IN THE LAMPARD INQUIRY

SKELETON ON BEHALF OF BEN JACKSON, THE GUILLE FAMILY AND X4 ("BM CPS")

Introduction

1. The BM CPs welcome the opportunity to be heard on topics concerning procedural matters by way of oral submissions at a public hearing on 8 December 2025[1]. The BM CPs in common with all bereaved and lived experience CPs welcome openness and transparency in every aspect of the Inquiry's work. This skeleton addresses the Inquiry's draft Statement of Approach: Investigative Strategy dated 13 November 2025 only[2]. The BM CPs responded by letter dated 27 November 2025 to the interim report of Professor Donnelly ("the data strand") and will address the Recommendation and Implementation Forum ("RIF") in accordance with the Inquiry timetable.

2. In summary, the BM CPs submit:

   (a) That maintenance of confidence in the Inquiry necessitates clarity on all aspects of its investigative strategy and integration of the illustrative cases with that broader strategy.
   (b) The plan to cluster the illustrative cases by issue/theme will be unworkable in practice and a chronological approach is proposed.
   (c) The Inquiry's proposal in relation to disclosure will create a wholly unreasonable imbalance.
   (d) The forensic product to be derived from illustrative cases would be improved by greater clarity as to how the matters examined will be marshalled and we offer suggestions.

The Inquiry's broader investigative strategy

<u>An integrated investigative strategy</u>

3. The BM CPs' seek reassurance that the work of the Inquiry will be capable of identifying the drivers for the catastrophic system collapse within the provision of mental health services in Essex and identifying where, why and how such determined resistance to change - in the face of external challenge - arose. In their submission it is of critical importance for the Inquiry to seek their views now, on the Inquiry's proposals as to how it will achieve those goals; that strategy must in their view integrate the Inquiry's various work strands (illustrative cases, the evidence of those with lived experience, benchmarking, governance, external oversight, data, RIF and so on) and identify how the evidence pertaining to each strand will be timetabled and brought together. A particular priority is to achieve an understanding of how the governance structures will be benchmarked and analysed. In our submission there is considerable merit to a planned modular approach to an inquiry of this nature.

4. Moreover, it has been emphasised by the bereaved and lived experience CPs from the outset that special care ought to be taken to forward plan the work of the Inquiry and to provide timely disclosure to facilitate the support they rely upon from their RLRs and to minimise the risk of re-traumatisation[3]. We regret therefore that is necessary to emphasise that the provision of the draft Statement of Approach to illustrative cases without also providing detail as to how this work will be integrated has occasioned upset to those whom we represent.

5. It will be recalled that in his opening statement of 13 October 2025 Mr Griffin KC explained that, in addition to progressing work on illustrative case studies, data and RIF, the Inquiry:

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[1] Joint submissions of the bereaved and lived experience CPs dated 3 October 2025 and ILT letter dated 9 October 2025.
[2] ILT email to Bhatt Murphy dated 13 November 2025 at 12:13.
[3] See for example, BM CPs' Closing Submissions following the April – May 2025 hearings at [19].

(a) Was seeking to improve its disclosure processes[4].
(b) Appreciated the need for expert evidence to (i) benchmark relevant inpatient standards[5] and (ii) consider *"common issues and themes that have arisen, focusing also on whether identifiable failings have been addressed since"*[6].
(c) Has sought further evidence and information from healthcare providers, enforcement agencies, regulators and other corporate stakeholders[7].
(d) Has approached historians and authors[8].
(e) Was scrutinising candour and accountability and the overall governance structures of the healthcare providers on a *"ward to board"* basis and would identify *"how services should be run"* and *"will measure what we are learning about how they are run"*.[9]

Progress to date and urgent disclosure requests

6. The BM CPs welcome:

(a) The creation of a CP workspace on Relativity but note that the only documents disclosed since April 2025 is the evidence provided by the bereaved families or is related to Oxevision.
(b) The protocol for the instruction of experts of August 2025 but note that the first stage in that protocol - the identification of disciplines and topics [8] - has not been started.
(c) The constructive and helpful counsel-to-counsel discussions that have occurred but consider that it would assist if the Inquiry would periodically report as to the action points that the Inquiry has adopted as a result of those discussions.

7. The BM CPs reiterate their requests for access to the *"multiple requests"* that have been made to the various document holders[10] (so that they might contribute) and early disclosure of documents that have been provided to the Inquiry (to facilitate their participation and to minimise the risk of their being overwhelmed by late disclosure). Their concern with regard to the Inquiry's current methodology (see further below at §§14-20) is that they will not have a timely opportunity to consider material. By way of example, a statement from Ms Sheridan dated 21 March 2025 addressing the important topic of EPUT's responses to adverse findings including PFD reports and records of inquest was disclosed to the bereaved and lived experience CPs in advance of the April hearings. At §§34-56 of that statement Ms Sheridan details EPUT's processes in response to PFDs and inquest outcomes and those paragraphs are replete with references to documents that were brought into existence in furtherance of those processes. This material is likely to be of critical relevance to the illustrative cases strand and ought to be available to the Inquiry and to the CPs before that work is commenced. We note that a number of Ms Sheridan's exhibits have not been disclosed[11]. Bereaved families ought not to be expected to engage with work in relation to their loved one's case blind sighted in relation to relevant documents held by EPUT and/or the Inquiry[12].

8. In similar vein the BM CPs reiterate and seek to place urgency upon their requests for the following evidence to be marshalled and disclosed:

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[4] Transcript, 13 October 2025, p13, LL16 – 18.
[5] Ibid, p13, LL14-16.
[6] Ibid, p18, LL10 – 13.
[7] Ibid, p19, LL1 – 4.
[8] Ibid, p19, L21.
[9] Ibid, p20, LL1-9.
[10] Ibid, p19, LL7 – 16.
[11] For example AS/239, AS/240-1; AS/250, AS/253.
[12] See further §19 below addressing the asymmetric disclosure proposal.

(a) All those documents the BM CPs have already requested including HSE investigation documents, disciplinary investigation documents and all other relevant material [13].

(b) Evidence from senior employees of the healthcare providers addressing their governance structures (including the committee structures) and methodology in relation to document handling, storage and retention.

(c) Chronological disclosure and tracking of evidence submitted to inquests for PFD purposes, PFD outcomes and responses to PFDs and records of inquest including the minutes of meetings and email communications addressing those responses (see also §7 above) so as to inform the family and lived experience CPs engagement with the illustrative cases strand.

(d) A complete document set of the CQC's engagement with the healthcare providers including inspection reports, correspondence and responses[14].

(e) The materials marshalled for the criminal prosecutions[15].

(f) The materials marshalled by the prior non-statutory investigations.

9. The BM CPs also remind the Inquiry of the request, in the interest of efficiency, focus and equality of arms, to fund shadow advisory experts for the individual CPs collectively[16].

<u>The engagement with and the evidence of those with lived experience</u>

10. This Inquiry clearly appreciates that it has an opportunity to affect meaningful change in the lives of those who have been so grossly affected by the events which necessitated its convening beyond its findings and recommendations. It has done so through demonstrable respect for the human dignity of the bereaved and through the commitment of the Chair to ensure their experience remains central to the Inquiry's work[17]. Inevitably, the focus to date has been upon the bereaved but in our submission, there is now a pressing urgency to ensure that those who participate with lived experience come into focus.

11. In his opening statement of 13 October 2025 Mr Griffin KC explained that the Inquiry was "*making considerable progress towards obtaining evidence from those who have lived experience*[18]*"*. It will be recalled that between the Inquiry's request of 9 October 2024 and the circulation of the lived experience Framework in July 2025, RLRs were inhibited from obtaining evidence from CPs with lived experience. X4 - while appreciating that the restriction was well-intentioned - found the prohibition disempowering, exclusionary and hampered his involvement in the Inquiry[19]. The Inquiry is in no doubt that the evidence of those with lived experience will inform all aspects of its ongoing work; we submit it will in particular assist with the systematic analysis of evidence from the illustrative case by providing a perspective on inpatient care beyond what has been deposed to medical records or observed by visiting family members.

12. Those with lived experience were not permitted to attend the recent Q&A session on 27 November 2025 and have not yet had introductory meetings with the Chair. It would in our submission significantly assist to convene a Q and A session for those with lived experience; offer meetings with the Chair and provide, a timetable for the issuing of r9 requests and evidential hearings for this cohort.

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[13] Jackson w. s [CP_BHAT007869] dated 27.5.25 §1.4-1.5; Guille family w.s [CP_BHAT010167] 3.6.25 ; §5.82; 19.4; 20.16; 21.8-21.10; Bhatt Murphy letter & emails dated 7 April 2025; 27 June 2025; 9 September 2025.

[14] See statement of Sir Julian Hartley, 27 March 2025, §§11-15. See also the comment of CTI to Sir Rob Behrens on 6 May 2025: CTI "Clearly this Inquiry will need to have regard to all relevant CQC inspections within the period we are concerned with?" Sir Rob Behrens: "Yes".

15 The sentencing remarks at the conclusion of the recent prosecution of NELT and Mr Aninakwa are informative: https://www.judiciary.uk/wp-content/uploads/2025/11/R-v-Benjamin-Aninakwa-and-NE-London-NHS-Foundation-Trust.pdf.

[16] BM Closing Submissions 30 May 2025 at [17].

[17] Chair's opening statement 9 September 2024 transcript p.5/25; p.6/1-3

[18] Transcript, 13 October 2025, page 15, LL 20-23.

[19] Bhatt Murphy letter dated 18 October 2024; [I/S] [I/S] Submissions on Dr Davidson dated 31 March 2025 para 3; BM Closing Submissions 30 May 2025.

Conclusion

13. A detailed roadmap of the Inquiry's broader investigative strategy will significantly enhance the quality of forensic product from the illustrative cases strand. This Inquiry must be more than an information gathering exercise.

The Draft Statement of Approach: Investigative Strategy

Reliance upon Illustrative cases of those who have died in principle

14. We acknowledge the practical benefits of illustrative case studies, as part of a planned and transparent overarching investigative strategy and support the inclusion of all cases where a family or friend has been granted CP status and the aspiration to achieve a balance of geographical location and to ensure that a range of mental health conditions and presentations are reflected[20]. In addition to the selection of inquests resulting in a neglect conclusions [9.d], the BM CPs propose that the views of the relevant coroners be sought as to any other cases that are especially illustrative[21].

Clustering on the basis of issue/theme will be unworkable

15. We agree that the evidence of the bereaved families has identified a series of recurring issues. Scrutiny of those patterns of neglect and substandard care is essential to identify the system failings that contributed to the wholesale collapse of mental health provision in Essex during the relevant period.

16. The evidence was of:

    (a) **Psychiatry**: poor practice in relation to diagnostic formulation, medication, risk management, delivery of therapeutic care and misapplication of the MHA and MCA.
    (b) **Care coordination**: lack of engagement with patients' families, failures in key worker allocation, lack of discharge planning and follow up, protracted inpatient stays without progress, and lack of reliance on psychological and occupational expertise.
    (c) **Ward environment**: including ligature points and access to ligatures.
    (d) **Nursing:** lack of respect for the human dignity of patients and toxic ward environments.
    (e) **Communication:** within and between teams leading to poor case coordination.
    (f) **Record keeping:** poor recording of detail and inaccuracy.
    (g) **Training and supervision**: staff insufficiently equipped and/or supported to discharge their assigned roles.
    (h) **Governance:** Failures to discharge the duty of candour/institutional defensiveness (including in relation to and in response to inquests), lack of timely and effective managerial intervention, failure to comply with legislation and guidance including the NHSE Serious Incident Framework.

17. It is also clear from the evidence heard that each of the deceased and their families experienced not one issue with the standard of care but a cluster of issues that had a cumulative impact; each exacerbating the other. It is striking how many of each of the issues set out at §16 above arose in relation to each of the deceased. It appears that the probable cause of the systematic collapse of the mental health service in Essex arose from failures to identify/remedy a wholesale failure to deliver reliably any of the rudimentary elements of a reasonable standard. Analysed in this way, the issues of internal governance and external oversight are likely to come more clearly into focus.

A chronological approach will be more effective

18. Therefore we consider that it will inhibit the forensic work of the inquiry to cluster illustrative case studies by issue/theme. Rather, a chronological approach to scrutinising individual cases will prove

[20] Draft Statement of Approach [8c. and 9a.].
[21] Neglect is an especially complex concept: see Leigh Day/Irwin Mitchell's response to CTI's paper on inquests at [31].

more fruitful not least because it will help establish what was known or ought to have been known at relevant points in time. Further, if a systematic approach is taken to identifying which issues arose, why and their impact (see further below at §20) the product from the illustrative cases strand is likely to prove of greater assistance to the related strands: (i) to the experts in different disciplines in drawing conclusions as to collective and individual failings and the governance structures; (ii) to the governance and data strands by identifying key events in context; and (iii) to the scrutiny of the external oversight bodies by identifying what ought to have been picked up at key points in time. We emphasise[22] that for the most part the inquests have scrutinised individual failings in care but not the contributions of governance and oversight failures.

Asymmetrical disclosure

19. The Inquiry's proposal to confine disclosure to bereaved CPs to within the cluster to which their own case has been allocated and only then where it is considered *"appropriate, necessary and proportionate*[23]*"* and to exclude lived experience CPs from the disclosure process entirely, will create a wholly unreasonable imbalance as the healthcare providers will be alone in having access to a complete or near complete body of material. It would be invidious to afford the healthcare providers an understanding of the full context in which a particular death occurred but to deprive the bereaved from that same understanding. Further, the approach would deprive the Inquiry of assistance from individual CPs and their legal teams in analysing governance and oversight, and leaves individual CPs offering maximum openness concerning their traumatic experiences without reciprocity.

Systematic reporting from the individual cases

20. The BM CPs' have several practical suggestions:

(a) That the experts appointed in each discipline should be consulted as to matters which should be the subject of systematic reporting from each case study.

(b) That the systematic reporting should include:

(i) The key failings in respect of the delivery of care identified (relying upon consistent headings such as those set out at §16 above) and sufficient detail to facilitate a qualitative analysis by the Inquiry's experts of the seriousness of any relevant failing, its causative potency and identification of unconscionable conduct. The fact that a case is especially indicative of relevant themes/issues ought also to be included.

(ii) Whether in evidence to the relevant inquests there were misrepresentations that identified system failings had been remedied including: (i) consideration of the key issues emerging from deaths post-dating the relevant representation; (ii) the evidence given and not only the witness statements provided to the inquests as it is probable that the relevant coroner and or interested persons will have challenged matters about which they were concerned[24]; (iii) whether any misrepresentation was material to a decision not to issue a PFD.

(iii) Whether the Serious Incident reporting accurately identified the contributory factors when compared with the inquest conclusions and if not, the reason for this (e.g. a misunderstanding of the causative potency of a particular contribution).

1 December 2025

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Sophy Miles
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[22] As acknowledged in the Draft Stament of Approach at [18]
[23] Draft Statement of Approach at [51a.].
[24] See draft Statement of Approach at [23 c.]