

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

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

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

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

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

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

25 The case summaries are neutral, and are useful

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the very significant challenges that we've been facing
2 on this front. The Inquiry's Terms of Reference require
3 me and my Inquiry Team to undertake a thorough
4 investigation of the systemic issues and failings
5 relating to the deaths of mental health inpatients in
6 Essex between the years 2000 and 2023, a period of
7 24 years. I recognise that the scale of this Inquiry's
8 task and the extensive remit of our Terms of Reference
9 mean that we're asking for a great deal of information
10 from relevant material providers.

11 Some of the providers we've sought information from,
12 including the main NHS trust in Essex, EPUT, have
13 struggled with answering our requests for information
14 for a number of reasons and have requested extensions of
15 time by which to comply. This is partly owing to the
16 breadth of the issues we're investigating and the
17 24-year time period over which we're seeking the
18 information.

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

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

1 hearing.

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

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

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

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

25 I anticipate that we will hear more about this in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 Ms Harris.

1 **Opening submissions by MS HARRIS KC**

2 **MS HARRIS:** Thank you, Chair.

3 Chair, this is the Lampard Inquiry's seventh public
4 hearing, which marks a shift into a different phase
5 evidentially. Having heard substantive accounts from
6 bereaved families over the course of the last three
7 hearings, the Inquiry will now move on to hear evidence
8 from some of those who were involved in the provision of
9 mental health inpatient care in Essex, and we will also
10 explore topics of immediate concern.

11 Chair, on behalf of your Inquiry team, may I please
12 add our thanks to all of the family members and to
13 others who have provided witness statements to the
14 Inquiry.

15 We do not take for granted how difficult it is for
16 those who have experienced significant trauma to share
17 again the details of their family members' deaths. We
18 thank them for their courage and for their assistance
19 and we confirm again that their evidence has formed the
20 foundation of our work.

21 Before I go any further, may I also stress that
22 during this opening statement and throughout this
23 three-week hearing, the Inquiry will once again be
24 referring to, and hearing about, matters that will be
25 distressing. We will be hearing evidence about

1 individual deaths. We will also hear from witnesses who
2 provide different perspectives about the care provided
3 on mental inpatient units -- mental health inpatient
4 units, including their views on where things went wrong.
5 These details may be difficult and painful for many of
6 those who are here today, or who are watching online.

7 As we've done at previous hearings, at the start of
8 each day we will briefly summarise the evidence to be
9 heard. This will give those attending, watching,
10 listening, the opportunity to decide whether they wish
11 to engage with that evidence. And the timetable for
12 this hearing is also on the Inquiry's website.

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

17 Anyone in this hearing room is welcome to leave at
18 any point. We have two support staff here from Hestia,
19 an experienced provider of emotional support services.
20 They're here today and for each day of this hearing.
21 There's a private room where you can talk to Hestia
22 support staff if you require emotional support at all
23 throughout the hearing. The Hestia support staff are
24 wearing orange-coloured lanyards and scarves.
25 Alternatively, please do speak to a member of the

1 Inquiry Team and we'll put you in touch with them. We
2 are all wearing purple-coloured lanyards.

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

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

11 The role and remit of the Lampard Inquiry is to
12 investigate mental health inpatient deaths. It is not
13 the role of the Inquiry to intervene in clinical
14 decisions for current patients or to act as a regulator,
15 or in the role of the police. We take safeguarding very
16 seriously, however. The Inquiry has a safeguarding
17 policy and we have team members who are specifically
18 responsible for overseeing safeguarding matters. Where
19 we receive any information which meets our safeguarding
20 threshold, we will pass it on to the appropriate
21 organisation.

22 Chair, there will be a number of the Counsel to the
23 Inquiry team involved in this hearing. This afternoon
24 you will hear from lead Counsel to the Inquiry, Nicholas
25 Griffin King's Counsel. You will also be assisted over

1 the next three weeks by Rachel Troup, Priya Malhotra,
2 Tom Coke-Smyth, Robert McAllister, Katie Sage, Teniola
3 Onabanjo, and Thomas Hayes. They have all been closely
4 involved with the evidence to be explored at this
5 hearing. They have each engaged with their respective
6 witnesses to ensure those witnesses provide their best
7 evidence as part of this inquisitorial process.

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

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

22 Whilst the Inquiry must be careful to preserve its
23 independence it continues to engage directly wherever it
24 can with all Core Participants and their legal
25 representatives. Specifically assigned members of the

1 Inquiry Team meet regularly with the legal team's
2 representing bereaved families and those representing
3 healthcare providers and other Core Participants. We
4 also meet with many other stakeholders as required.

5 The Inquiry also continues, wherever appropriate, to
6 provide Core Participants with opportunities to engage
7 with its work. Current opportunities for engagement
8 include the Inquiry's ongoing process of seeking Core
9 Participant input in relation to its illustrative case
10 summaries and invitations to Core Participants to
11 provide submissions in relation to proposed expert
12 instructions.

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

21 Chair, the Lampard Inquiry has made very significant
22 progress in 2026. And whilst the scale of the task
23 remaining should not be underestimated, you have
24 a dedicated team full of people to whom this work is of
25 crucial importance, all of whom are committed to driving

1 this process forward. At present the majority of the
2 Inquiry's work, much of which is in the investigative or
3 preparation stage, is taking place away from public
4 hearings.

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

9 The Inquiry continues to engage with the families
10 and the friends of those who died whilst under the care
11 of Trusts in Essex, and to obtain evidence from all
12 those who wish to provide it. As you have already
13 stated, Chair, the families and friends of those who
14 died will always be at the very heart of the Inquiry's
15 work. And whilst the hearings dedicated solely to
16 family evidence have come to a close, you made quite
17 clear in your response published in January this year,
18 and have done so again today, that you will continue to
19 receive witness statements from bereaved families and
20 you will invite further families to give oral evidence
21 in circumstances where you consider that you will be
22 assisted by that oral evidence.

23 Further witness statements from bereaved families
24 have been disclosed in advance of this hearing and will
25 be published in due course.

1 You have invited three further families to give oral
2 evidence during the course of this hearing, and you have
3 directed that a recorded evidence session be arranged
4 for a fourth.

5 Furthermore, in April this year, the Inquiry heard
6 from ten more families who provided their firsthand
7 accounts during recorded evidence sessions. Chair,
8 these are sessions where evidence is provided in a less
9 formal setting without the pressure of a public hearing.
10 The Inquiry has been pleased to hear from those who
11 attended these sessions how helpful they have found them
12 as a way in which to provide evidence to the Inquiry in
13 a more flexible setting. For that process, other Core
14 Participants were invited to engage with the evidence in
15 the usual way by sending to the Inquiry any questions
16 they had for those witnesses in advance.

17 The evidence sessions took place over a period of
18 three weeks and the recordings will be published on the
19 Inquiry's website.

20 You've already confirmed today that you've watched
21 all of those recorded sessions in full, and furthermore,
22 the evidence provided in those sessions has already
23 underpinned investigations undertaken by your team. The
24 Inquiry is hugely grateful to all of those who took part
25 in those recorded evidence sessions because once again,

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

3 The Inquiry continues to place significant value on
4 evidence from those with lived experience of mental
5 health inpatient care in Essex. Following consultation
6 on the Inquiry's draft statement of approach to lived
7 experience cases, submissions were received from a range
8 of Core Participants and interested organisations.
9 Those submissions have been carefully reviewed and are
10 currently being considered as part of the process of
11 finalising that statement of approach.

12 Alongside that work, the Inquiry has issued Rule 9
13 Requests for evidence to 12 lived experience Core
14 Participants and continues to adopt a flexible and
15 trauma-informed approach to engagement, closely working
16 with legal representatives and support services to
17 ensure that appropriate support, reasonable adjustments,
18 and special measures are available where required.

19 To date the Inquiry has received one witness
20 statement from a lived experience Core Participant. As
21 further evidence is received, it will be reviewed as
22 part of the Inquiry's wider investigations.

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

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

3 A major part of the Inquiry's work in 2026 has
4 involved the investigation of its illustrative cases.
5 The Inquiry's statement of approach to investigating
6 illustrative cases was finalised in January this year
7 having taken into account the submissions invited from
8 Core Participants and their legal representatives. To
9 date, the Inquiry has identified 147 illustrative cases,
10 each of which reveals one or more of the systemic issues
11 emerging through the Inquiry's work.

12 Those issues have been divided into themes, and are
13 listed as clusters on the Inquiry's website. The
14 Inquiry's dedicated investigations team is working
15 tirelessly to obtain relevant material and to examine
16 carefully those emerging systemic issues and themes.
17 The Inquiry has issued hundreds of requests for evidence
18 in relation to the investigation of its illustrative
19 cases. It has obtained important evidence using the
20 arrangements we have in place for sharing information
21 with other organisations, such as those with
22 His Majesty's Coroner, Essex Police, and some of the
23 healthcare regulators.

24 The Inquiry has now completed its initial
25 evidence-gathering stage in relation to all 147 cases

1 and is in the process of disclosing draft case summaries
2 to those who are connected as a matter of fact to each
3 particular case in order that they can provide their
4 comments and views.

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

12 Firstly, there is a separate cluster of cases which
13 illustrate issues with post-admission ongoing
14 assessment, through which the Inquiry will focus on
15 assessments that took place once a patient has been
16 admitted to an inpatient unit.

17 And secondly, the Inquiry has divided its
18 examination of older adult care and co-occurring health
19 conditions into two, to ensure clearer focus on the
20 issues in each.

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

1 illustrative case is the firsthand account and the oral
2 evidence provided by the family or friend of those who
3 died, where that evidence is available. The
4 investigations team begins by looking carefully at that
5 evidence in its entirety, and it is the full account
6 that informs the Inquiry as to the further investigative
7 steps required. The case summaries then identify and
8 set out clearly each family's concerns.

9 And they are just that: case summaries. They are
10 intended as a neutral but effective presentational tool
11 by which the Inquiry can collate and disseminate large
12 volumes of relevant material and facilitate the
13 important engagement of those connected to the case in
14 the process.

15 Chair, you've indicated that you have found the case
16 summaries helpful. They do not replace the evidence the
17 Inquiry has obtained. They certainly do not replace the
18 comprehensive and detailed witness statements and oral
19 evidence provided to the Inquiry by bereaved families.
20 That evidence is taken into account in full by you and
21 your team, and it forms a vital part of the Inquiry's
22 evidential record.

23 Since February this year, the Inquiry has been
24 inviting families and other organisations connected to
25 each illustrative case to engage directly with the

1 Inquiry's investigative process. So far, 94 case
2 summaries and the associated documents on which they are
3 based, have been disclosed to the families and
4 organisations involved in each case. Those who have
5 received the case summaries have been invited to provide
6 input and comments. The Inquiry's investigations team
7 is grateful to those who have responded and has been
8 assisted by those who have engaged constructively in
9 what we acknowledge to be a challenging process for
10 many.

11 Twenty-four of those case summaries have been
12 amended and updated as a result of this engagement
13 exercise and they formed part of the disclosure for this
14 hearing. This work will continue over the summer, and
15 will ensure that the Inquiry captures all of the
16 systemic concerns that have been raised by families. We
17 encourage Core Participants to work with us on this.
18 I should also stress the Inquiry intends to keep all
19 case summaries under review, and will update them as
20 appropriate, should further evidence be received.

21 Another very important aspect of the Inquiry's
22 ongoing work in 2026 is the identification and
23 instruction of suitably qualified and experienced
24 experts to provide specialist opinion.

25 Chair, you have identified quite properly, that

1 there are systemic issues emerging from the illustrative
2 changes and questions relating to the provision of
3 mental health inpatient care more widely, where you
4 require expert assistance to navigate the matters
5 arising.

6 Last year, after liaison with Core Participants, the
7 Inquiry published its protocol on the role and
8 instructions of experts. The Inquiry has now instructed
9 a number of experts in accordance with this protocol
10 which allows for effective engagement from Core
11 Participants in respect of areas of expertise, proposed
12 candidates, and the broad topics on which expert opinion
13 should be obtained.

14 The Inquiry has also invited suggestions for experts
15 from its Core Participants. The Inquiry has made
16 contact with over 100 potential expert witnesses and has
17 interviewed a significant number of those contacted.
18 There are now experts instructed and working in relation
19 to a number of thematic issues. Furthermore, the
20 Inquiry previously announced its intention to explore
21 the issue of suicide preventability. As the Inquiry's
22 work has progressed and further illustrative cases have
23 been investigated, the need for the Inquiry to tackle
24 questions around suicide predictability and
25 preventability has become all the more apparent. The

1 Inquiry intends to instruct Dr Chloe Beale, consultant
2 psychiatrist, to provide expert opinion on this topic.

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

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

12 Whilst the focus of recent public hearings and
13 recorded sessions has been evidence from bereaved
14 families, the Inquiry continues to send multiple
15 requests for evidence to healthcare providers,
16 enforcement agencies, regulators, charities, and a wide
17 variety of other corporate organisations and
18 stakeholders, all of whom have material relevant to our
19 Terms of Reference.

20 Given the broad remit of those Terms of Reference,
21 and the growing need for national comparison and
22 analysis, the Inquiry's work includes not only sending
23 out of requests for evidential -- evidence crucial to
24 the investigation of our illustrative cases and to the
25 exploration of themes identified, but also includes

1 sending out requests for the evidence required to
2 understand more generally how mental health inpatient
3 care has been and continues to be provided in Essex, and
4 beyond.

5 We have already obtained evidence from the relevant
6 Government and arm's-length bodies and as I say, the
7 scale of the task should not be underestimated.

8 In summary, Chair the Inquiry has sent in excess of
9 500 Rule 9 Requests seeking witness and documentary
10 evidence to corporate organisations and stakeholders.
11 Chair, you have already exercised your statutory powers
12 to compel the provision of evidence where necessary and,
13 as you have already stated, have issued 14 Section 21
14 Notices requiring certain stakeholders to provide
15 relevant material without delay.

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

23 The Inquiry intends to scrutinise the overall
24 governance structures of those who provided and continue
25 to provide mental health inpatient care in Essex at one

1 of its final hearings. This governance work, which will
2 look ward-to-board at how services should be run, is now
3 well under way. The Inquiry has already amassed
4 extensive evidence from its providers and intends, where
5 possible, to effect disclosure of that material later
6 this year to allow Core Participants the time required
7 to review it.

8 Given the broad remit of the Inquiry's Terms of
9 Reference and the length of the relevant period, the
10 Inquiry continues to face considerable challenges in
11 securing comprehensive and reliable evidence from
12 healthcare providers and other corporate stakeholders in
13 a timely manner.

14 This has been the case with EPUT in particular,
15 about which I'll provide more detail later in this
16 opening statement. But these challenges and delays
17 inevitably have a knock-on effect on the Inquiry's
18 ability to progress its work, including reviewing
19 material, identifying follow-up queries and/or other
20 lines of inquiry, providing relevant material to
21 experts, finalising a disclosure scheme, along with
22 planning and preparing for hearings and so on.

23 Chair, it was partly owing to these challenges that
24 in April this year you directed that this July hearing
25 be re-focused as the Inquiry was simply not confident

1 that it would receive all of the important evidence it
2 required in sufficient time. The Inquiry remains
3 concerned about receiving evidence on time, and is
4 planning accordingly and I will also provide information
5 about future hearings at the conclusion of this
6 statement.

7 But the Inquiry remains committed to ensuring that
8 its request for evidence from corporate Core
9 Participants and material providers are met with timely
10 and comprehensive responses using its statutory powers
11 when required.

12 A great deal of the work required to achieve this
13 necessarily takes place behind the scenes, by way of
14 weekly meetings between legal teams, written
15 correspondence, and the issuing of the formal Section 21
16 Notices to compel evidence to which you and I have
17 already referred. It is of paramount importance that
18 there is sufficient time for both the Inquiry team and
19 the wider cohort of Core Participants to react, respond,
20 and engage as fully as possible with any material
21 disclosed.

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

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

3 Unhappily, Chair, there are still ongoing issues in
4 obtaining the list from our main healthcare provider,
5 EPUT. The Inquiry acknowledges that given the scope of
6 our investigations and the fact that EPUT's two
7 predecessor trusts no longer exist, there are challenges
8 in reviewing the records to complete this exercise.

9 What remains to be seen, however, is whether those
10 challenges are insurmountable. The Inquiry will
11 continue to work closely with EPUT to support this
12 exercise. We have required a further iteration of
13 EPUT's List of Deceased to be provided to us by the end
14 of this month.

15 The Inquiry remains committed to doing all that we
16 can to obtain, as far as possible, accurate and
17 definitive Lists of Deceased. We are deeply troubled
18 that we still cannot say with any certainty how many
19 people died during the relevant period whilst under the
20 care of Trusts in Essex and we may never have
21 a completely accurate figure.

22 We will continue to work with EPUT to establish the
23 position as best we can. We consider it our
24 overwhelming responsibility to do so. But in the
25 meantime, Chair, our position remains that it would be

1 wholly irresponsible to publish any numbers until we are
2 confident that they are at least close to being
3 accurate.

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

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

20 And this denominator data relating to the population
21 of patients who were admitted to the same wards during
22 the same period will allow Professor Donnelly and her
23 team to place the final Lists of Deceased into their
24 proper context. Once we have completed our work to
25 finalise the Lists of Deceased and provided those lists

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

4 Professor Donnelly and her team have provided
5 assistance to the Inquiry in other important ways in the
6 meantime, however, and we will hear the views of
7 Professor Donnelly and her team in relation to the
8 evidence base for Oxevision and similar technologies
9 during the third week of this hearing.

10 Chair, against the background of poor staff
11 engagement with the Essex Mental Health Independent
12 Inquiry, the Lampard Inquiry has worked very hard indeed
13 to secure the cooperation of current and former staff
14 members who worked in mental health inpatient units
15 during the relevant period. There is, within the
16 Inquiry team, a specific Staff Team dedicated solely to
17 engaging with current and former members of staff.

18 A number of individuals have come forward of their
19 own volition and we are very grateful to them for their
20 assistance and their candour, and for the fact that some
21 of them have been willing to speak about their
22 experiences whilst they remain employed by EPUT. In
23 addition, the Inquiry has identified many more potential
24 staff witnesses. Our starting point for that exercise
25 was the Terms of Reference, followed by careful analysis

1 of the illustrative cases and a wider review of other
2 relevant evidence already held by the Inquiry.

3 It is important to reiterate, however, that this
4 Inquiry is not tasked with relitigating previous
5 inquests or other proceedings. It is also not our role
6 or responsibility to scrutinise the actions of
7 individual members of staff, save where it's necessary
8 to do so to explore whether there are systemic issues at
9 play.

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

18 The Inquiry is aware, however, that there may still
19 be many staff who we do not currently know about and who
20 have not come forward, not only because they fear
21 workplace repercussion should they give evidence about
22 colleagues and employers, but also because they fear
23 professional repercussions should they now provide
24 evidence that could have been provided before. We hope
25 that when they see that their colleagues have assisted

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

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

13 Let me move now, please, to say a few words about
14 this hearing, which runs from today until Thursday,
15 23 July.

16 Over the next three weeks, the Inquiry will hear
17 evidence from a variety of witnesses. We will hear
18 evidence from further bereaved families. We will hear
19 evidence from healthcare professionals who are or who
20 were employed by EPUT and its predecessor organisations.
21 We will hear evidence from the undercover reporter who
22 featured in the Channel 4 Dispatches documentary and we
23 will explore issues relating to resuscitation and to
24 observations in the use of technology.

25 Chair, this hearing will begin, however, with

1 evidence from senior representatives of EPUT, who you
2 have determined to call to account for EPUT's failure to
3 engage effectively with the Inquiry over a sustained
4 period of time. We will hear evidence this afternoon
5 from Paul Scott, who was Chief Executive Officer of EPUT
6 from October 2020 until the end of last month.

7 The background to this is as follows: last year, the
8 Inquiry became increasingly concerned about EPUT's
9 ability to engage with the Inquiry. The Inquiry raised
10 this concern repeatedly with EPUT, querying firstly the
11 composition of EPUT's Inquiry project team, and
12 secondly, their capacity to meet the demands and
13 obligations of a statutory Inquiry.

14 On 19 September last year, the Inquiry requested
15 a Data Assurance Statement from EPUT and this request
16 sought confirmation from EPUT, amongst other matters,
17 that their Inquiry Project Team was appropriately
18 resourced, that in responding to the Inquiry's
19 evidential requests, EPUT were using senior, clinical
20 and managerial input and oversight where appropriate.

21 The Inquiry was also concerned that we didn't have
22 a clear picture as to EPUT's methodology or any
23 limitations in responding to Rule 9 Requests. EPUT's
24 Data Assurance Statement was received by the Inquiry on
25 5 December 2025.

1 By way of example, on 18 August 2025, the Inquiry
2 issued a Rule 9 Request to EPUT seeking evidence
3 relating to the monitoring and evaluation of services
4 provided. This was, to a large extent, a request for
5 further information following the evidence given by
6 Dr Karale during the Inquiry's hearing in April last
7 year. It was an evidential request of which EPUT were
8 on notice.

9 After a lengthy period of repeated extension
10 requests, partial compliance and missed deadlines,
11 including the deadlines proposed by EPUT themselves, on
12 27 February this year you determined, Chair, to issue
13 a Section 21 Notice to compel EPUT to provide the
14 information first requested in August 2025.

15 The Inquiry remained concerned, however, that EPUT
16 were unable to meet the Inquiry's evidential requests,
17 of which there have now been over 200 to EPUT.

18 After protracted correspondence and continued
19 failures with compliance during February and March this
20 year, Chair, you determined to request a Position
21 Statement from EPUT which required them, amongst other
22 matters, to account for their failures in engagement, to
23 provide proper information as to their current capacity
24 and ability to discharge their obligations to the
25 Inquiry and to explain arrangements for Senior

1 Leadership transition and for reflections and learning.

2 Counsel to the Inquiry, Mr Griffin King's Counsel,
3 will explore the contents of that Position Statement
4 with Mr Scott this afternoon.

5 We will hear admissions made by Mr Scott on behalf
6 of EPUT that there were failures in EPUT's engagement
7 with the Inquiry which resulted in the Inquiry's loss of
8 confidence in EPUT's ability to engage effectively and
9 about the impact this may have on bereaved families and
10 other Core Participants.

11 Mr Griffin will ask questions about why those
12 failures occurred and seek assurances that EPUT has put
13 in place appropriate measures, such as to guarantee
14 future compliance. Tomorrow morning the Inquiry will
15 hear from Mr Loy Lobo, who is currently the acting Chair
16 of EPUT's board of directors following the sad death of
17 Hattie Llewelyn-Davies in May of this year.

18 Put shortly, Chair, you were so concerned by EPUT's
19 failures to date and the impact those failures have had
20 on the Inquiry's work, that you determined it necessary
21 not only to call EPUT to account but also to seek public
22 affirmation of EPUT's commitment to assisting the
23 Inquiry going forward.

24 The Inquiry acknowledges that over the past few
25 months, there has been a marked improvement in EPUT's

1 compliance. However, we consider that it is too soon to
2 determine whether the recent changes represent
3 sustainable long-term progress on the part of EPUT or
4 enhanced short-term delivery under significantly reduced
5 operational pressure.

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

12 As for previous hearings, the Inquiry has invited
13 the family witnesses to give evidence of their firsthand
14 accounts, observations, recollections and concerns. And
15 we've also invited them to give their current views on
16 what recommendations should be made for change. The
17 Inquiry will not be seeking comments or analysis from
18 the family witnesses on other documents that relate to
19 their relative's care and treatment.

20 Over the course of this week and next, the Inquiry
21 will hear from the following three bereaved families:
22 tomorrow, we will hear evidence from Lisa Wolff. Lisa
23 will give evidence about her daughter, Abbigail Smith,
24 who was born on 23 June 1995 and died on
25 16 February 2022, aged 26.

1 On Monday next week, Victoria Sebastian will attend
2 to give evidence about her daughter Elise Sebastian, who
3 was born on 24 May 2004 and who died on 19 April 2021,
4 aged just 16.

5 Lynne Breaker-Rolfe will give evidence next Tuesday
6 about her husband, Roy Breaker-Rolfe, who was born on
7 19 April 1957 and died on 21 April 2021 aged 63.

8 Those bereaved families highlight their experiences
9 of a number of failings that have become sadly familiar
10 to this Inquiry and to those following it, including:
11 failures throughout to communicate with the families and
12 support networks of patients, to listen to their
13 concerns or to seek input from those who knew the
14 patient best; dismissive, defensive and hostile
15 attitudes towards families who were attempting to
16 provide input into the care and treatment of their
17 relative or to understand or question -- or question
18 planned approaches to care and treatment; inadequate
19 assessments that failed to take proper account of a
20 patient's history, background and risk factors, with
21 reliance placed, instead, on immediate presenting
22 symptoms and assurances from the patient that all was
23 well; failures to plan appropriately for safe discharges
24 as well as wholly inadequate support and care following
25 discharge; medication errors; a lack of care, compassion

1 and therapeutic intervention during inpatient stays with
2 allegations of inappropriate restraint, bullying and ill
3 treatment; diagnostic confusion and overshadowing, with
4 diagnoses being applied, withdrawn, and re-applied
5 without proper foundation or valid, robust assessment;
6 physical health issues ignored or overlooked; clear
7 failures in observations of patients and management of
8 risk, including in relation to the use of Oxevision
9 surveillance technology; in relation to resuscitation,
10 delays and basic failures with staff inadequately
11 trained and unfamiliar with equipment or proper
12 processes; significant failures in recordkeeping,
13 including falsified observation records, and the mixing
14 of records of patients; inadequate or non-existing
15 training for staff on autism; and wholesale failures to
16 identify, understand, or plan appropriately for the
17 needs of autistic patients or, at the most basic level,
18 to take neurodiversity into account in any aspect of
19 care and treatment.

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

23 **THE CHAIR:** If that suits you.

24 Ten minutes?

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

1 **THE CHAIR:** We'll return at 11.30.

2 **(11.02 am)**

3 **(A short break)**

4 **(11.33 am)**

5 **THE CHAIR:** Ms Harris.

6 **MS HARRIS:** Thank you again, Chair.

7 Chair, as you and I leave already outlined, this
8 hearing marks the first hearing at which we will hear
9 evidence from those who work or have worked in mental
10 health inpatient units in Essex. The evidence those
11 witnesses will give represents their own experiences and
12 recollections and will ultimately be assessed by the
13 Inquiry in conjunction with all other evidence in the
14 round.

15 The first staff witness from whom the Inquiry will
16 hear on Wednesday this week is Stuart Ayris, a retired
17 Registered Mental Health Nurse.

18 Mr Ayris will give evidence about what he saw and
19 experienced whilst working within EPUT and its
20 predecessor organisations over a period of almost
21 22 years.

22 He worked in adult settings, including the
23 Christopher Unit and Finchingfield Ward at the Linden
24 Centre, and Ardleigh Ward at The Lakes.

25 Mr Ayris raises concerns about the culture at EPUT

1 and its predecessor trust, North Essex Partnership
2 University NHS Foundation Trust, NEPT. He reports
3 understaffing, overuse of medication, disjointed
4 approach to physical conditions and deficient treatment
5 of those with drug and alcohol dependency, dementia and
6 learning disabilities, amongst other matters.

7 He also expresses concerns about the environment of
8 some wards. He reports issues with family engagement
9 and shortcomings with IT systems. Mr Ayris's evidence
10 also touches upon the deaths of Diana Hammond, Ben
11 Morris, and Glenn Holmes.

12 Chloe Cawston is currently employed by EPUT as
13 a service manager covering the Linden Centre and the
14 Crystal Centre in Chelmsford. She has been a service
15 manager since 2020, initially covering the Basildon
16 Mental Health Unit and the Linden Centre.

17 Ms Cawston will give evidence about her experience
18 working within EPUT, and its predecessors, NEPT and
19 SEPT. She gives evidence, amongst other matters, about
20 barriers to assessment, modification to the ward
21 environment, shifts in treatment, high turnover in staff
22 and the impact of the national shortage of nurses on the
23 provision of mental health care.

24 She has witnessed compassion fatigue amongst staff
25 and acknowledges the risk of desensitisation amongst

1 those working on inpatient units. She will also speak
2 to her experience of the use of Oxevision.

3 Ian Arthur is a Registered Mental Health Nurse. He
4 completed his training in August 2000 and has worked for
5 EPUT and its predecessor organisations since 2003.
6 Mr Arthur is currently seconded to the Mid and South
7 Essex NHS Foundation Trust, MSEFT, working as the
8 Integrated Discharge Hub Mental Health lead. His
9 previous experience includes working at various
10 managerial levels on older adult wards, dementia care
11 wards, and during various periods from 2018 to October
12 2023, he was also responsible for managing the Peter
13 Bruff Unit, an assessment unit for North Essex-based
14 patients.

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

21 Zoe Bunting has been a Registered Mental Health
22 Nurse since 1997 holding a range of clinical and
23 managerial roles in that time for NEPT and then EPUT for
24 around 29 years. She worked as Ward Manager of the Ruby
25 Ward at the Crystal Centre Chelmsford, an older adult

1 inpatient mental health ward, between 2016 and 2020, and
2 thereafter as Ward Manager and Acting Matron at the
3 Peter Bruff Assessment Unit until 2024. She is
4 currently a Professional Nurse Educator at EPUT.

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

11 Ms Bunting will give evidence about her experience
12 working in NEPT and EPUT. She will provide her views on
13 the assessment process. She will describe how admission
14 decisions were often heavily influenced by bed capacity
15 constraints and systemic pressures rather than being
16 driven by purely clinical need.

17 Ms Bunting's evidence will also touch upon the
18 assessment of falls, which is a key issue arising from
19 the death of Doris Smith. She will also explain how she
20 was asked to complete the Patient Safety Incident
21 Response Framework investigation into the death of
22 Christopher Nichols without having received training and
23 how she found that extremely challenging.

24 Ms Bunting will provide evidence about various ward
25 environments, expressing her view that the Peter Bruff

1 Unit was not fit for purpose. She will touch upon her
2 experience of training around Oxevision, which was not
3 immediately available to her on joining the Peter Bruff
4 Unit with little by way of guidance.

5 Brian O'Donnell is currently employed by EPUT as the
6 Clinical Lead for Compliance and Assurance. He was
7 previously the Clinical Lead at the St Aubyn's Centre, a
8 Child and Adolescent Mental Health Service, a CAMHS
9 unit, in Colchester. Mr O'Donnell has worked in CAMHS
10 throughout his career. He initially began working as
11 a Healthcare Assistant in 2003, working mostly on
12 Longview Ward, which is NEPT, before qualifying as
13 a Registered Mental Health Nurse in 2009. He returned
14 to Longview Ward as a Registered Nurse. In 2014 he
15 became the Ward Manager of Larkwood Ward, a CAMHS
16 Psychiatric Intensive Care Unit, and in 2020 he moved
17 back to the Longview Ward as a Ward Manager.

18 Mr O'Donnell will give evidence about the working
19 conditions for staff on CAMHS wards, including training,
20 internal recruitment, staffing levels, admission
21 decisions, patient observations, and the use of
22 Oxevision.

23 He will also give evidence of his experience on
24 adult wards and his views on culture and leadership at
25 the trust.

1 Mr O'Donnell's evidence touches upon the deaths of
2 Rebecca Watkins, Charlotte Cobbold, Madison Naylor,
3 Molly-Ann Sargeant, Antonia Trapani and Elise Sebastian.

4 Stuart McGough is also a retired Registered Mental
5 Health Nurse. He worked in mental health settings in
6 Essex between August 1999 and December 2008. Mr McGough
7 will give evidence about his experience of mental health
8 inpatient care in Essex and in particular his experience
9 of working at the Linden Centre, where he held the role
10 of Clinical Manager and oversaw Galleywood and
11 Finchingfield Wards. He will speak to ward environment
12 and refer to staffing and the reliance placed on agency
13 and bank staff. He will give evidence about the
14 management support in place for staff, including when
15 they were undertaking investigations.

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

21 Louise Borton is a Registered Mental Health Nurse.
22 Her first role as a staff nurse was in October 2016 on
23 the Cedar Ward at Rochford Hospital. She has worked in
24 ward manager and matron roles at Basildon Mental Health
25 Unit since 2018. She will also give evidence of her

1 experience of working within EPUT and its predecessor,
2 SEPT. Ms Borton's evidence will touch upon risk
3 assessments and the lack of access to appropriate
4 services for those with comorbidities, including drug
5 and alcohol dependency. She will describe how physical
6 changes to the ward environment, in particular the move
7 from dormitory to single rooms, has led to improvements
8 in privacy, dignity, safety, and respect for personal
9 space, better supporting recovery.

10 Her evidence will touch upon the barriers to
11 treating those living with emotionally unstable
12 personality disorder, EUPD, and the obstacles in the
13 process of transferring patients which, in her
14 experience, persisted after the recommendations arising
15 from the death of Bethany Lilley.

16 She will speak about the difficulties in updating
17 patient records and how, in practice, care plans were
18 often treated as an administrative requirement rather
19 than a dynamic clinical tool.

20 She will give her experience -- sorry, her evidence
21 about her experience of the use of Oxevision, which she
22 states "negatively impacted inpatient mental health
23 care" and about ward culture, which she states was "not
24 consistently positive".

25 Beverley Switzer is a Healthcare Assistant with over

1 10 years' experience. She will also provide her
2 evidence by way of a pre-recorded session to be played
3 thereafter. Ms Switzer has worked within EPUT Community
4 Dementia Services since 2022. Prior to this, she worked
5 on the Peter Bruff Unit from August 2020. Ms Switzer
6 will give evidence about her experience of working
7 within EPUT, touching on ward environment and
8 facilities, observations in the use of Oxevision,
9 staffing, training, and her experience of serious
10 incidents and the response to those incidents.

11 Chair, you will recall that on the first day of the
12 Inquiry's hearing in April 2005, the Inquiry played the
13 Channel 4 Dispatches documentary "Hospital Undercover:
14 Are Our Wards Safe?" That documentary shed light on
15 practices across four wards within EPUT. Dawn Low was
16 the undercover reporter who appeared in that
17 documentary.

18 As part of her deployment under cover, Ms Low worked
19 as a Healthcare Assistant during a two-month period from
20 5 April 2022 to 8 June 2022. She undertook shifts in
21 the Willow Ward, Rochford Hospital, the Mental Health
22 Urgent Care Department in Basildon Hospital, Cherrydown
23 Ward in Basildon Mental Health Unit, and Galleywood Ward
24 in the Linden Centre. She will give an account of her
25 experience whilst working under cover, which includes

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

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

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

5 Chair, in March of this year, having heard a number
6 of accounts given by bereaved families, and having
7 considered concerns raised by Core Participants in
8 submissions, you directed your team to look closely at
9 issues relating to the resuscitation of patients and
10 emergency response on mental health inpatient units, and
11 to do so without delay.

12 Some of the evidence that the Inquiry has already
13 heard gives rise to serious questions about clinical
14 response, emergency decision making, and the adequacy of
15 resuscitation practices and procedures, past and
16 present, within mental health inpatient settings.

17 You determined that this was an emerging area of
18 investigation with potential implications for the safety
19 of current patients. You considered that it was
20 important to begin exploring these issues straight away
21 and that is what your team has done. Given that you
22 were concerned about the risk of harm to current
23 patients, you directed that the Inquiry focus on current
24 and recent practices in order to help you identify
25 quickly whether there is a need for a more immediate

1 change in this area.

2 On Monday, 20 July, as timetabled, the Inquiry will
3 provide a more detailed update on the work it has done
4 on this standalone topic. The Inquiry has already
5 disclosed a significant quantity of material, including
6 some of the case summaries of the illustrative cases
7 which reflect these issues. We will also provide an
8 overview of our proposed next steps during that update
9 on Monday, 20 July.

10 The Inquiry will also hear evidence on Monday,
11 20 July from Adam Benson-Clarke who is the director of
12 clinical and service development at the Resuscitation
13 Council UK, RCUK for short. RCUK issues resuscitation
14 standards and guidance for the healthcare sector in the
15 UK, including specific standards and guidance for mental
16 health inpatient units. Mr Benson-Clarke will explain
17 what cardiac arrest is and give an overview of how it is
18 treated, including cardiopulmonary resuscitation, CPR,
19 and the use of automatic external defibrillators.

20 He will explain the development and application of
21 RCUK's quality standards for CPR training, equipment and
22 drugs on mental health inpatient wards, covering what
23 RCUK consider to be obligatory, normal, and best
24 practice.

25 The Inquiry's investigation into practices

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

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

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

21 As part of our investigations, the Inquiry has
22 sought to understand how Oxevision has been used at
23 Trusts outside of Essex, so as to provide important
24 context to the evidence that we have heard. The Inquiry
25 has therefore obtained evidence from a number of other

1 NHS Trusts who use Oxevision in order to assist us in
2 our assessment of how the system has been implemented,
3 governed, and used in practice across different
4 settings.

5 The comparator evidence is intended to assist the
6 Inquiry in assessing whether the issues arising from the
7 evidence concerning EPUT are Trust specific, or whether
8 they are reflected more widely in the implementation and
9 use of Oxevision elsewhere. It also helps us understand
10 whether other Trusts have taken a different approach to
11 that in Essex.

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

22 In addition, in the last two days of this hearing,
23 the Inquiry will hear evidence from two expert
24 witnesses. Firstly, Jill Archibald will provide
25 evidence as to expected practices in respect of

1 observations and therapeutic engagement, and also the
2 role technology can play in patient care. And secondly,
3 Professor Donnelly and Dr Maria Christodoulou will
4 provide expert evidence looking at the strength of the
5 academic literature supporting the use of Oxevision as
6 well as providing important contexts about the design of
7 medical studies and the limits on their interpretation.

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

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

14 As with our previous hearings, the witness
15 statements and the expert reports provided for this
16 hearing by those attending to give oral evidence will
17 also stand in full as their evidence. Statements will
18 not be read out during the course of the hearing.
19 Rather, the witnesses will be asked careful and focused
20 questions about what they've written and topics they can
21 assist with.

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

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

5 Firstly, staff names. Staff names, including those
6 of junior staff, will generally be disclosed in the
7 course of the Inquiry. Individuals can apply for their
8 names to be withheld, however, in line with relevant law
9 and the Inquiry's protocol on restriction orders. Each
10 application for a restriction order is considered
11 individually by you, Chair, and some staff may need time
12 to decide whether to apply for anonymity and to seek
13 legal advice and while they're given this time, their
14 names will be redacted temporarily. This ensures
15 fairness. And to be clear, in many cases, those
16 redactions are likely to be temporary only.

17 Secondly, methods of self-harm inflicted death or
18 self-harm. These details, as well as other highly
19 distressing content, may be redacted to protect the
20 public from potential harm. The Inquiry may also apply
21 redactions where it considers the information is unusual
22 and could instruct others.

23 Thirdly, there is other information which may fall
24 under the Inquiry's Privacy Information Protocol. This
25 will be information which is personal in nature and

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

5 And finally, in terms of giving evidence, can
6 I remind those following and engaging with the Inquiry
7 that we have in place various further protocols. This
8 is with the aim of assisting those who wish to engage
9 with the Inquiry in providing the best possible
10 evidence, in a way that ensures they are also supported
11 throughout the process.

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

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

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

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

8 It is, of course, not necessary to attend the
9 hearing in person to follow the Inquiry's proceedings.
10 Core Participants and their lawyers who are not
11 attending in person can watch the hearing live on
12 a secure weblink. The hearing will also be streamed on
13 the Lampard Inquiry YouTube channel for anyone who
14 wishes to follow us remotely. But please note that this
15 will be streamed with a time delay of ten minutes.

16 Chair, as the work of the Lampard Inquiry
17 progresses, the size of our task continues to grow
18 exponentially. This is because, as you have already
19 stated, it is becoming increasingly clear that the
20 serious concerns and systemic issues we are
21 investigating are unlikely to be individual to Essex,
22 and the work of the Lampard Inquiry will be of national
23 importance. It is for this reason that the Inquiry is
24 increasingly looking to achieve meaningful comparisons
25 with other Trusts across the UK. Whilst the Inquiry

1 must apply serious scrutiny to practices in Essex, how
2 do these practices really differ to what goes on
3 elsewhere?

4 The Lampard Inquiry awaits news of the statutory
5 Inquiry into the Tees, Esk and Wear Valleys NHS
6 Foundation Trust, TEWV, to which you have referred, with
7 particular interest. The Inquiry notes from the
8 material available that the serious concerns and
9 systemic issues to be investigated in relation to those
10 who died under the care of TEWV are likely to mirror
11 very closely those we are already examining in relation
12 to those who died under the care of Trusts in Essex.

13 They are clearly national concerns and issues, and
14 as previously outlined, the Lampard Inquiry will hear
15 evidence from the Director of Nursing and Quality at
16 TEWV in the third week of this hearing.

17 Furthermore, the Lampard Inquiry has been following
18 closely the evidence being given at the Nottingham
19 Inquiry. The Nottingham Inquiry is seeking to
20 understand the events, acts and omissions that led
21 Valdo Calocane brutally killing three individuals and
22 seriously injuring three others. Prior to those
23 attacks, Valdo Calocane interacted with mental health
24 services.

25 The serious concerns and systemic issues that appear

1 to have given rise to the tragic events in Nottingham,
2 particularly those issues relating to poor care
3 planning, treatment and management of those with serious
4 mental illness, echo the concerns and issues emerging in
5 the Lampard Inquiry. We also note that there has been
6 similar criticism about the way in which the Trust in
7 Nottingham responded to concerns raised. We note that
8 Sir Rob Behrens provided markedly similar evidence to
9 the Nottingham Inquiry as that which he provided to the
10 Lampard Inquiry, referencing lack of candour and
11 defensiveness on the part of NHS Trusts.

12 Furthermore, the Lampard Inquiry has reviewed with
13 care the recently published report of the Muckamore
14 Abbey Hospital Inquiry to which you've already referred.
15 Whilst, as you say, Chair, the recommendations of the
16 Muckamore Inquiry are limited to Northern Ireland, it is
17 striking, once again, to read that a significant number
18 of the systemic failures identified by that Inquiry are
19 the same alleged systemic failures that we are
20 investigating within Trusts in Essex.

21 Systemic issues in inpatient mental health care are
22 very evidently a national problem. Recommendations made
23 by the Lampard Inquiry will inevitably include national
24 recommendations. Against this background, Chair, we do
25 not underestimate the importance of our work, nor our

1 responsibility to bring about lasting change. And it is
2 clear, Chair, that change is very much needed still. As
3 part of its work, for example, the Inquiry will hear
4 evidence, amongst other matters, about historic issues
5 on Ardleigh Ward at The Lakes in Colchester. It was
6 with real disquiet, therefore, that the Inquiry learnt
7 of very recent CQC concerns relating to Ardleigh Ward
8 following an unannounced inspection in January this
9 year.

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

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

25 The Inquiry will therefore commence its substantive

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

4 This revision to the Inquiry's hearings plan will
5 provide an opportunity to EPUT and to the other material
6 providers to demonstrate consistent and timely
7 compliance with evidential requests. The revision will
8 also allow the Inquiry to develop further its system of
9 disclosure outside of hearings, enabling Core
10 Participants to review material for hearings next year
11 in shorter time.

12 Chair, the aim of this Inquiry is to bring about the
13 long-awaited and greatly needed improvements to
14 inpatient mental health care both in Essex and beyond.
15 As I said at the outset of this opening statement,
16 Chair, your team remains committed absolutely to
17 assisting you with this task, and we will continue to
18 work without let-up towards that aim. Whilst the mental
19 health landscape is changing in the UK, there is
20 a considerable way to go.

21 This Inquiry welcomes all work being undertaken,
22 locally, or nationally, towards positive change. We
23 were pleased last month, for example, to read the
24 interim report of the Independent Review into Mental
25 Health Conditions, ADHD and Autism, which whilst not yet

1 reaching conclusions, provides an update of what they
2 have learned so far and their plans for the next phase
3 of that review.

4 The evidence being explored by that review dovetails
5 with the important issues that we are investigating,
6 issues which will feature again during the course of
7 this hearing.

8 Chair, the purpose of this Inquiry is to make
9 recommendations for that long-term change and for this,
10 we remain committed to our recommendations and
11 implementation forum. This Inquiry is focused not only
12 on making meaningful recommendations but also on
13 achieving their implementation going forward.

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

19 **THE CHAIR:** Until 1.30. Thank you.

20 **(12.06 pm)**

21 **(The Short Adjournment)**

22 **(1.33 pm)**

23 **THE CHAIR:** Mr Griffin.

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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.

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

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

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

15 "a. The failures to meet deadlines to date;

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

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

23 And can you confirm, Mr Scott, that over the
24 13 pages of the appendix, the Chair required EPUT
25 address certain specific matters and concerns, namely

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

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

11 **A.** That's correct.

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

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

15 **A.** Yes, we did.

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

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

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

21 **A.** Yes.

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

24 **A.** Yes.

25 **Q.** Do you have it in front of you?

1 **A.** Yes.

2 **Q.** Is it 31 pages long?

3 **A.** Yes.

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

5 **A.** Yes.

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

10 Now the Statement of Truth, does it say this:

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

15 And does it go on to say that:

16 "I confirm that:

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

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

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

1 tested in oral evidence; and

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

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

9 **A.** I have, yes.

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

13 **A.** Yes.

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

16 **A.** Yes.

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

21 That can go down, please. Thank you.

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

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

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

2 **A.** No.

3 **Q.** You provided a Position Statement dated 27 March 2025 on

4 behalf of EPUT and came to give evidence at our hearing

5 on 15 May last year.

6 **A.** Yes, I did.

7 **Q.** On that occasion did the Position Statement address, in

8 very general terms, EPUT's involvement in the care of

9 mental health inpatients during the period being

10 considered by the Inquiry?

11 **A.** Yes.

12 **Q.** When you gave evidence last year, you informed the Chair

13 that you became CEO of EPUT in October 2020. You left

14 that role at the end of last month. Was it 30 June, the

15 date that you --

16 **A.** The 30th, yes.

17 **Q.** Does that mean, though, that overall you were EPUT's CEO

18 for about five and a half years?

19 **A.** Yes.

20 **Q.** Did you officially take up your new role at the start of

21 this month, July?

22 **A.** I'm employed by the organisation, in my new role, but

23 I am taking some leave and I won't start there until

24 21 July.

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

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

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

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

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

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

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

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

24 **A.** Ipswich and Colchester.

25 **THE CHAIR:** And your offices will be where?

1 **A.** There's two headquarters.

2 **THE CHAIR:** Thank you.

3 **MR GRIFFIN:** Was the move connected to criticism the Trust

4 has received during the currency of this Inquiry, and as

5 a result of other processes?

6 **A.** No.

7 **Q.** Has anyone in a senior role at EPUT suggested that you

8 should leave the organisation?

9 **A.** No.

10 **Q.** Have you moved on because you feel it's job done, that

11 the various issues that have been identified have now

12 been addressed?

13 **A.** Well, I think I made clear last year that there's still

14 more to do. I think -- I hope I leave the organisation

15 in a better position than I joined it and I've steered

16 the organisation through some difficulty.

17 **Q.** Do you think leaving now might actually be premature and

18 it should have waited until the end of this Inquiry?

19 **A.** I wouldn't say so. I think, you know, six years is

20 a long time to lead an organisation as complex as EPUT

21 and I think, you know, we've also got, you know, I do

22 recognise the needs of the Inquiry. We've also got to

23 recognise the needs to make sure we've got the right

24 energy and focus in the leadership.

25 **Q.** You refer in this statement to the transfer of

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

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

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

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

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

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

18 **A.** Yes.

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

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

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

1 recently.

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

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

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

25 **THE CHAIR:** Thank you for that.

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

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

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

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

18 We covered some of this when you gave evidence
19 before but it's probably helpful briefly to remind
20 ourselves of it now. Was EPUT the Trust formed on
21 1 April 2017?

22 **A.** Yes.

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

1 University Foundation Trust, or NEPT?

2 **A.** Yes.

3 **Q.** We might refer to them as the predecessor trusts as we
4 go along. This Inquiry is looking at events over
5 a 24-year period from the start of 2000 to the end of
6 2023, and that clearly means, doesn't it, that we'll be
7 looking at events within the predecessor trusts as well
8 as at EPUT?

9 **A.** Yes.

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

14 **A.** Yes.

15 **Q.** Has one method by which this Inquiry asked for
16 information and documentation been to issue what's known
17 as a Rule 9 Request in writing under the Inquiry Rules
18 2006?

19 **A.** Yes.

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

24 **A.** That's correct, yes.

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

1 in response to the requirements of a Section 21 Notice.
2 The Inquiry has issued Section 21 Notices for other
3 information and material held by EPUT too. Are you now
4 aware, Mr Scott, that Section 21 of the Inquiries Act
5 2005 empowers the Chair, by notice, to require a person
6 or an organisation to give evidence and to produce
7 documents and materials to the Inquiry?

8 **A.** Yes.

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

13 **A.** Yes.

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

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

24 So this is what you say:

25 "The Trust recognises that aspects of its engagement

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

7 And paragraph 5:

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

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

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

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

23 **A.** Yes.

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

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

5 Yes, could you expand 107, thank you.

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

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

16 So just dealing with that first.

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

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

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

25 **A.** Yes.

1 **Q.** We can see on the screen there, on the top line, that
2 you say that "EPUT underestimated at the outset". Could
3 you just explain what you mean there by "outset"?
4 **A.** Well, I think -- at the outset, I guess the start of the
5 Inquiry, we resourced what we thought was appropriate
6 for the Inquiry, and for many months, that was suitable
7 for certainly the Inquiry. We didn't appreciate or
8 didn't estimate -- underestimated, I think, the increase
9 and intensity of the evidence required by the Inquiry as
10 we came into the latter half of last year.
11 **THE CHAIR:** So that was the statutory Inquiry?
12 **A.** The statutory Inquiry, yeah.
13 **MR GRIFFIN:** Would you agree that this should have been
14 clear from the Terms of Reference of the original
15 non-statutory Inquiry, which was established in
16 September 2021? They required it to review the
17 circumstances and practices surrounding the deaths of
18 mental health inpatients over a 21-year period, that was
19 up until the end of 2020, and to draw conclusions both
20 on a local Essex and national basis?
21 **A.** Look, I think we accept responsibility. We did
22 underestimate the level of resource that was going to be
23 needed to serve the Inquiry, and I think we say in our
24 Position Statement, EPUT or any NHS organisation is
25 not -- this is, you know, new to all of us, actually,

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

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

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

17 **Q.** Because I mean, we've just spoken about the
18 non-statutory Inquiry established in September 2021,
19 then there were the Terms of Reference of the statutory
20 Inquiry from April 2024, and then of course there was an
21 18-page list of issues from early 2025. So these are
22 all massive signposts, aren't they, Mr Scott, making
23 clear the nature and extent of EPUT's proper involvement
24 in this Inquiry?

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

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

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

11 **A.** Sorry, can you just repeat that?

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

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

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

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

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

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

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

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

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

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

25 **A.** Yes.

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

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

8 A. Yes.

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

12 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

5 **A.** Sorry, can you just --

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

8 **A.** Sorry, what paragraph was it?

9 **Q.** Paragraph 26 at the bottom of page 6.

10 **A.** Yes, okay.

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

12 **A.** Yes.

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

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

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

24 **Q.** Thank you.

25 Might it mean learning lessons from the way in which

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

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

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

11 **A.** Yeah.

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

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

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

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

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

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

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

12 Having a look at the first example, this was
13 a request for evidence that led to a series of delays in
14 complying and ultimately led to the Chair issuing
15 a Section 21 Notice on EPUT. So this relates to Inquiry
16 Rule 9, number 26, so Rule 9(26), which was issued on
17 18 August 2025, and that was for a witness statement
18 from EPUT, and supporting material, in respect of the
19 issue of monitoring and evaluation.

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

25 Do you accept that EPUT's approach to monitoring and

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

3 **A.** Yes.

4 **Q.** Thank you.

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

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

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

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

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

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

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

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

5 "The Inquiry issued the Rule 9(26) request on
6 18 August 2025 with a 4-week deadline ..."

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

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

14 **A.** Yes.

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

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

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

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

25 "During a weekly meeting between legal teams on

1 16 September 2025, EPUT's legal representatives
2 indicated that they had started work on the response to
3 Rule 9(26) but were not in a position to set down
4 a timeline for completion yet."

5 Dropping down to paragraph 8:

6 "During a weekly meeting between legal teams on
7 30 September 2025, EPUT's legal representatives
8 indicated that good progress was being made in relation
9 to the Rule 9(26) response and requested an extension of
10 time to mid-December. The Inquiry indicated that EPUT
11 should make this request in writing but that it would
12 likely be accepted."

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

17 **A.** Yes.

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

22 **A.** (No audible answer given).

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

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

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

3 So that was a different request.

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

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

20 But:

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

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

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

4 Paragraph 19:

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

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

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

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

23 **A.** Yes.

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

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

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

5 **A.** Yes.

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

7 **A.** Yes.

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

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

1 through it.

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

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

14 **A.** I -- well, yes. Yes.

15 **Q.** Can we take that down, please.

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

22 **A.** Yes.

23 **Q.** Thank you. The starting point is a letter written by
24 the Inquiry to EPUT's legal representatives on
25 3 February this year, concerning -- the title was

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

2 **A.** Yes.

3 **Q.** And have you read it recently?

4 **A.** Yes.

5 **Q.** Can you confirm that it provided EPUT with a list of

6 Rule 9 Requests from the Inquiry that were sitting with

7 EPUT and that it should prioritise?

8 **A.** Yes.

9 **Q.** And that the letter expressed that providing the

10 prioritised requests was "critical to the Inquiry's

11 ability to prepare and deliver the content for the July

12 hearings", so this hearing, "and to achieve the wider

13 hearing timetable that's been published." Can you

14 confirm that the letter included that?

15 **A.** Yes.

16 **Q.** And finally that in the letter the Inquiry sought

17 assurance from EPUT that it's able to meet the Inquiry's

18 request for evidence to the deadlines stated or, where

19 this assurance can't be provided, a clear explanation of

20 what action EPUT is taking to ensure that it's able to

21 do so, for example securing additional resources? Does

22 the letter cover that as well?

23 **A.** Yes.

24 **Q.** And in fact does it also say that any, "any assurances

25 provided must be grounded in realistic and achievable

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

4 **A.** Yes.

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

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

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

10 And you go on to say, paragraph 33:

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

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

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

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

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

24 **A.** I completely understand that, yes.

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

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

4 **A.** Yes.

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

9 **A.** Yes.

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

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

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

15 **A.** Yes.

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

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

25 "The failure to forward 30 Next of Kin letters

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

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

12 **A.** Yes.

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

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

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

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

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

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

1 escalated.

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

5 **A.** Yes.

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

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

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

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

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

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

19 Can you just expand on that, please.

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

25 **Q.** What changes have been made to improve the culture

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

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

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

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

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

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

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

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

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

10 **THE CHAIR:** What -- (overspeaking) --

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

18 **THE CHAIR:** Have you had those conversations with people?

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

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

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

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

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

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

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

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

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

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

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

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

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

24 **A.** Yes.

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

1 of information?

2 **A.** Yes.

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

7 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

24 **A.** Yes.

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

1 **A.** Yes.

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

5 **A.** Yes.

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

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

11 **A.** Yes, and -- yes they do.

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

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

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

22 **A.** Yeah.

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

25 **A.** Yes.

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

6 A. Yes.

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

11 A. I think so, yes.

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

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

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

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

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

1 were used by the predecessor trusts?

2 **A.** Yes.

3 **Q.** Yes? Thank you.

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

8 **A.** Yes.

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

14 **A.** **(Witness nodded)** .

15 **Q.** What is the current position with the EPR?

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

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

19 **A.** Yes.

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

22 **A.** Yes, it will, substantially, yeah.

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

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

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

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

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

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

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

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

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

21 **Q.** Do you know what Single Patient Record is?

22 **A.** Sorry?

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

1 **A.** Right, okay.

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

3 **A.** Yes, yes.

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

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

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

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

22 **A.** No.

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

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

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

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

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

13 **A.** Yes.

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

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

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

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

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

1 issue in relation to the information from predecessors?

2 **A.** Yes.

3 **Q.** But if I've understood your evidence correctly, you're
4 not entirely sure about the extent to which it might
5 affect EPUT information?

6 **A.** I am confident in the EPUT information, but the change
7 in search capability, I don't know what impact that
8 would have had but I'm sure we'll come to --

9 **Q.** Let's see how far we get as we work through what you've
10 said.

11 This issue that we've got up on the screen, are you
12 aware that the Inquiry only found out about it in
13 September last year?

14 **A.** Yes.

15 **Q.** Do you know why EPUT didn't notify the Inquiry about
16 this issue earlier on?

17 **A.** The issue, sorry?

18 **Q.** So this issue here, these limitations in relation to
19 search capability prior to 2025, the Inquiry heard from
20 EPUT about these limitations only very late -- in
21 September 2025. Do you know why it took so long for
22 EPUT to notify the Inquiry of this particular
23 limitation?

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

25 **Q.** We're going to come on to two software platforms that

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

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

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

9 **A.** Yes.

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

11 **A.** Yes.

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

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

16 **Q.** Thank you.

17 **A.** It was very labour intensive.

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

23 **A.** Yes.

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

1 then be subjected to more sophisticated searching?

2 **A.** Yes.

3 **Q.** Is the plan to continue to upload documents to

4 Relativity to benefit from its functionality?

5 **A.** My understanding is that Relativity is used for

6 a document management system and search capability for

7 documents that have been used to disclose Rule 9

8 information so we'll continue to update that as we

9 supply Rule 9 -- (overspeaking) --

10 **Q.** But the limitation of Relativity, if that's the correct

11 term, is that a document has already to have been

12 identified and uploaded --

13 **A.** Yes.

14 **Q.** -- to the system before that search functionality can be

15 used; is that correct?

16 **A.** Yes.

17 **Q.** Thank you. You say at paragraph 42 that the database

18 continues to be updated with material and currently

19 contains a repository of some 167,000 documents?

20 **A.** Yes.

21 **Q.** Moving on to Netwrix, which you refer to in paragraph 43

22 as a "data classification and search tool" that allows

23 EPUT more thoroughly to search its shared drives, you

24 say that Netwrix searches all text within documents

25 using key search terms across document titles, and

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

5 **A.** Yes.

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

9 **A.** Yes.

10 **Q.** Are you still using it now?

11 **A.** Yes.

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

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

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

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

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

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

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

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

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

14 **A.** Yes, that started -- the process of that started in
15 2023, as I said and, you know, we were constantly trying
16 to enhance the team so we'd brought associate directors
17 of -- for the project team in. We brought a project
18 director who had much more experience of dealing with
19 these kind of -- this kind of work. So it was
20 a constant evolution but the absolute, "We've got to
21 fundamentally change", was November.

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

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

1 **THE CHAIR:** Thank you.

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

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

9 This is dealing with Relativity and Netwrix. You
10 say:

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

13 Just pausing there; is that correct?

14 **A.** Yes.

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

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

19 **Q.** But you go on to say this:

20 "... important limitations remain."

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

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

1 Can you expand on that, please?

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

6 **Q.** Understood.

7 **A.** But I understand that they're not readable on our
8 servers and the only way to access that information is
9 to log into that software itself. So therefore the
10 Netwrix capability is not available to those systems,
11 and then furthermore, there's paper records, we've got
12 40,000 boxes of paper records which aren't available to
13 Netwrix, as well.

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

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

21 And you say at (i):

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

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

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

4 **A.** Yes.

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

7 **A.** Yes.

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

11 **A.** No.

12 **Q.** Thank you.

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

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

20 **Q.** Were these paper records?

21 **A.** Yes.

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

24 **A.** We don't.

25 **Q.** What assessment has EPUT undertaken of the impact of

1 that loss of documentation on the Inquiry's
2 investigations?

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

4 **Q.** Can you take that down, please.

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

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

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

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

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

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

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

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

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

10 **A.** I can't here today, no.

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

14 **A.** I don't know.

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

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

20 **Q.** Just dealing with that list that we can see on the
21 screen, you refer at (b), can you see that, to
22 "incomplete or inconsistent historic data migration."
23 Can you explain what that refers to, please?

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

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

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

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

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

14 **A.** Yes.

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

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

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

1 **A.** Yes.

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

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

6 **Q.** Oh really?

7 **A.** Yes.

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

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

17 **Q.** Understood.

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

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

24 **A.** Yes.

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

1 something else?

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

3 **Q.** So there may be more examples as well?

4 **A.** I'm not aware of any more.

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

7 **A.** Yes.

8 **Q.** Thank you.

9 Can you take that down, please.

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

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

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

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

18 **A.** Yes.

19 **Q.** So perhaps you can answer your own question.

20 **A.** Yes.

21 **Q.** What were you referring to there?

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

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

1 April 2017 is needed?

2 **A.** Yes.

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

8 **A.** Yes.

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

14 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

18 Are those the records you've just been describing?

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

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

1 happened and what has gone wrong?

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

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

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

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

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

21 **Q.** And has that changed?

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

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

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

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

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

14 **A.** I don't.

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

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

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

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

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

8 **A.** Yeah.

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

13 What did you mean by that?

14 **A.** Sorry, which paragraph are we on?

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

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

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

20 **A.** No.

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

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

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

3 **THE CHAIR:** What would you think was the reason for that?

4 I mean, you've said you didn't know until about November
5 but others must have known they were having difficulty.
6 What was the reason for that?

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

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

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

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

22 **A.** Yes. Prior to November?

23 **THE CHAIR:** Yes.

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

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

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

7 **A.** Which electronic systems are you referring to?

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

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

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

17 **A.** Yeah.

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

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

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

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

1 winter --

2 **THE CHAIR:** But by November, you said it was clear that you

3 weren't going to be able to manage --

4 **A.** Yes.

5 **THE CHAIR:** -- even so.

6 **A.** Yes.

7 **THE CHAIR:** So had others in your team become aware of that?

8 When did the others in your team ...?

9 **A.** So I'm trying to think how to answer how this developed

10 for us, I guess, isn't it? How did this develop and

11 emerge as a system?

12 **THE CHAIR:** And how did you find out?

13 **A.** So the volumes went up in August, September and

14 continued into the winter and autumn, and historically,

15 we'd managed to deal with the spikes and increases in

16 demand by flexing our resource. And that was working,

17 up until November. Now, so in November that was very

18 clearly becoming an issue that we were missing

19 deadlines. People were signalling the pressure on the

20 system but they weren't signalling that we were not

21 going to sustainably going to meet deadlines.

22 And the continued sort of Rule 9 Requests meant we

23 hit an issue in November, and we had a significant

24 shortfall between capacity and demand that rolled into

25 -- and our work then, that was escalated quite seriously

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

13 Does that answer your question, Chair?

14 **THE CHAIR:** It does, thank you.

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

18 **A.** Yes.

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

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

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

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

8 A. Yes.

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

11 A. Yes.

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

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

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

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

24 And you say:

25 "EPUT accepts that it has been more forthcoming

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

4 What did you mean by that?

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

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

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

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

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

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

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

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

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

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

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

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

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

13 **Q.** Understood.

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

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

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

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

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

8 **A.** Okay.

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

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

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

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

1 Q. Okay, thank you.

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

6 So you say this:

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

13 Then you go on to say what that includes.

14 How long has this approach been in place?

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

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

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

21 And we can see at (c):

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

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

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

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

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

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

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

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

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

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

1 we see quite a bit throughout the Position Statement.

2 I just wanted to ask you about that, please.

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

7 **A.** Sorry, what were you referring to?

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

10 "The Trust has adopted an approach focused on
11 reasonableness, proportionality, and layered validation
12 ..."

13 Do you see that?

14 **A.** Yes.

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

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

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

23 **A.** Sorry, can you repeat the question?

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

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

4 **A.** Yes.

5 **Q.** -- and therefore not do it?

6 **A.** Yes.

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

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

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

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

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

1 Rule 9s.

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

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

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

11 A. We can carry on.

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

15 A. Yes.

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

19 A. Yes.

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

1 Inquiry up to 30 November 2025 was £13.5 million?

2 **A.** Yes.

3 **Q.** Does that sound about right?

4 **A.** Yes.

5 **Q.** And that EPUT is forecasting a £30 million spend to meet

6 the needs of the Inquiry. Again, does that sound about

7 right in total?

8 **A.** Yes.

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

10 **A.** Yes.

11 **Q.** Do you recognise the profound importance to bereaved

12 families of understanding events that occurred over many

13 years across the predecessor organisations and EPUT?

14 **A.** Yes, I do.

15 **Q.** Do you also recognise the importance of assisting the

16 Inquiry in establishing a full understanding of matters

17 relevant to its Terms of Reference and in identifying

18 learning that may improve future services?

19 **A.** Yes, I do.

20 **Q.** Overall, do you and EPUT understand the significance of

21 the Lampard Inquiry and the requirement fully and

22 properly to engage with it?

23 **A.** Yes.

24 **Q.** One question that does arise is why, with that budget,

25 EPUT was not able to implement appropriate processes to

1 support the Inquiry at an earlier stage?

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

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

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

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

11 **A.** Yeah.

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

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

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

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

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

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

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

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

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

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

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

23 **A.** Okay.

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

1 correct?

2 **A.** Yes.

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

6 **A.** Yes.

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

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

14 **A.** Yes.

15 **THE CHAIR:** Are they all in post?

16 **A.** Yes, I believe they are.

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

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

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

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

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

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

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

1 Q. Thank you.

2 THE CHAIR: When was that, that report?

3 A. That was commissioned in January and talked about in

4 February, mid-February.

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

6 A. Yes, yes.

7 MR GRIFFIN: I've referred recently to the Data Assurance

8 Statement. That shows that several of the high-level

9 staff changes had been made by that stage, so that was

10 towards the end of last year, November 2025, I think.

11 What further changes had been made, what new people had

12 been brought in since the issues that you experienced in

13 February 2026 and that we've discussed?

14 A. So we've brought a new dedicated Senior Responsible

15 Officer in. The Programme Director has started that I

16 talked about. There's a project management office head,

17 as well. So one of the things we've strengthened is to

18 make sure we've got project management over our Rule 9s

19 because they've got more complex. There's four Clinical

20 Advisor posts now.

21 Q. So this is all new this year?

22 A. Yes.

23 Q. After February?

24 A. Yes, yes.

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

1 role in formulating responses to the Inquiry?

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

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

13 **A.** Yes.

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

17 **A.** So that role is an executive level role and has access
18 to the board and reports to the Chief Executive to make
19 sure that we've got the -- and that's dedicated.
20 I think the difference from the past was that was shared
21 with other portfolios, and this is completely focused on
22 the Inquiry.

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

24 **A.** Yes.

25 **Q.** Thank you.

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

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

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

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

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

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

1 complexity of the Inquiry's demands."

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

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

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

15 **A.** No.

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

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

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

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

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

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

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

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

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

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

5 **A.** No, I don't think so.

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

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

9 Do you actually now believe that to be the case?

10 **A.** Yes.

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

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

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

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

22 **Q.** Strong confidence?

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

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

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

4 **A.** I expect that to be the case.

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

7 **A.** Yes.

8 **Q.** Thank you.

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

15 **A.** I completely understand that, yes.

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

17 Chair, those are the questions I have for Mr Scott.

18 Now, do you have any further questions?

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

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

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

25 **THE CHAIR:** Thank you.

1 **(4.08 pm)**

2 **(A short break)**

3 **(4.20 pm)**

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

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

9 **THE WITNESS:** Thank you.

10 **MR GRIFFIN:** Thank you.

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

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

15 **THE CHAIR:** Thank you. 10.00.

16 **(4.22 pm)**

17 **(The hearing adjourned until 10.00 am the following day)**

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