IN THE LAMPARD INQUIRY

Witness name: Daniel Leader
Statement No. 1
Dated:..08/10/2025..

SECOND WITNESS STATEMENT OF DANIEL LEADER

I, Daniel Leader, provide this second statement on behalf of the Leader family further to a letter from the Inquiry Legal Team dated 26 September 2025, and will say as follows:

Introduction

1. I provide this statement further to my first witness statement provided to the Inquiry dated 14 July 2025. Any references to 'we' unless otherwise stated are to my family.

2. As requested in a Rule 9 request dated 8 September 2025, I recently provided a number of documents relating to Josh and EPUT. This statement is to provide the inquiry with context and explanatory information about some of these documents, which I hope the Inquiry will consider alongside them. In particular these documents provide examples of EPUT's approach and actions after Josh's death.

Engagement by the PSII investigation with family

3. Following Josh's death, as a family we were very clear that things had gone badly wrong in his care and treatment and hoped that EPUT would learn lessons and make improvements. We sent a list of our concerns about Josh's care to EPUT on 29 November 2020, within a week of his death (as set out at paragraph 132 of my first statement), which set out clearly our views that EPUT had failed Josh in the months previously as well as on 22 November during assessment at The Lakes hospital. Following this, on 28 February 2021 (as set out at paragraph 134 of my first statement), we sent a list of recommendations which also clearly reflected our concerns of what had gone wrong with Josh's care.

4. We hoped that EPUT's internal Patient Safety Incident Investigation ('PSII'), which we understood was ongoing at the time we wrote to them, would acknowledge and address our concerns and make tangible and practical recommendations for improvements EPUT could implement to prevent deaths from the same or similar failures. Despite our attempts to engage constructively with the investigators, the report did not come close to achieving this and I explained in my first statement (paragraphs 135-137) my family's deep frustration with the final report dated 28 October 2021. The report does not explain why they do not agree with the family's views on recommendations, and in fact does not even acknowledge that we had provided any views on recommendations.

5. Our family's strong view is that the concerns and proposed recommendations for change that we sent to EPUT – including in the days after Josh's death – have stood the test of time, not least because our concerns were largely supported by the Coroner's findings and the independent psychiatric expert who provided evidence in Josh's inquest (Dr Mynors-Wallis, a copy his report has been provided to the Inquiry). We feel

that not only were we ignored when Josh was alive and we were trying to get him the support he desperately needed, but that EPUT continued to ignore us after his death.

EPUT engagement with the inquest

6. Following the PSII process, we and EPUT participated in the inquest into Josh's death, which again we hoped would be another opportunity for EPUT to acknowledge our concerns and the failures in care. In April 2023 my mother Florence Leader, and I, provided detailed witness statements for the inquest, which unlike my earlier communications with the PSII investigation, were prepared with the benefit of legal advice and having had sight of Josh's medical records. These statements were shared with EPUT's legal representatives as part of the inquest process.

7. The inquest into Josh's death was held from 8 to 11 July 2024 (and had in fact also been listed for February 2024 before being postponed). The first statement of [I/S] Deputy Director North East Essex Community Services, was received by my legal team on the working day before the inquest started (5 July 2024). The DD NEECS' statement states that its purpose is to explain "the current position of relevant Trust services", improvements made after Josh's death, and that they hope it "demonstrates that learning is iterative and ongoing".

8. Accompanying this statement is a document called the 'EPUT Safety Action Plan'. I understand that the Action Plan flows from the PSII report produced by EPUT, and that it sets out their response to the recommendations the report identified. The Action Plan includes a stated 'start date' of 19 June 2024. The Action Plan was therefore started over 2.5 years after the PSII report made recommendations, and approaching 4 years after Josh's death. My family was only provided with a copy of it the working day before the inquest into Josh's death. While we believed the recommendations from the PSII report were inadequate and incomplete, we had hoped by implementing them that at least some improvements would be made to help prevent other EPUT patients facing the kind of barriers Josh did. It is impossible to understand how or why there was such a long delay and we are very concerned that without any steps to implement or monitor the recommendations made by EPUT's own report, other patients' lives may have been put at risk. It appears likely to us that the recommendations were only considered in June 2024 as EPUT were aware the inquest into Josh's death was about to be held, which would raise serious questions about what changes had been made. We are concerned that this is evidence of an unwillingness to learn lessons from Josh's death, as even the limited recommendations made by the report were not proactively addressed and may not have been at all were it not for the approaching inquest.

9. I am also concerned that neither the DD NEECS' statement nor the Action Plan demonstrate that EPUT were willing to implement the PSII recommendations, whether delayed or not. For example, I was particularly alarmed to see that the Action Plan is left entirely blank for 'PSII recommendation 2' (which is about a review of the Crisis Team's handover process). The DD NEECS' statement appears to simply provide a description of the current handover process and does not suggest that any kind of review has taken place despite the recommendation. 'PSII recommendation 5' included that an audit be conducted to confirm that patients' next appointments were being properly documented. The DD NEECS' statement again appears to simply provide an explanation of what EPUT's appointment process is and does not indicate an audit has been carried out.

10. I am also concerned that EPUT's responses to PSII recommendations 3 & 4 seem to entirely miss the points being made by the family and show a lack of understanding about what went wrong. Recommendations 3 & 4 are about the provision of s.117 aftercare and family engagement/involvement in a patient's care. Our strong view is that Josh's case was so complex that it required a holistic multi-disciplinary approach to come up with a new strategy to break the cycle of his non-compliance with medication and psychosis. This was clearly not being met by his existing care plan and so we completely reject the suggestion (in paragraph 22 of **the DD NEECS'** statement) that his care plan "did cover his 117 after care needs" and that the only issue was that the care plan "did not specifically reference them as 117". I also strongly disagree with any suggestion that the issue with Josh's care was a "carer's assessment", which I understand to relate to making sure that a carer can cope with their caring responsibilities. This does nothing to address the failure in Josh's case to ensure that clinical decision making was properly informed by the perspective of his family, who knew him best and who had been providing his care consistently for years. Nothing we have seen from EPUT since Josh's death, including the PSII report, the Action Plan and **DD NEECS'** statement, acknowledges that this had been a major failure in Josh's care or seriously grapples with how this could be avoided in the future. Had there been effective mechanisms in place to ensure that the family's views were heard and carefully evaluated and followed up at the outset and a strategy arrived at which dealt with Josh's non-compliance I believe Josh would have stabilised and gone on to live a full and productive life.

11. On the final day of the inquest EPUT provided a statement from **AD UCIS [I/S]** (Associate Director for Urgent Care and Inpatient Services), which she explains is to provide information to the Coroner about work underway at that time to improve Urgent Care Pathway services. As set out in my first statement, at the conclusion of the inquest, EPUT indicated a full audit of all crisis services was ongoing, and that they would later provide an update to the Coroner on this. EPUT provided a joint statement on 8 October 2024 from **DD QS** (Deputy Director of Quality & Safety) and **DD NEECS**, which also explained some changes to services since Josh's death. Neither of these statements acknowledge the failures in Josh's care, and consequently do not provide any reassurance that the suggested changes will prevent a repeat of the failures in Josh's care. They contain vague and ill-defined references to improved training in suicide prevention and an increased willingness to engage and listen to families' concerns. This is particularly shocking as **DD QS** and **DD NEECS'** statement came *after* the Coroner found serious failings in Josh's care and that his death had been contributed to by neglect. There is nothing in their statement which demonstrates a serious change in perspective following the Inquest's adverse findings. Despite the reference to a willingness to engage with and listen to families, there has been no attempt to engage with my family about our concerns. We remain entirely unconvinced that any meaningful attempt has been made to understand our concerns and to truly improve the system failures which led to Josh's death.

12. We communicated our view on the stark failures and lessons to be learned very shortly after Josh's death, and so we do not think EPUT has any excuse for not making appropriate improvements in a timely manner. The apparent further failure by EPUT to make any improvements following the detailed examination of evidence in the inquest and highly critical findings of the Coroner is appalling. We hope that the Inquiry will be able to gather evidence of other families' experience of how EPUT engaged with investigations following a death, as we are very concerned our experience

demonstrates an institutional attitude of defensiveness and unwillingness to admit failures or learn lessons. That defensiveness may have contributed to further preventable deaths of those in a similar position to Josh. We sincerely hope the Inquiry will be able to use its powers and resources to consider if there were deaths which were preventable had we been listened to and these lessons been promptly learned from Josh's death.

13. I have provided all of the EPUT statements as referred to above to the Inquiry, and we hope the Inquiry will carefully consider them and whether the changes made by EPUT since Josh's death have been effective at addressing the issues Josh faced.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: [I/S]

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DANIEL LEADER

Date: 08/10/2025

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