INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

5 July 2021

**Open Letter RE: Essex Mental Health Independent Inquiry**

Tricia Rich
Deputy Secretary
Essex Mental Health Independent Inquiry
Sent via Email

Dear Ms Rich,

For many years INQUEST has been working with families bereaved as a result of failings of Essex mental health services. One of the most soul destroying aspect of our work has been our experience of attending inquest after inquest where deaths are marred by failures that are repeated time and again and include: poor information sharing and record keeping, inadequate risk assessments, poor observations, dangerous ligature points and neglect. There have been countless investigations, inspection reports and inquests highlighting these failures, but despite these, preventable deaths have continued.

We remain deeply concerned about the failing systems of treatment and care for people with mental ill health and inadequate scrutiny, oversight and accountability of Essex mental health services. It is because of this that INQUEST supported the family-led campaign involving more than 67 individuals who died or were severely mistreated whilst in the care of mental health services, either as inpatients or in the community, for a statutory public inquiry to look into these failings across the county.

We felt that the seriousness of the issues warranted an inquiry operating in public, with powers to compel witnesses and providing much-needed transparency and the opportunity for wide participation. It was this that we felt could offer the greatest opportunity to uncover systemic failings and identify the learning and action needed to be taken to prevent future deaths.

INQUEST provided a background parliamentary briefing to support this campaign.

Central to this campaign was Melanie Leahy, who INQUEST have worked with since the contentious death of her son Matthew. A particularly memorable part of our relationship with Melanie was when her and Lisa Morris, whose son also died at the Linden centre, questioned the CQC on why, despite the identification of dangerous ligature points after Matthew's death, these had not been removed and Lisa's son had died. This was during a Family Listening Day in December 2016, which we were commissioned to run for the CQC as part of their review on how the NHS investigates deaths in NHS Services.

The successful Health and Safety Executive prosecution on 16 June 2021 over the deaths of 11 patients between 2004 and 2015 reveals the shameful failure to remove ligature points which had been identified as unsafe. This reveals once again the inaction of oversight bodies and the accountability gap. What were the CQC and NHS England doing during the 11 years these preventable deaths were allowed to continue? What happened to the inquest and investigation findings and recommendations? Who was joining in the dots and making it their business to prevent future deaths?



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If it wasn't for the persistence of the bereaved families, none of these dangerous practices would have come to light. Hefty fines, apologies, and platitudes about 'learning lessons' do not represent justice for countless families who have been affected by deaths under Essex mental health services. Nor do they reveal the full scale of failures leading to a pattern of ongoing deaths. This includes the current investigation process and its lack of independence pre inquest, unlike other deaths in state detention which have their own investigatory body. This is, in effect, the NHS and private companies investigating themselves.

INQUEST considered in detail the extent to which the Essex Mental Health Independent Inquiry would tackle these issues and the experiences of the families of the 67 individuals. We were shocked to hear from families that the majority are in fact excluded from the remit of the inquiry: only 9 of the 67 cases we know of fall within the remit and they have all told us that they do not want to engage with it.

We therefore have to question the ability of this inquiry to look at the grave, repeated and systemic failures surrounding Essex mental health services. As we have said since the outset, family engagement, confidence and trust in the review is an essential condition for its success.

We therefore have made the regrettable decision that INQUEST cannot engage in this review. The fact that it is essentially being conducted behind closed doors and does not command the trust, confidence and effective participation of those most affected make our participation as an organisation impossible. The family's grief and trauma has been exacerbated by the Governments refusal to listen to them. Their motivation is trying to ensure future deaths are prevented, an aspiration that is in the interests of us all.

Yours sincerely,

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