10 April 2024

Terms of Reference for the Lampard Inquiry

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

1. The Inquiry will investigate the circumstances surrounding the deaths of mental health inpatients within this timeframe.

2. To the extent necessary, to investigate the deaths and fulfil these Terms of Reference, the Inquiry will consider:

    a. serious failings related to the delivery of safe and therapeutic inpatient treatment and care, which may include consideration of circumstances where serious harm short of death occurred;

    b. how and the extent to which patients were engaged with and involved in decisions in relation to their care;

    c. how and the extent to which families, carers, or other members of a patient's support network were engaged with and involved in decisions in relation to the patient's care, including any engagement after the patient's death;

    d. matters relating to physical and sexual safety within mental health inpatient units at the Trust(s);

    e. the actions, practices and behaviours of permanent, temporary and agency staff providing mental health inpatient care at the Trust(s);

    f. the approach to staffing, training and working conditions of permanent, temporary and agency staff providing mental health inpatient care at the Trust(s); including the support provided to and the supervision of such staff;

    g. the actions, practices and behaviours of leadership in relation to mental health inpatient care at the Trust(s);

    h. the culture and the wider governance of and at the Trust(s);

    i. the quality of investigations undertaken or commissioned by the Trust(s) in relation to mental health inpatient care;

    j. the quality, timeliness, openness and adequacy of any response by or on behalf of the Trust(s) in relation to concerns, complaints, whistleblowing, investigations, inspections, and reports (both internal and external); and

k. the interaction between the Trust(s) and other public bodies, (including, but not limited, to commissioners, coroners, professional regulators, and the Care Quality Commission).

3. The Inquiry's definition of an inpatient death will include some deaths outside of mental health inpatient units, as set out in the Explanatory Note. The Explanatory Note does not form part of these Terms of Reference but indicates how the Chair is minded to interpret them.

4. The Inquiry will make recommendations to improve the provision of mental health inpatient care.

5. Investigations will focus on the Trust(s); 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 inpatient health care in other areas or have evidence which may be relevant to the issues which the Inquiry is investigating.

6. To fulfil these Terms of Reference the Chair may investigate or obtain additional evidence in respect of any issue which she deems relevant and important to a fair and considered understanding of the provision of mental health inpatient care, or which may be a factor in mental health inpatient deaths.

7. 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 information and evidence should be met promptly and with complete candour.

8. In undertaking its investigations, the Inquiry may consider information which is available from the various published and unpublished reviews, court cases, and investigations which have so far concluded.

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

10. Personal and sensitive information provided to the Inquiry will be appropriately handled. It will only be shared or made public as is necessary and proportionate for the Inquiry to fulfil these Terms of Reference.