Public consultation on the Inquiry's Terms of Reference

On 1 November 2023, Baroness Lampard launched a public consultation on the Inquiry's Terms of Reference. This will run for 4 weeks, and close on 28 November 2023.

The Inquiry welcomes written contributions from the public throughout the consultation period. To respond to the Terms of Reference consultation in writing, you can either:

- complete a webform (available on our website)
- complete the webform and email it to **contact@lampardinquiry.org.uk**
- email your views to **contact@lampardinquiry.org.uk**
- write to us at
  The Lampard Inquiry
  PO Box 78136
  London
  SW1P 9WW

As part of the Inquiry's commitment to the principles of the Equality Act (2010), the Inquiry team can offer reasonable adjustments for anyone who is unable to participate in the written consultation. Please contact the Inquiry team who will be able to provide you with more information about this.

Proposed Terms of Reference:

To investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex between 1 January 2000 and 31 December 2023.

1. The Inquiry will investigate the following:
   i. the circumstances surrounding the deaths of mental health inpatients within this timeframe;
   ii. the extent to which and how patients, their families, carers, or other members of their support network were communicated with and included in decision-making;

iii. serious failings related to the delivery of safe and therapeutic inpatient treatment and care;

iv. the culture, leadership, management of staff, and governance at the NHS Trust(s) providing mental health inpatient care in Essex ("the Trust(s)");

v. the quality of investigations undertaken or commissioned by the Trust(s) into mental health inpatient deaths and serious incidents;

vi. the response of the Trust(s) to investigations, inspections, and reports (internal and external) including to any recommendations.

2. The Inquiry will make recommendations to improve the provision of mental health inpatient care.
3. Investigations will focus on NHS Trusts in Essex; however, the Chair may make national recommendations as she considers appropriate. To do so, she may seek evidence from individuals, organisations or from Trusts who are either involved in the provision of mental health care in other areas or have evidence which may be relevant to the issues which the Inquiry is investigating.
4. To fulfil these Terms of Reference the Chair may investigate or obtain additional evidence in respect of any issue which she considers relevant and important to an understanding of the provision of mental health inpatient care or which may be a factor in mental health inpatient deaths.

The Inquiry requires all individuals and organisations engaged with it to operate in a spirit of openness and co-operation. Requests made by the Inquiry for evidence should be met promptly and with complete candour.

Those engaging with the Inquiry are to be treated by all parties with courtesy and respect.

Notes from the Chair on the Inquiry's Intended scope:
As well as amending the Terms of Reference the Chair is minded to make the following amendments to the Inquiry's scope:

- Dates: 1 January 2000 to 31 December 2023

Email: contact@lampardinquiry.org.uk
Address: The Lampard Inquiry, PO Box 78136, LONDON, SW1P 9WW
Tel: 020 7972 3500

- Locations: Investigations will focus on NHS Trusts in Essex; however, the Chair may make national recommendations as she considers appropriate. To do so, she may seek evidence from individuals, organisations or from Trusts who are either involved in the provision of mental health care in other areas or have evidence which may be relevant to the issues which the Inquiry is investigating.
- Inquiry's definition of inpatient death:
    - those who died on an NHS mental health inpatient unit or in receipt of NHS funded inpatient care within the private sector. Units to be included are:
        - acute adult mental health units
        - psychiatric intensive care units (PICU)
        - child and adolescent mental health services (CAMHS) - acute and PICU units
        - mental health assessment units
        - mother and baby mental health units
        - older adult mental health units
        - eating disorder units
        - forensic units
    - those who died while on leave from any of the above units
    - those who died while absent without leave or having absconded from any of the above units
    - those who died following transfer from any of the above units, including transfer to a physical health setting or to an out of area mental health service
    - those who died while awaiting an assessment under the Mental Health Act or while waiting for a bed in a mental health inpatient unit following a clinical assessment of need
    - those who died following any mental health assessment provided by a relevant Trust where the decision was not to admit as an inpatient (this includes but is not limited to any death following a review in A&E, or an assessment under section 135 and 136 of the Mental Health Act)
    - those who died up to 3 months following discharge from any of the above units

Email: contact@lampardinquiry.org.uk
Address: The Lampard Inquiry, PO Box 78136, LONDON, SW1P 9WW
Tel: 020 7972 3500

- As well as hearing from the families of those who have died, the Chair will hear from patients and former patients, as well as their families.
- The Chair is minded to identify a sample of cases, representative of the issues, that will be investigated in detail in order to draw wider conclusions.
- The Chair may investigate or obtain additional evidence in respect of any issue which she considers relevant and important to an understanding of the provision of mental health inpatient care or which may be a factor in mental health inpatient deaths.

Email: contact@lampardinquiry.org.uk
Address: The Lampard Inquiry, PO Box 78136, LONDON, SW1P 9WW
Tel: 020 7972 3500