Letby Inquiry - Prof Brian Edwards

27th May 2025

Essex Mental Health

Stuck at the Crossroads

The first segment of the Lampard inquiry "setting the context" has now concluded and the problems in Essex are emerging more clearly.

There had been a long-term reduction in the employment of registered Mental Health nurses resulting in an increased reliance on health support workers.

This had led, according to a former Chief Nurse, to a reduction in patient engagement and increased risk to both patients and staff.

A number of organisations had given evidence to the Inquiry about staff shortages and burn out.

A Consultant psychiatrist had talked about staff being "run off their feet" in a culture where professionals feared being blamed for "whatever decision they took."

A charity leader had claimed that the Trust had tried to pressure Coroners not to issue PFD [Prevention of Future Death] reports in order to protect its reputation.

Nor, they had claimed, had the Trust complied with its obligations under the Duty of Candour law.

The Chief Executive of the Trust made his first appearance. The Trust had tried to learn from the past but had been overwhelmed by the 19 regulatory bodies that had oversight of the Trust, all with their own recommendations for action.

He acknowledged that following the merger that created the Essex Trust the Board had been "more focused on governance and management than patient safety."

Commissioning in Essex had been too fragmented which did not help consistency of planning and funding.

Counsel challenged that his evidence so far had concentrated on success and change rather than really digging down into what had gone wrong in the past.

He had talked about "Safety First" and "Time to Care" policies but was not convincing when pressed about results.

> *Culture change took a long time he said. But, you have been in post now for quite a long time now [4.5 years] challenged Counsel. Why was it taking so long?*

Some important changes had been made but they were the easy ones like creating mechanisms for listening to patients and their families.

The Inquiry will want to know what then

happened. What did the Trust learn from its early conversations?

The HSE prosecution had been sobering and shocking as had the undercover investigation by Dispatches.

The Trust had had to pay the fine of £1.5m itself but out of a turnover of £650m this had not generated a major problem.

Recruiting skilled staff had been more of a problem than financial resources.

The Trust Board now regularly visited front line services but the last time the Chief Executive had been on a ward was three weeks ago. Raised eyebrows all around.

The Executive Directors did not work shifts on the front line.

The use of agency staff had reduced by 20-30% but the Chief Executive could not recall the exact number. This was not the first time our witness had responded with "I will have to get back to you on that".

He was admonished by Counsel to be better prepared the next time he gave evidence.

It felt, to an observer, that he was dealing with the Inquiry as just another pressure on his time. He had not created the problems in the first place and had tried to resolve them.

He needs to understand that his, and his Boards, performance in first understanding the problems and then taking action to resolve them will come under critical scrutiny in the coming months.

They will not be able to shift the blame onto other bodies for inaction. Few Chief Executives have survived such scrutiny.

Managing a Trust under such scrutiny must be extraordinarily difficult as must taking decisive action when so many different organisations, with oversight powers, have their own view about policies and priorities.

This Trust looks as if it is stuck at the crossroads waiting for the next set of advice from an inspectorate, a national plan, an NHS England expert group, commissioning decisions and the Inquiry report in two years' time.

The Trust, like others, are currently focused on cutting their corporate headquarters staff at the demand of the DHSC.

None of these external bodies are going to offer a clear, consistent, and coherent view on safety and culture.

Fine words and platitudes are more likely.

A strict adherence to Safety First will create tensions with some of the organisations focused on priorities such as reducing waiting lists.

However, no further advice is required about safety issues such as ligature points or encouraging staff to "speak up."

The Trust should move now. Lead not wait in the interests of their patients and their families.

The next public hearings will start in July and examine some, perhaps many, of the patient deaths whilst in NHS care.

Hard times for the Trust are about to begin.
