IN THE INQUIRY INTO MENTAL HEALTH TREATMENT IN ESSEX

('THE LAMPARD INQUIRY')

SUBMISSIONS ON BEHALF OF CORE PARTICIPANTS REPRESENTED BY BINDMANS LLP

RE: INQUIRY INVESTIGATIVE STRATEGY

Introduction

1. These brief submissions, as invited by the Inquiry, address the Draft Statement of Approach ("SoA") on the investigation of illustrative cases of those who have died, and the wider concerns of the Core Participants ("CPs") we represent.

2. At the outset, we acknowledge the work that has evidently been put into the development of the draft SoA and the very significant task that faces the Inquiry Legal Team in making good what it promises. Any close consideration of individual deaths, the stark failings they reveal and the many investigative failures that followed, will serve to remind the Inquiry that ongoing participation in these proceedings by bereaved families is an enormous act of courage over fear. Reliving in detail their experiences of being failed by mental health services in Essex, exposing systemic failings and pushing for future change comes at significant personal cost. The only goal of the families we represent is to make this Inquiry as effective as possible. To fail in this goal would be to compound their trauma, and to let down those who so desperately need action to be taken.

3. It is in that spirt that these observations are made. Our families hope that in providing constructive criticism at this stage, the Inquiry will urgently reflect on its future shape and direction, with particular reference to:

   a. The Inquiry's investigative strategy, timing and issues to be investigated; and
   b. Effective participation.

The Inquiry's investigative strategy, timing and issues to be investigated

4. This SoA does not represent what was anticipated to be received at this stage. In declining an opportunity for oral submissions during the October hearings, reliance was placed by the Inquiry on the delivery of *'the Inquiry's investigative strategy'* in November 2025. Thus, in Opening, CTI observed:

   > "The Inquiry's investigative strategy is now finalised and will be published in November. The strategy clearly sets out, **amongst other features**, how illustrative cases will be assessed..."[1]

5. Having addressed the Inquiry's approach to illustrative cases under the wider investigative strategy, CTI continued to point out that in addition, the Inquiry was seeking the further evidence it needs from providers, enforcement agencies, regulators and other stake holders. CPs were told that under the investigative strategy, the Inquiry is rigorously exploring data on

[1] Transcript Monday 13 October, p.17 L22-25

core issues such as physical and sexual safety in inpatient units and that the Inquiry will *'scrutinise candour and accountability and the overall governance structures [of providers]... looking at ward to board of how services should be run and measure what we are learning about how they are run against those standards".* We were told that obtaining, as far as possible, a definitive list of deceased was an '*absolute priority*'; that the Inquiry's expert health statistician, Prof. Donnelly '*remains engaged and ready to assist*'. Reference was made to early engagement with CPs in respect of proposed experts, with specific reference to neuro-divergence, autism and ADHD experts and an expert to address the suggestion that suicide may in certain circumstances not be preventable. CTI spoke about '*staff evidence*' and noted the '*considerable interest*' in how the Inquiry intends to secure relevant evidence from those who have seen or heard first hand exactly what happens on a mental health ward.

6. Accordingly, it was with some anticipation that our families awaited the promised publication of the Inquiry's investigative strategy in November, and it is with a significant degree of concern and disquiet that we note that what we have received, is not that. Whilst the SoA in relation to illustrative cases is welcome, it is but one stream of the Inquiry's investigative strategy and therefore does not provide the CPs we represent with meaningful insight into the Inquiry's '*other features*' of work, either for the evidence-gathering phase, or generally for how this investigation will sit alongside the Inquiry's wider processes. It is difficult for our clients to comment meaningfully on the content of the draft SoA without this information. It is also difficult for our families to retain confidence in the Inquiry, when 14 months into the hearings, and with fewer than 10 months remaining, the investigative strategy remains elusive.

7. We invite the Inquiry to publish, as a matter of urgency, a clear, transparent and achievable investigative strategy or route-map for the remainer of this ***public*** inquiry, allowing for meaningful consultation as to whether the proposed strategy enables the inquiry to deliver on its Terms of Reference.

8. By now, the CPs we represent would have expected a clear investigative strategy to include:

    a. the areas of evidence which remain to be investigated outwith the investigation of illustrative cases of those who have died. The draft SoA acknowledges, for example, that it does not address the approach to the evidence of CPs with lived experience of inpatient mental healthcare in Essex during the relevant period, and the Inquiry's proposals in this regard remain to be seen;
    b. clarity on the breadth and depth of evidence requests or r.9s issued to date, indicating at least in broad terms to whom evidence requests have been sent, the nature of those requests, a clear time frame for responses and an indication of what has been received to date – thus allowing CPs the opportunity to make submissions about the nature of the Inquiry's requests and/or suggest further lines of Inquiry. Such a process would also favour transparency and allow CPs the opportunity to consider which future witnesses might be called.
    c. a plan for disclosure of evidence which CPs and their representatives can consider, digest and effectively engage with, with timeframes which allow CPs' representatives to plan and allocate their resources for the benefit of the Inquiry and the bereaved families who should be at its heart. We note that in order to address previously raised concerns about the Inquiry's disclosure process[2], it was said on 7 July 2025 that a "*Disclosure Plan*" and "*timetable as to when disclosure of witness statements and other materials relevant*

[2] See for example joint correspondence from INQUEST and bereaved CP RLRs dated 18 December 2024 and letter from Bindmans dated 24 January 2025.

to the Terms of Reference is likely to take place" and it would be provided when Relativity was made available to CPs in August[3]. It was also indicated in a private meeting between counsel on 1 July 2025 that future disclosure would be on a rolling basis and effected through Relativity[4]. None of this has been initiated or achieved; and

d. A clear and comprehensive proposal for the expert evidence. It is of particular concern that the Inquiry has not, by this stage (and notwithstanding the numerous submissions we and other CPs have made in this regard), formally identified all the areas in which it intends to obtain expert evidence, let alone which experts it intends to instruct or within what scope. The CPs we represent expect to participate fully in this process which is so important to assisting the Inquiry in reaching conclusions and making meaningful recommendations;
e. a clearer picture of the proposed Recommendations and Implementation Forum including timeframes, how it will sit alongside the Inquiry's wider investigations, and what recommendations, including interim recommendations, the Inquiry is considering at this stage, or an opportunity to make formal submissions on the same.

9. It is understood that the Inquiry intends to hold public sessions between 2-19 February 2026, 20 April–7 May 2026 and 6-23 July 2026 – with a hearing in October 2026 (dates to be confirmed) for Closing Statements. Not including the February 2026 hearings (which we understand to be a continuation of vital evidence from families of those who died whilst under the care of EPUT), and assuming four-day sitting weeks as has been the practice of the Inquiry so far, that appears to allow a maximum of 24 sitting days for evidence which we say must include (but not be limited to) the following central issues within and related to the Inquiry's List of Issues and arising from the evidence heard:

a. The care and treatment of Autistic people in the mental health system including a rigorous examination of the interplay between mental ill health and autism, and how this should be managed, and patients safeguarded[5];
b. Racism in mental health care, including a proper examination of its causes, its disproportionate outcomes and what needs to be done to address it;[6]
c. Sexual safety and gendered discrimination in mental health care;[7]
d. Surveillance of patients on wards;[8]

---

[3] CTI Opening Statement on 7 July 2025
[4] Meeting between Bindmans CP counsel and CTI counsel on 1 July 2025
[5] This has been repeatedly raised by Ms Julia Hopper (bereaved mother of Christopher Nota) directly to CTI and Chair from the inception of the Inquiry also within her Commemorative and Impact statement given orally on 23 September 2024, it was also raised in INQUEST's Opening Statement dated 21 August 2024 and orally in September 2024, by Bindmans when instructed by Ms Hopper: see correspondence dated 25 April 2025, which suggested further lines of evidential enquiry and the need for appropriate expert evidence. Reiterated in closing submissions sent on 29 May 2025, formed part of submissions on expert evidence to Dr Davidson dated 1 April 2025, suggested R10 questions for Davidson and Nelligan under cover letter dated 22 April 2025 and more recently themes for expert evidence on neurodivergence dated 25 September 2025.
[6] Raised as an issue with the Inquiry in Bindmans Opening Statement dated 4 November 2024; Commemorative and Impact Evidence of Mrs Joyce Nsilu dated 1 November 2024; evidence of Deborah Coles (INQUEST) on structural racism in mental health care on Monday 12 May 2025 (and her Witness Statement dated 1 April 2025, including **Exhibit DC-17**: '*Achieving Racial Justice At Inquests*')
[7] Raised in consultation with the Inquiry on its List of Issues in submissions dated 31 July 2024, as an issue with the Inquiry in Bindmans Opening Statement dated 4 November 2024; Witness Statement of Tammy Smith dated 26 June 2025 (minor typos amended in finalised statement dated 10 September 2025); basis for proposed R10 questions for Maria Nelligan on behalf of Bindmans CPs under cover letter dated 22 April 2025 (not adopted by CTI).
[8] Raised in consultation with the Inquiry on its draft list of issues on 31 July 2024, in Bindmans Opening Statement dated 4 November 2024 (with reference to obtaining expert evidence from the Restraint Reduction Network), First and Second Witness Statements of Stop Oxevision (24 March 2025 and 22 September 2025); Tammy Smith's Witness Statement dated 26 June 2025, oral evidence of Hat Porter OBO Stop Oxevision heard on 13 May 2025 and Tammy Smith on 23 October 2025; basis for proposed R10 questions to Laura Cozens and Zephan Trent; Bindmans submissions on further lines of enquiry dated 25 April 2025, Bindmans closing submissions dated 29 May 2025, detailed submissions in support of interim recommendations dated 18 November 2025; Bindmans correspondence raising concerns about data retention of vulnerable patients dated 18 November 2025. In CTI's Closing Statement after the October 2025 hearings it was noted: "*it remains unclear … the extent to which trusts… have considered how this relatively new technology should be applied… The Inquiry will look further to understand the evidential basis for the deployment of Oxevision…*

e. The use and overuse of restraint on patients on Essex mental health wards;[9]
f. The use and overuse of medication on mental health patients in Essex;[10]
g. The role of private mental health care providers;[11]
h. The role of regulatory bodies and the fundamental need for oversight;[12]
i. Observation levels and the way in which observations were carried out on Essex mental health wards;[13]
j. Failures in co-operation between local authorities and mental health care providers including in particular in respect of ongoing safeguarding concerns being raised about the care of vulnerable individuals in Essex;[14] and
k. Substance misuse and diagnosis.[15]

10. It is vital that this Inquiry's investigation, and evidence gathering are ventilated in public. Openness should be at the heart of any Public Inquiry. Cases such as *R (Wagstaff) v Secretary of State for Health* [2001] 1 WLR 292 and *R (Persey) v Environment Secretary* [2003] QB 794 have discussed the benefits of open evidence, going so far as to identify what *"amounts to a presumption that a [public inquiry] will proceed in public"*.[16] This Inquiry's own expert, Professor Ireton, has underscored the importance of such transparency in supporting an Inquiry's very efficacy: *"[p]ublic confidence in the findings or recommendations of an inquiry is diminished where evidence on which they are based has not been made publicly available"*.[17]

---

scrutinise carefully the application of Oxevision... in particular the operating models... used by EPUT... The Inquiry is currently taking stock of the evidence... will seek further information on this topic as [the Chair] consider necessary. This Inquiry needs to understand to what extent and in what form there is purpose or place for Oxevision in mental health in-patient settings".

[9] Raised with the Inquiry in Bindmans Opening Statement dated 4 November 2024, orally 25 November 2024, alongside reference to relevance of unedited footage from Channel 4 Dispatches documentary; Bindmans submissions on further evidence to be obtained by the Inquiry on 25 April 2025, repeated need for evidence from the Restraint Reduction Network. Not addressed by CTI in closing submissions following the October 2025 hearings.

[10] Raised in Bindmans Opening Statement dated 4 November 2024, oral opening on behalf of Bindmans bereaved Core Participants on 26 November 2024 and specifically with reference to expert evidence to cover this: "*Chair, we urge you to consider obtaining the expert assistance of a psychopharmacologist*". Written correspondence from Bindmans reiterated obtaining evidence from an expert psychopharmacologist in letter dated 25 April 2025 and Closing Submissions sent on 29 May 2025. The high relevance of this issue also covered by Witness evidence of Tammy Smith, Melanie Leahy; prominently in the evidence of Dawn Johnson (putting patients only on an 'even keel'), Jane Stanford (errors in medication remedied via new medication), Melanie Leahy (medication/oversedation), Sally Mizon (informal prescription of medication), Sofia Dimoglou ('cavalier' attitude to medications), Robert Wade (medications as replacement to therapy), Timothy Whitfield (dangerous side effects), Ralph Taylor (inappropriate prescription), Alex and Paul Guille (prescription of antipsychotic medication) who all gave oral evidence in October 2025.

[11] Bindmans addressed the need to incorporate regulatory oversight of Independent Providers in consultation with the Inquiry on its List of Issues on 31 July 2024, as well as ensure relevant Independent Providers had been identified as potential Core Participant. It was addressed generally as an important area to scrutinse in Bindmans in Opening Statement dated 4 November 2024 and orally on 25 November 2024. INQUEST also asked the Inquiry to consider what changes are necessary to ensure that private sector organisations proactively disclose the full extent of their knowledge surrounding fatal events on 21 August 2024.

[12] Raised widely during the Inquiry, including in Bindmans from first formal consultation on 31 July 2024, Opening Statement dated 4 November 2024; INQUEST opening statement dated 21 August 2024; evidence of Deborah Coles (INQUEST) dated 1 April 2025 and witness evidence of Stop Oxevision/Hat Porter and Tammy Smith heard in October 2025;

[13] Raised widely in bereaved witness evidence to the Inquiry, including evidence of Tammy Smith 26 June 2025 and oral evidence on 23 October 2025. As well as Stop Oxevision in their First and Second Witness statements and oral evidence on 13 May 2025.

[14] Relevancy of this is recognised in the Inquiry's List of Issues, importance of effective working relationships is covered by Inquiry Expert Dr Davidson's expert evidence heard on 8 May 2025 and this has been reiterated by bereaved evidence on early intervention and discharge failures heard in October 2025. It is also reflected in relevant inquest findings such as those related to Chris Nota's death – mentioned in commemorative and impact evidence of Julia Hopper heard on 23 September 2024

[15] Raised widely in witness evidence to the Inquiry, including commemorative and impact evidence of Julia Hopper heard on 23 September 2024 ((whose son Chris Nota had his diagnosis of autism frequently doubted, and clinicians placed an undue emphasis on cannabis / drug induced psychosis as the origin of all his symptoms), evidence of Sally Mizon (on the particular stigma attached to substance misuse); it formed basis of suggested submissions on Dr Davdison dated 1 April 2025, suggested Rule 10s and the relevance of it has been reiterated by a significant amount of bereaved evidence, including by Emma Harley whose evidence was heard in October 2025. CTI has acknowledged the importance of substance misuse and treatment in closing submissions following the October 2025 hearings.

[16] *R (Wagstaff) v Secretary of State for Health* [2001] 1 WLR 292 at [319]

[17] Emma Ireton, 'How public is a public inquiry?' [2018] *Public Law* pages 277–298 at 297, accessed here: https://irep.ntu.ac.uk/id/eprint/32144/7/653860_a2440_ireton.pdf

11. These issues have been raised before. At this stage, however, the CPs we represent are concerned that, given the breadth and magnitude of the evidence we say remains to be explored, if this Inquiry does finish in October 2026, it risks doing so without having properly started. However, if its evidential hearings extend to an unknown time beyond October 2026, the CPs we represent fear – justifiably, on basis of their experience and on the evidence they have heard – that continuing uncertainty will be another excuse for mental health care providers in Essex (and more widely) to further delay making any real change. We acknowledge the need for some flexibility in the Inquiry's investigative strategy; but keeping the strategy too flexible at this stage risks important matters simply not being covered, adequately or at all, within the limited remaining timetable.

12. At this stage, in the absence of a true strategy for the remainder of the Inquiry, it is difficult to see how it can hope to do justice to the issues set out above.

Effective Participation

13. Effective participation should be at the heart of a fair Public Inquiry and the Chair's duty to act with fairness (pursuant to s.17(3), Inquiries Act 2005). The draft SoA explicitly acknowledges (at para 51) "*the importance and value of input from bereaved families in relation to the Inquiry's investigative process*".

14. Concerns have repeatedly been raised with the Inquiry about issues including:

    a. the limits imposed on the Inquiry's Rule 10 procedure;
    b. the very limited response to proposed amendments or suggestions to previous expert reports (for example, those of Dr Davidson and Ms Nelligan);
    c. CPs' representatives' inability to address and seek rulings from the Chair, or address any disputes which arise, during evidential hearings;
    d. the Inquiry's response, or (more commonly) lack of response, to correspondence and submissions made on issues of concern to CPs;
    e. the timing (lateness) and limited nature of disclosure of evidence to CPs and their representatives;
    f. the lack of proactive, transparent, or consistent communication with CPs' representatives regarding the Inquiry's plan of work

15. It is through the prism of concerns previously raised about effective participation that our clients note the procedure set out at para 51 of the draft SoA. Such is the strength of their feeling that, at present, they lack confidence that their participation in the investigation of illustrative cases of those who have died will be full, fair or effective – and they seek the Inquiry's firm assurance in this regard.

16. This begins, foundationally with transparency and full and prompt communication in relation to the Inquiry's consideration of their case, including documents received and considered, witness evidence collated, previous internal or external investigations, identification of individual or systemic issues and failings and clarity into which 'clusters' their case will fall. The families we represent, not by choice, are experts by experience in their respective cases and early engagement with them will be to the Inquiry's benefit.

17. This includes provision of disclosure, and opportunities to feed into the Inquiry's analysis of that material. It remains to be seen what disclosure underlying the proposed Case Summaries will be provided to families "*where appropriate, necessary and proportionate in*

line with TOR 10 and the Inquiry's Privacy Information Notice", but we would urge the broadest possible approach to such disclosure to families and their representatives.

18. For the CPs we represent, effective participation also necessitates public scrutiny of as much of the Inquiry's work as possible. It is noted (at para 54) of the draft SoA that "*not all illustrative cases or clusters will be subject to further oral evidence and/or hearings*". The families we represent are therefore concerned by the lack of detail in the draft SoA about how any evidence relating to the investigation of illustrative cases of those who have died will be heard or scrutinised in public, in particular any expert comment relating to them or responses from the providers.

19. For the reasons set out above, in a Public Inquiry concerning such a significant number of deaths in the care of the State, there is a very strong public interest in conducting as much of this important stream of the Inquiry's work in public. The Inquiry should therefore set out clearly how and in what ways this evidence will be heard in and made public.

Brenda Campbell KC
Tom Stoate

Instructed by Bindmans LLP
1 December 2025