House of Commons: Written Statement (HCWS729)

Department of Health and Social Care

Written Statement made by: **Minister of State (Minister for Patient Safety, Suicide Prevention and Mental Health) (Ms Nadine Dorries)** on 21 Jan 2021.

Independent Inquiry into mental health inpatient deaths in Essex

The Parliamentary and Health Service Ombudsman (PHSO) published his report *Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust* on 11 June 2019 which found that there were a series of significant failings in the care and treatment of two vulnerable young men who died shortly after being admitted to North Essex Partnership University NHS Foundation Trust. I have previously announced my commitment to an inquiry into these tragic events.

Today, I am announcing the establishment of a Non-Statutory, Independent Inquiry into the circumstances of mental health inpatient deaths at the former North Essex Partnership University NHS Foundation Trust, the former South Essex Partnership University Trust and the Essex Partnership University NHS Foundation Trust which took over responsibility for mental health services in Essex from 2017. This will cover the period from 1 January 2000 to 31 December 2020.

In announcing this Inquiry, I am mindful of the current, extraordinary demands on the NHS as it responds to the worst pandemic in living memory. The Essex Partnership University NHS Foundation Trust was one of the first to declare a major incident and the Inquiry will schedule its work in a way that is sensitive to these pressures.

I have also listened carefully to the arguments proposing a more formal, statutory inquiry into these events. I share the desire for a robust and independent process that will get to the truth and deliver the necessary learning. I remain convinced that a non-statutory, independent inquiry is the best way to do this and identify the necessary improvements in the timeliest way.

I have asked the distinguished psychiatrist Dr Geraldine Strathdee CBE to chair the Inquiry and am delighted that she has agreed to take on this important role. Dr Strathdee worked for many years as a consultant psychiatrist in the NHS. She brings a wealth of experience in mental health policy, regulation and clinical management and is a co-founder of the Zero Suicides Alliance. Dr Strathdee is a person of the utmost integrity and I will expect her to conduct this inquiry without fear or favour. In order to ensure her independence, she will step down from her current role as a National Professional Adviser at the Care Quality Commission when her term ends in March of this year.

The Chair will be supported by expert advisers, including a legal adviser.

The Inquiry will consider issues including:

- the key factors that led to the deaths of individual patients, whether issues of omission or commission;
- aspects of culture and governance that inhibited the Trust(s) ability to learn and take action following any breaches of safety;
- the quality of any previous investigations by the Trust(s), the conclusions and recommendations of those investigations and the subsequent actions;

- the response of the wider system to these events and the actions taken by the Trust(s) in response to investigations or reviews conducted by any other body; and
- the further lessons for the Essex Partnership University Foundation NHS Trust and what actions are necessary for the new Trust Chief Executive and its Board to ensure that current and future patients receive sustainable safe care; and
- further lessons arising for the mental health services, the NHS and the wider system.

The Inquiry will not reopen the investigation of fixed potential ligature points that has given rise to the prosecution of Essex Partnership University NHS Foundation Trust by the Health and Safety Executive but may consider the evidence in this area.

The Inquiry will be able to interview witnesses to determine if there were failures in care, safety, governance or professional standards and will examine all relevant records to get to the truth. We owe the families nothing less.

My Department will co-operate fully with the Inquiry's investigation, including provision of any documents it might hold that are relevant to these issues and are requested by the Inquiry. Similarly, all NHS employees will be expected to give the inquiry their full cooperation.

I am moving forward with this important inquiry in order to shine a clear light on what happened at the Trusts so that lessons can be learnt by the current Trust and the NHS more widely. These lessons must be applied to the Trust and the NHS to ensure that the provision of mental health services is improved and, critically, that lives are saved. This will require the investigation of some, possibly all, mental health inpatient deaths that occurred across the county between 2000 and 2020. Our focus must be on how we learn the lessons to improve services and prevent inpatient deaths in the future. The Chair will want to consider what level of scrutiny of individual deaths is necessary to do this. However, there may be limits on the scrutiny that is possible of the earlier deaths that occurred during this period.

The Chair will recommend a final Terms of Reference following consultation with the families and others affected by these events which I will communicate to Parliament in due course.

The Inquiry will be formally established from April 2021 and will aim to report in the Spring of 2023.