10 April 2024

TERMS OF REFERENCE – STATEMENT OF APPROACH

INTRODUCTION

The Inquiry's Terms of Reference are being published today. They can be found at this link. In this Statement of Approach I intend to explain a little about the background to the review leading to these Terms of Reference and to address some of the issues I have considered and decisions I have reached. These Terms of Reference have been reviewed and set by the Secretary of State for Health and Social Care.

I would like first to stress the seriousness of the issues which lie at the heart of this Inquiry and recognise the suffering and loss which many have endured. I offer my sincere condolences to those who have lost family members and loved ones or have otherwise been affected by the matters which the Inquiry has been established to investigate. I recognise also the courage, resilience and strength that they have demonstrated in these most tragic of circumstances, including in bringing to light some of the matters I will be looking into. I will be considering ways to ensure that they remain central to the Inquiry's work and that its procedures are appropriately informed by their experiences.

The Essex Mental Health Independent Inquiry was initially established by the government in April 2021 to investigate mental health inpatient deaths in Essex. This was a non-statutory inquiry. A decision was made by the government in June 2023 to convert it to a statutory inquiry. I was appointed as Chair on 26 October 2023 and the Inquiry's name was later changed to the Lampard Inquiry. To be clear: the Lampard Inquiry continues the work of the Essex Mental Health Independent Inquiry. On 27 October 2023, the Department of Health and Social Care issued a formal notice of conversion, confirming the Inquiry's statutory status. This means that the Inquiry now operates within the framework of the Inquiries Act 2005, with powers to compel evidence.

I have decided that the Inquiry will operate under the Inquiry Rules 2006. I am not required to import the Inquiry Rules in this way, as the Inquiry started life as a non-statutory inquiry. However, I have decided to rely on the Rules because they provide a well-understood framework that will help the Inquiry to act with fairness and with regard also to the need to avoid any unnecessary cost. They will provide a proper framework for participation by those who wish, or are asked, to engage with the Inquiry.

The Terms of Reference define the scope of the Inquiry. They set out the issues and associated parameters that it will investigate. I considered it appropriate to review them in light of the Inquiry's new status and undertook a public consultation on draft Terms of Reference between 1 – 28 November 2023.

The Inquiry received a total of 61 responses, including from the families, friends and carers of deceased patients; current and former patients; current and former staff;

Essex Partnership University NHS Trust and other individuals and organisations with an interest in the matters which the Inquiry is investigating. I am very grateful indeed for the thought and care that went into these many responses.

I have considered each response with care and, as will be seen, I have decided to make a number of amendments to the draft Terms of Reference to reflect this. In some cases, I have concluded that the points being made were already covered in the Terms of Reference and therefore no changes were required. There are further cases where I have concluded that the points being made should not result in a change.

I believe that the Inquiry will be assisted by the creation of a separate List of Issues, which will address in greater detail the matters for consideration by the Inquiry. Various matters raised in the responses may therefore come to be reflected in the List of Issues, where they are not explicitly referred to in the Terms of Reference. The Inquiry will provide further information about the creation of the List of Issues shortly.

MAIN POINTS ARISING IN THE RESPONSES TO THE CONSULTATION

I turn now to address some of the major issues raised in the responses to the consultation. This is not intended to be a comprehensive review of those responses, although it should be noted that I have considered all points raised, whether or not I refer to them here.

The draft Terms of Reference have been amended to reflect responses to the consultation and also to provide further clarity and focus.

Timeframe

The draft Terms of Reference extended the proposed end date for the Inquiry's investigations from December 2020 to December 2023. This was to reflect the fact that issues of concern continue, including a number of deaths which post-date 2020, in which very serious failings have been identified. There was general agreement in the responses to this change. It was suggested by some that the timeframe should extend even further and that the Inquiry should continue to gather evidence about incidents happening as the Inquiry progresses. I have concluded that December 2023 remains the appropriate end date. The timeframe already covers 24 years and the end date provides necessary clarity and finality to the Inquiry's work.

Serious harm

Several respondents to the consultation noted the importance of the Inquiry considering incidents where individuals have not died but have been caused serious harm. I accept that these incidents may raise the same or similar issues as incidents that resulted in death and may therefore be relevant to the circumstances of those deaths which the Inquiry is investigating. I have amended

the Terms of Reference accordingly, to make clear that the Inquiry's consideration of serious failings related to the delivery of safe and therapeutic inpatient treatment and care may include consideration of circumstances where serious harm short of death has occurred; see Term 2(a).

Community care and outpatient deaths

One of the most common themes within the public consultation responses was the expansion of the Inquiry scope to include deaths of patients receiving community and outpatient care. Some responses called for a consideration of community care services more generally, even beyond those cases where death occurred.

I have decided not to include changes of this kind. Doing so would considerably expand the Terms of Reference beyond the Inquiry's original core purpose of examining the circumstances surrounding mental health inpatient deaths. I am concerned to ensure that the Inquiry delivers a thorough report quickly and effectively. The public would expect nothing less of me where issues of concern remain current and further avoidable deaths may occur. Amending the Terms of Reference to include community deaths (and community care more widely) would take the Inquiry well beyond the basis on which it was established and would increase the scope of the matters that the Inquiry would be required to investigate. My proposed definition of inpatient deaths (see below) will enable me to examine the circumstances of those who died up to three months post-discharge and some aspects of care received in the community will inevitably fall within the Inquiry's investigations in any event.

Inpatient deaths

The Terms of Reference do not provide a definition of inpatient deaths. This is addressed in the Explanatory Note in relation to Scope accompanying the Terms of Reference. The Explanatory Note does not form part of the Terms but is provided to indicate how I intend to interpret them, as the new 3rd Term makes clear.

The definition of inpatient death in the Explanatory Note includes those who died within 3 months of discharge from a mental health inpatient unit. A small number of responses to the consultation included requests to extend this period to include deaths which occurred 6 months, 12 months or indefinitely following an inpatient stay. Having considered these points and the available evidence, I do not consider it appropriate to extend the definition of inpatient beyond 3 months post-discharge. I have concluded that the 3-month period is an appropriate and proportionate period of time to allow the Inquiry to consider matters relevant to the Terms of Reference which may have taken place in the period following discharge. This time period post-discharge was also the basis of the investigations of the non-statutory inquiry.

I have amended the definitions of inpatient death in the Explanatory Note to make clear that the same 3-month period applies in certain other circumstances specified there. For example, the Inquiry will consider those who died while absent without leave from a relevant unit, within 3 months of going absent without leave.

I have decided to make additional changes to the definition of inpatient death in the Explanatory Note to reflect further consultation responses and to produce greater clarity as to those deaths which I do consider should fall within the scope of the Inquiry's investigations. It is now expressed to include: those detained at a relevant location *informally* as well as under section; those who have died whilst on *supervised* leave as well as while on unsupervised leave; those who died *during* transfer as well as following transfer from a relevant unit; and those who died as inpatients *receiving NHS funded care within the independent sector* as well as those in NHS units.

Extending beyond Essex

Several responses suggested that the Inquiry should consider the provision of mental health support in areas other than Essex, whether by way of inpatient care or otherwise. I have concluded that the focus on Essex, which has been at the heart of the Inquiry since its inception, remains right and necessary. I believe the issues raised can be addressed to the extent appropriate under the 5th Term of Reference, allowing me to make national recommendations and, in order to do so, to seek evidence from organisations and others outside Essex.

Staffing and leadership

The draft Terms referred simply to the *"culture, leadership, management of staff, and governance"* at the relevant Trust(s). Several responses addressed the staffing and leadership issues that the Inquiry should investigate and in turn, how this may have impacted patient care. This has caused me to revisit this aspect of the Terms and to clarify and provide greater detail of the matters under investigation. This is now reflected in the Terms at 2(e) to (h).

Actions of other bodies and organisations and care within other settings

Several responses suggested that the roles of other bodies and organisations should be expressly included within the Inquiry's Terms, such as the Health and Safety Executive, the Care Quality Commission and the Essex Coroner. Other respondents asked for the Inquiry to add a Term to explore post-death processes for the bereaved, such as investigations, inquests and prosecutions. I have concluded that the Inquiry should focus on the Trusts' *responses* to the actions and investigations of these bodies and organisations, rather than on the effectiveness with which other bodies performed their respective roles, as now addressed in greater detail at Term 2(j). This Term also now refers to the response of the Trust(s) to concerns, complaints and whistleblowing to reflect further consultation responses received by the Inquiry. This underlines the potential significance of concerns, whether they have been raised formally or less formally by individuals or through other channels.

I received some requests during the consultation to include individuals solely under the care of non-health bodies, for example the prison services or the police. I have decided not to include this in the Terms as it extends beyond the original focus of the Inquiry of deaths within healthcare settings. However, where a mental

health inpatient was in contact with other services, I do consider it appropriate for the Inquiry to consider how the different organisations interacted with the Trust if it is pertinent to the individual's case and the relevant mental health care which they received. This is addressed in the Terms at 2(k) which also now refers to interaction with commissioners and professional regulators (and others) to reflect further responses received.

In my view, this provides an appropriate and proportionate approach to the matters I must consider and will allow the Inquiry to conclude its tasks within a reasonable period of time.

Neurodiversity

The issue of the adequacy of treatment of people who are neurodiverse, in the context of mental health inpatient care, emerges as a serious matter of concern in the responses. In my view, it is important to reflect this within the work of the Inquiry. Whilst I do not believe this requires amendment of the Terms, a reference to neurodiversity has been added to the Explanatory Note, amongst the factors which I may consider when undertaking investigations into inpatient deaths.

Data

One organisation raised in its response the significance of data captured by the Inquiry, and how it should be treated and analysed. Whilst I do not believe that this requires a change to the Terms, I recognise the importance of the points raised. The Inquiry is addressing these matters, including the need for appropriate resource and access to expert advice and assistance.

Serious allegations

A number of responses raise serious allegations about the way in which the Trust(s) and staff members have acted. The Terms already allow for the Inquiry's investigation of such matters. Nevertheless, I have decided it is appropriate to clarify certain points, and the Terms now also expressly extend to matters relating to physical and sexual safety within the relevant units at 2(d). Furthermore, the Terms make clear the need for the Inquiry's requests for information and evidence concerning these matters (and more generally) to be met promptly and with complete candour. Where this information is not forthcoming, the Inquiry will rely on its new statutory powers to the fullest extent necessary to compel its production. Where employees of the Trust(s) have relevant information, I will expect them to come forward to the Inquiry with it. It should be noted that I will take necessary steps to facilitate this (including where appropriate protecting the identity of the information provider). I am determined to conduct a full and thorough inquiry and I will refer matters on to the police, professional regulators or other bodies should I consider it appropriate to do so.

CONCLUSION

I am satisfied that the revised Terms of Reference provide the breadth of scope needed to thoroughly address the significant areas of concern identified. But they

are also appropriately focused and proportionate, allowing me to report and make recommendations within a reasonable period of time. This is key given the urgency of the matters I am looking into.

Finally, I would once again like to express my gratitude to all those engaging with the consultation and for the assistance I have received from the many points raised in the responses.

Baroness Kate Lampard CBE, 10 April 2024