragraph here to proportionality. And in fact proportionate -- proportionality -- that's a word that

we see quite a bit throughout the Position Statement. I just wanted to ask you about that, please.

With regard to the reliance on the concept of proportionality as justifying the placing of limits on the extent of searches being undertaken, what does that mean in practice?

A. Sorry, what were you referring to?

Q. Do you see at the top of -- the bottom line of the top paragraph 47:

"The Trust has adopted an approach focused on reasonableness, proportionality, and layered validation ..."

Do you see that?

A. Yes.

Q. So is proportionality sometimes used as a reason not to conduct a search? For example, EPUT considers it would be disproportionate to search a particular system in order to respond to a request from the Inquiry? So is proportionality used as one of the tests whether you're going to search something?

A. And there's a wide range of interpretation.

Q. But, first of all, is the answer "yes"?

A. Sorry, can you repeat the question?

Q. So the question is about using the concept of proportionality when deciding what to search to respond

to the Inquiry's requests. So does it -- does EPUT sometimes decide it would be disproportionate to search, say, a particular system --

A. Yes.

Q. -- and therefore not do it?

A. Yes.

Q. Thank you. So my question was this -- shall I just repeat it? So with regard to relying on proportionality as justifying placing limits on searches, what would that mean in practice? How would that play out?

A. So my understanding of this is that there has to be an approach of proportionality when you're trying to look at a database, you know, you've got 24 years of data. We can't look at every single bit of data for every single Rule 9 Request so we start to say, okay, can we narrow that down on the basis of what is likely to be relevant to the current patient?

And so for example, if the data that we chose not to search was pre-dating the birth date of that patient, that would be a very obvious one. But there would be other reasons as well.

Q. Has EPUT ever notified the Inquiry when it's decided not to search something on the basis of proportionality, as far as you're aware?

A. I don't know what has been disclosed in individual

Rule 9s.

Q. I'm not going to pursue the line of questioning I had on proportionality. It may be something we take up separately.

Mr Scott, that brings me to the end of the section of questions I had for you on EPUT's search capability. I want to come on to one final topic, which is resourcing and governance.

Before I do, can I make sure you're happy to carry on or would you like a brief break?

A. We can carry on.

Q. Thank you. So what I want to talk to you about is funding and governance and you mentioned funding at the start, do you remember, and I said we'd come back to it?

A. Yes.

Q. You say that the Trust has committed substantial financial and human resource to the Inquiry in the Position Statement; is that correct?

A. Yes.

Q. In terms of financial resource, we can see from EPUT's Data Assurance Statement and correspondence from the Trust's legal representatives, these are things that have been disclosed to Core Participants, that financial spend by EPUT in support of, first of all, the Essex Mental Health Independent Inquiry and the Lampard

Inquiry up to 30 November 2025 was £13.5 million?

A. Yes.

Q. Does that sound about right?

A. Yes.

Q. And that EPUT is forecasting a £30 million spend to meet the needs of the Inquiry. Again, does that sound about right in total?

A. Yes.

Q. So those are substantial figures, aren't they?

A. Yes.

Q. Do you recognise the profound importance to bereaved families of understanding events that occurred over many years across the predecessor organisations and EPUT?

A. Yes, I do.

Q. Do you also recognise the importance of assisting the Inquiry in establishing a full understanding of matters relevant to its Terms of Reference and in identifying learning that may improve future services?

A. Yes, I do.

Q. Overall, do you and EPUT understand the significance of the Lampard Inquiry and the requirement fully and properly to engage with it?

A. Yes.

Q. One question that does arise is why, with that budget, EPUT was not able to implement appropriate processes to

support the Inquiry at an earlier stage?

A. So that's not a budget, that's a forecast spend because our position is we need to spend what we need to spend to serve the question.

Q. So it was £13.5 million up until the end of November last year?

A. Yeah, so that's a historical spend and then we're forecasting what might be needed going forward.

Q. I totally understand the difference, but just focusing then on the historical spend of £13.5 million.

A. Yeah.

Q. Given that amount of funding, are you able to explain why the appropriate processes that have now been put in place weren't put in place at an earlier stage?

A. So yeah, I mean, we chose and we thought we had put in place resources that were appropriate for the demand that were being placed on us by the Lampard Inquiry. We have established that we underestimated that quite a lot. And stepping up those resources was very important, and we had to provide further financial resources --

Q. And we'll come on to exactly that in a moment.

A. So if the question is: why didn't you have more capacity earlier in the way you set yourself up to support the Lampard Inquiry, we didn't believe we needed it. Now,

that's an error that we made. And we, you know, and we're cautious about spending money we don't need to spend because there's no separate funding for the Lampard Inquiry from EPUT so we'd be making difficult choices there and we don't want to take staff out of frontline services in order to -- unless it's needed and of course if it's needed we'll do it.

Q. Thank you. Are you able to confirm that there should be no financial bar to EPUT's full engagement with the Inquiry and its response to the Inquiry's reasonable requests for information?

A. Our position is we'll make the resources available.

Q. So that's the financial resource. Can we come on to the human resource, please.

What prompted the recruitment of additional people to the Trust's Inquiry Project Team?

A. Well, again that's an unfolding situation. So there was -- and I don't know the background. There was, in August, two associate directors joined.

Q. Well, if you're going to deal with that can I suggest you have paragraph 83 at page 20 in front of you because that's what I wanted to go on to ask you about anyway.

A. Okay.

Q. So at paragraph 83, you explain the current make-up of the Inquiry team at least at a senior level; is that

correct?

A. Yes.

Q. And without reading it, does it refer there to the project team including a Senior Leadership Team, including a Senior Responsible Officer or SRO; correct?

A. Yes.

Q. Programme Director, two Associate Directors, a Portfolio Lead, six Senior Response Leads. You refer to some of this also at paragraph 90. And an Analytics Lead, five Clinical Advisors, an Inquiry Manager and deputy and a data and administration team.

In summary, is that what you set out there and then later on in the statement?

A. Yes.

THE CHAIR: Are they all in post?

A. Yes, I believe they are.

THE CHAIR: You believe they are. Do you know for certain?

A. I haven't looked at the latest position recently, I'm sorry. But we were pushing very hard to make sure they were, Chair, and my understanding when I left the Trust is they were in place.

MR GRIFFIN: You say this at paragraph 113(c), so this is page 28:

"EPUT has redesigned its team structure and functionality introducing a senior tier that reports

into the associate directors to bring additional capacity and capability to improve the speed of responses, and ensure that commitments align more closely with what is deliverable."

The Chair has just asked you whether these people are all in post but how recent, in general terms, is this structure that we've just been covering?

A. So -- in general terms, so this structure had genesis in a review that was done by our new Programme Director, who joined in January, who gave us feedback that we needed to strengthen -- I think, Chair, I'm just -- just coming back to the question that you asked earlier about when did we know, and there's lots of points that we might have known and reflected on, and here's one of them, I think, which is when the Programme Director gave his report about the need to strengthen the team -- and this was a fresh eyes sort of approach. So he started to build a proposal that would enhance the team and change the governance and I think then that came into conversations with the Inquiry about making sure we had the correct resource in place, and I think those conversations also shaped some of the structure which is now in place. I think it needs constant review because it needs to evolve with the changing needs of the Inquiry and the changing demands of the Inquiry as well.

Q. Thank you.

THE CHAIR: When was that, that report?

A. That was commissioned in January and talked about in February, mid-February.

THE CHAIR: That's 2026, just to be clear?

A. Yes, yes.

MR GRIFFIN: I've referred recently to the Data Assurance Statement. That shows that several of the high-level staff changes had been made by that stage, so that was towards the end of last year, November 2025, I think. What further changes had been made, what new people had been brought in since the issues that you experienced in February 2026 and that we've discussed?

A. So we've brought a new dedicated Senior Responsible Officer in. The Programme Director has started that I talked about. There's a project management office head, as well. So one of the things we've strengthened is to make sure we've got project management over our Rule 9s because they've got more complex. There's four Clinical Advisor posts now.

Q. So this is all new this year?

A. Yes.

Q. After February?

A. Yes, yes.

Q. Just dealing with the clinical advisors. What is their

role in formulating responses to the Inquiry?

A. They're there to advise, I think, the -- well, they bring the subject matter expertise in their specific field. Now, they are quite narrow, and therefore -- but they're also there to guide the searches to make sure that we've -- I guess it's to do some of the work that we're asking operational and clinical colleagues from the front line to do earlier in terms of making sure that the search teams have the right information and context to operate in.

Q. Bringing to bear their specialist knowledge in a clinical area?

A. Yes.

Q. Just the SRO, the Senior Reporting Officer, which is, as I understand it, one of the new roles, just explain a little bit more about that role.

A. So that role is an executive level role and has access to the board and reports to the Chief Executive to make sure that we've got the -- and that's dedicated.

I think the difference from the past was that was shared with other portfolios, and this is completely focused on the Inquiry.

Q. So the SRO has a direct reporting to the CEO?

A. Yes.

Q. Thank you.

You refer in the statement, and this is at page 22, paragraph 91, to the fact, dealing with the project team, that EPUT is able to flex up this provision when needed. You say something similar at paragraph 84 in relation to the solicitor team resource. In terms of specifically the solicitor team, would flexing up mean accessing lawyers -- sorry, additional lawyers -- who already had experience of working in connection with the Inquiry or might these be new, potentially quite junior people?

A. My understanding is that they were new junior people who were able to -- I mean, relatively junior, I guess, but people able to hold the pen on some of the Rule 9 responses.

Q. Do you regard that EPUT's project team is now sufficiently resourced for anticipated demand?

A. I think yes, with the caveat that it needs constant attention, and ensuring that we've got a responsive system in place to make sure we can meet the demands in the future.

Q. You say -- just picking up on that very point, you say that -- this is paragraph 83 still:

"This composition provides a clear, resilient structure, with dedicated capacity, defined roles and specialist support aligned to the scale, pace and

complexity of the Inquiry's demands."

The caveat you've just mentioned, how will all of this be monitored?

A. I think there's a much -- and you'll explore this, I'm sure, with the interim chair tomorrow, there's a much more intense oversight of the Rule 9 performance, and more prospective reporting as well, because we've got better project management arrangements in place now. And I think that there is conversations about making sure there's some independent assessment of the structure, as well, from an internal audit function or another way of looking at it.

Q. Has there been any audit or review, internal or external, of the Inquiry project team?

A. No.

Q. Do you think an independent external audit is something that EPUT should consider?

A. We should -- I think -- you normally put your resources around internal audits where you think there's significant areas of risk, and our experience of serving the Inquiry up until August and into November was: we can manage this. Our learning over the winter in making sure we can get, you know, I think 150-odd Rule 9s in over that period has shown that we haven't got the capacity. And I think, by putting what we believed to

have the right capacity, I think it is definitely worth testing.

Q. Thank you. You suggest -- this is paragraph 89 at page 21 -- that the Trust has recovered its position. Would you mind explaining what you meant by that?

A. We have now dealt with all of the Rule 9s that were missing deadlines and issued in the period prior to March, and from, I think, from 5 or 6 March we are substantially on track to deliver the deadlines set by the Inquiry. So the recovery is we can now meet the deadlines set by the Inquiry and serve the Inquiry's needs.

Q. I'd like to put something else up on the screen now, please, and we've now reaching the end of my questions for you, Mr Scott. And I'd like to look at a part of the Position Statement that brings together someone of the points that we've been discussing.

Could you put up page 6, please, and expand paragraphs 23 to 25.

So you say here -- I'm not going to read all of this -- this is near the second half of the top paragraph:

"The Trust implemented a substantial remedial programme designed to strengthened governance, oversight and capacity arrangements."

And then you list some of the points I think that we've raised already. Is there anything more about that aspect of your evidence in the Position Statement that you would like to raise now?

A. No, I don't think so.

Q. You go on to say this at paragraph 24:

"These changes have resulted in a more stable and coordinated operating model."

Do you actually now believe that to be the case?

A. Yes.

Q. And finally, you say this at paragraph 25:

"Whilst the Trust recognises that confidence must be rebuilt through sustained performance over time, it considers that its governance and operational arrangements are now materially stronger than those in place during much of 2025 and early 2026."

Now, to what extent do you now expect that EPUT will respond to the Inquiry's requests for information and documents within a reasonable timeframe and as requested?

A. I've got strong confidence that's the case.

Q. Strong confidence?

A. Sorry, I didn't quite -- how did you phase the question? Sorry.

Q. To what extent do you now expect that EPUT will respond

to the Inquiry's requests for information and documentation within a reasonable time frame and as requested?

A. I expect that to be the case.

Q. And you said strong confidence. Do you maintain that now that I've repeated the question?

A. Yes.

Q. Thank you.

Do you acknowledge that EPUT is now at the stage that -- you do acknowledge here, of having to rebuild the confidence. Do you accept that the confidence that needs to be rebuilt is not just that with the Inquiry but it's also with bereaved families and others engaging with the Inquiry?

A. I completely understand that, yes.

MR GRIFFIN: Thank you. Could you take that down, please.

Chair, those are the questions I have for Mr Scott. Now, do you have any further questions?

THE CHAIR: No, I don't, thank you.

MR GRIFFIN: Mr Scott, the procedure is now that we're going to take a break. We may come back with -- and I may have some further questions for you then but we're near the end of your evidence.

So, Chair, can I suggest that we come back at 4.20.

THE CHAIR: Thank you.

(4.08 pm)

(A short break)

(4.20 pm)

MR GRIFFIN: Chair, there are no further questions for Mr Scott. So that brings his evidence to an end for now.

THE CHAIR: Thank you very much indeed for coming to give us your evidence. I appreciate it.

THE WITNESS: Thank you.

MR GRIFFIN: Thank you.

THE CHAIR: And now we are going to rise until 10.00 tomorrow.

MR GRIFFIN: Rise until 10.00 tomorrow morning for the resumption of evidence then. Yes, please.

THE CHAIR: Thank you. 10.00.

(4.22 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X