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CHAIR OF LANDMARK MENTAL HEALTH INQUIRY MAKES URGENT APPEAL FOR PEOPLE TO COME FORWARD

The Chair of an unprecedented public inquiry into mental health care deaths has appealed for the families and loved ones of those who died to come forward.

The Essex Mental Health Independent Inquiry is examining cases of people who died while they were mental health in-patients at NHS Trusts in Essex from January 2000 to December 2020.

It's the first public inquiry into mental health ever to have been held in England and commissioned by a Government Minister.

Dr Geraldine Strathdee, who's leading the Inquiry, said: "I am committed to making sure everyone who wants to participate in the Inquiry can, so I am inviting anyone with evidence, or anyone who wants to tell the Inquiry about their experience or that of their loved one, to contact us."

The Inquiry had a good response after it published its Terms of Reference and held a consultation in August 2021. Since then, the Inquiry team has been gathering information about the scale and nature of the issues surrounding mental health deaths in Essex.

So far, the Inquiry has heard from 14 families of those who've died and people who have been inpatients themselves. More people are coming forward and booking evidence sessions.

Dr Strathdee said: "Their stories will form the backbone of our evidence and will help inform change to how mental health inpatients are cared for - but we know there are others."

The Chair added that some families and loved ones may have moved on from Essex and that others may not have heard of the Inquiry or know how to get in contact. She also appealed for healthcare staff with relevant information to come forward.

The Inquiry has been made aware of some 1,500 individuals who died while they were a patient on a mental health ward in Essex over the 21-year period or within three months of being discharged.

Some of the deaths are likely to be unrelated to the treatment and care they received, but others may not be. The Inquiry team is trying to establish as much information as possible about those who died; so far, it has been given the cause of death in only around 40% of cases.

Dr Strathdee said the families and former patients who have already given evidence have shared personal and detailed accounts of their experiences. “They have told the Inquiry about the care provided to them or their loved one, the journey that led to their loved one becoming an inpatient, the deaths of their loved ones, and their experiences as family members.

“Most mental health care is provided in the community, so it is important that we understand the full journey of individuals through the system – not just the time they spend on an inpatient ward,” she said.

Although each family’s story and patient experience is unique, the Chair said she had identified some common areas of concern:

- A lack of basic information being shared with patients and their families about their care and treatment, their choices, and the plans to get them better.
- Patients and their families voicing serious concerns about patients’ physical, mental and sexual safety on the ward
- Major differences in the quality of care patients receive - in the attitude of staff and in the use of effective treatments

Dr Strathdee said the Inquiry had heard details of compassionate, effective care that had transformed patients’ lives - as well as unacceptable examples of dispassionate behaviour that families believed had contributed to the death of their loved one.

She reassured people who want to come forward that they would be treated with respect and have the opportunity to talk with her highly skilled team in a way that felt right for them. Private and confidential evidence sessions are available to families, patients and healthcare staff but people will also have an opportunity to give their evidence in public, should they wish.

As part of the Inquiry, the Chair and her team will be looking at how Essex compares to other areas in England to see if the issues identified are unique to the county.

At the conclusion of the Inquiry, in 2023, the Chair will make recommendations to the Government on what changes are needed to keep mental health inpatients safe and to improve how their loved ones are dealt with.

Dr Strathdee said: “One thing that is so clear to me in listening to families is that while every story is different, everyone I’ve spoken to has had a resolve that in telling theirs they want to help stop any other family from enduring the unimaginable pain and heartache they have.

“We all know people who are affected by mental ill health at some stage in their lives and this needs to be treated with the importance and urgency of any critical health condition. It is essential that we get this right and I am grateful to everyone who takes this opportunity to improve mental health inpatient care now and in the future.”

MORE INFORMATION OR INTERVIEW REQUESTS:

Contact Crest Advisory - which is supporting the Inquiry on communications:

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NOTES TO EDITORS:

1. People can email the inquiry at: contact@emhii.org.uk or leave a voicemail on: 020 7972 3500 or write to PO Box 78136, London, SW1P 9WW.
2. The Inquiry website is: https://www.emhii.org.uk/ This contains full details of the Terms of Reference and details about Geraldine Strathdee.
3. Updates and information are posted on the website and on the official Inquiry Twitter feed: @EssexMHInquiry