IN THE STATUTORY INQUIRY INTO MENTAL HEALTH DEATHS IN ESSEX

'THE LAMPARD INQUIRY'

WRITTEN SUBMISSIONS

INTRODUCTION

1. These submissions are made on behalf of the largest cohort of Core Participants ('**CPs**'), represented by Hodge Jones & Allen ('**HJA**'), in the Inquiry. These are submitted at this critical juncture in the determination of methodology, with the Chair's prior permission, in order to seek to assist in her consideration of the Inquiry procedure, pursuant to s.17 Inquiries Act 2005. These submissions supplement those on the Draft Investigative Strategy which have also been provided on behalf of the HJA CPs. Both will be addressed within the time allocated at the hearing on 8 December 2025 and are interlinked.

2. These submissions address three matters:

   a. Why Article 2 of the European Convention on Human Rights ('**ECHR**') applies to the Inquiry and the way in which the Inquiries Act 2005 is to be applied having regard to the same;

   b. What, if any, difference that makes to the procedure the Inquiry adopts to meet its Terms of Reference and what the Chair is asked to consider doing as a result; and

   c. Briefly, other ECHR rights that may also be engaged which also warrant consideration by the Chair and those advising the Chair.

ARTICLE 2 ECHR: OVERVIEW OF THE LAW

3. The Terms of Reference for the Inquiry of 10 April 2024 ('**TOR**') provide that the Inquiry is to investigate the circumstances surrounding the deaths of mental health inpatients under the care of Essex NHS Trusts within the timeframe 1 January 2000 to 31 December 2023 with further detail as to the matters which are to be considered provided for in paragraph 2 of the same.

4. The obvious implication of this defined scope is that the Inquiry simply cannot investigate in minute detail the deaths of every person who falls within the definition of being an inpatient who died under the care of an Essex NHS Trust within the relevant period of time. That the Inquiry cannot be sure now that it has complete and accurate data as to how many patients in fact died in the index period lends force to this point. It

is understood that the Inquiry is focussing on systemic issues by investigating inpatient deaths and near misses to a sufficient degree to be able to appreciate the systemic issues at play and to inform any recommendations it makes. The Inquiry is uniquely placed to address such systemic issues with the support and cooperation of the HJA CPs as well as other CPs.

5. The Inquiry, as a public authority within the meaning of the Human Rights Act 1998 ('**HRA**')[1], has a duty to determine for itself its obligations under the ECHR. To date, it is unclear what the Inquiry's position is in this regard or if it has already taken this potential duty into account.

6. The nature of the duties derived from Article 2 was comprehensively considered by Popplewell LJ in R (Morahan) v West London Assistant Coroner[2] . His judgment was upheld by the Court of Appeal[3] and cited with approval by the Supreme Court in R (Maguire) v Blackpool and Fylde Senior Coroner[4].

7. Popplewell LJ explained that Article 2 has been interpreted as imposing three distinct duties on states and those exercising state functions:

   (i) a negative duty to refrain from taking life without justification;

   (ii) a positive duty to protect life (which itself subdivides into a framework duty and an operational duty); and

   (iii) an investigative duty to inquire into and explain the circumstances of a death: Morahan at [30].

8. It is submitted that the Inquiry ought actively to consider the positive duty in (ii) and investigative duty in (iii) as explained further below, in respect of deaths (and not in our submission near deaths / harm unless the Inquiry considers that it should[5]).

9. The positive duty in (ii) above has two aspects, the "positive operational duty" and the "framework duty, of which the latter aspect is sometimes referred to as a "systems duty": Morahan at [30](2). The legal principles relevant to each of these aspects are set out in Morahan at [22]-[33] and [34]-[37].

10. Popplewell LJ explained the nature of the duty further in Morahan thus:

"38. The positive operational duty arises where the state agency knows or ought reasonably to know of a real and immediate risk to an individual's life, and requires it

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[1] See paragraph 102 of Foreign & Commonwealth Office v Warsama [2020] EWCA Civ 242, [2020] QB 1976).
[2] [2021] EWHC 1603 (Admin), [2021] QB 1205
[3] [2022] EWCA Civ 1410, [2023] KB 81
[4] [2023] UKSC 20, [2023] 3 WLR 103
[5] Please note that this is a different position to that taken by the applicant in R(EA (By her Litigation Friend) and BT v The Chairman of the Manchester Arena Inquiry [2020] EWHC 2053 (Admin).

to take such measures as could reasonably be expected of it to avoid such risk (Osman v UK[6]... paras 115, 116). In this context:

> *(1) Risk means a significant or substantial risk, rather than a remote or fanciful one. In Rabone the risk in question was one of suicide and was quantified as being 5%, 10% and 20% on successive days, which was held to be sufficient (see paras 35-38).*
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> *(2) An immediate risk to life means one that is "present and continuing" as opposed to "imminent" (Rabone para 39).*
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> *(3) The relevant risk must be to life rather than of harm, even serious harm (G4S Care and Justices Services Ltd v Kent County Council[7] paras 74-75 and R (Kent County Council) v HM Coroner for the county of Kent[8] at paras 44-47).*
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> *(4) Real focuses on what was known or ought to have been known at the time, because of the dangers of hindsight (Van Colle v Chief Constable of the Hertfordshire Police[9] at para 32).*
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> *(5) Overall, in the light of the foregoing considerations viewed cumulatively, the test is a stringent one (see Van Colle, per Lord Brown of Eaton-under Heywood at para 15; and G4S, paras 71-73). It will be harder to establish than mere negligence, but that is not because reasonableness here has a different quality to that involved in establishing negligence; rather it is because it is sufficient for negligence that the risk of damage be reasonably foreseeable, whereas the operational duty requires the risk to be real and immediate: see Rabone at paras 36-37.*

It is also clear that the existence and scope of the duty must not impose an impossible or disproportionate burden on state agencies in carrying out their necessary state functions and must take into account the individual's rights to liberty (article 5) and private life (article 8): see Osman at para 116, Rabone at 104 and Fernandes de Oliveira[10] v Portugal... at paras 111, 125, 131."

11. "Real" in this context means objectively well-founded: *Re Officer L*[11] at [20].

12. The duty applies only "in certain well-defined circumstances": Osman at [115]. More specifically, it is not all risks to life, or even all risks to life within limited categories, which attract the duty, but only real and immediate risks to life in those categories of which the state agent is or ought to be aware: Morahan at [48]. This reflects the

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[6] [1998] 29 EHRR 245
[7] [2019] EWHC 1648 (QB)
[8] [2012] EWHC 2768 (Admin)
[9] [2009] 1 AC 225]
[10] (Application No 78103/14) (2019) 69 EHRR 8, EctHR (GC)
[11] [2007] UKHL 36, [2007] 1WLR 2135

conclusion of Lord Dyson JSC in Rabone at [21] to the effect that "the existence of a 'real and immediate risk' to life is a necessary but not sufficient condition for the existence of the duty".

13. Rabone had concerned the self-inflicted death of a voluntary psychiatric patient during a home visit which the defendant hospital had authorised. At [21]-[24], Lord Dyson identified certain "indicia" or essential features of case in which the Strasbourg court had recognised the existence of the duty while, as Popplewell LJ held in Morahan at [44] "recognising that they did not necessarily provide a sure guide in what was a developing jurisprudence". Popplewell LJ continued at [44]:

"The four identified factors were (1) the existence of a real and immediate risk to life as a necessary but not sufficient condition for the existence of the duty; (2) an assumption of responsibility by the state for the individual's welfare and safety, including by the exercise of control; (3) the especial vulnerability of the individual; and (4) the nature of the risk being an exceptional risk, beyond an ordinary risk of the kind that individuals in the relevant category should reasonably be expected to take".

14. Applying the "real and immediate" test in Rabone, Lord Dyson agreed with Simon J and the Court of Appeal that the risk of suicide had been "real" (rather than "remote or fanciful") even when it had been only 5% (at the point the deceased was allowed to leave the hospital), as well as over the subsequent days when it rose to 10% and 20%: [35]-[38]. Lord Dyson also agreed with the Court of Appeal that a risk could be "immediate" even if it was not "imminent", because when applying the test "[t]he idea is to focus on a risk which is present at the time of the alleged breach of duty and not a risk that will arise at some time in the future". The risk of suicide had been immediate at the point the deceased left the hospital and remained so during the two days until her death: [39]-[41].

15. In Morahan having reviewed the key authorities from [41]-[64], Popplewell LJ derived "three important and related points" from his analysis:

"65…First, the existence or otherwise of the operational duty is not to be analysed solely by reference to the relationship between the state and the individual, but also, and importantly, by reference to the type of harm of which the individual is foreseeably at real and immediate risk. This follows from the operational duty to protect life having the unifying feature of being one of state responsibility, and the need to focus on the scope of the duty which may be owed. There may be an operational duty to protect against some hazards but not others.

66. Secondly, the foreseeable real and immediate risk of the type of harm in question is a necessary condition of the existence of the duty, not merely relevant to breach. Without identifying such foreseeable risk of the type of harm involved, it is impossible to answer the question whether there is an operational duty to take steps to prevent it.

67. Thirdly, in cases where vulnerable people are cared for by an institution which exercises some control over them, the question whether an operational duty is owed to protect them from a foreseeable risk of a particular type of harm is informed by whether the nature of the control is linked to the nature of the harm...".

APPLICATION OF THE OPERATIONAL DUTY TO THIS INQUIRY

16. The factual matrices emerging vividly from the evidence of CPs to the Inquiry are varied, but many relate to instances where the deceased was detained (or was not detained but only because of a voluntary admission in recognition of seriously poor mental health and risk of death by suicide, in some cases further to a plea by the deceased to be kept safe from the risk of taking his or her own life). There is at the very least a strongly arguable case that the Inquiry will find that the Essex NHS Trusts were under a positive operational duty in some cases and that this was breached in circumstances of (i) real and immediate risk to life, (ii) assumption of responsibility for welfare and safety including exercise of control, (iii) vulnerability and (iv) exceptional risk.

17. Thus it is submitted that the Inquiry must take steps to ascertain whether the positive operational duty has or has arguably been breached by the state now, while it is finalising its plans to investigate illustrative cases and create a final roadmap to the end of the Inquiry, and not later when it is too late to pivot to meet the task at hand. It is submitted that the necessary threshold is met now. Per Morahan Popplewell LJ stated at paragraph 75 that the threshold

"....must amount to more than mere speculation. There must be a real evidential basis which makes the suggestion of a breach of a substantive obligation by the state a credible one".

ARTICLE 2 ECHR: THE FRAMEWORK DUTY AND ITS APPLICATION TO THE INQUIRY

18. Turning next to the other aspect of the positive duty in Article 2, namely the framework or systems duty, in *Morahan* at [30](2)(a), Popplewell LJ described this aspect of the positive duty to protect life in the following terms:

"(a)...a duty to put in place a legislative and administrative framework to protect the right to life, involving effective deterrence against threats to life, including criminal law provisions to deter the commission of offences, backed up by a law enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions; and in the healthcare context having effective administrative and regulatory systems in place (Van Colle v Chief Constable of the Hertfordshire Police[12] at para 28, Rabone v Pennine Care NHS Trust (INQUEST intervening)[13] at paras 12 and 93).

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[12] [2009] 1 AC 225
[13] [2012] 2 AC 72

This is the framework duty, of which the latter aspect is sometimes referred to as a systems duty".

19. He observed, citing *R (L (A Patient)) v Secretary of State for Justice*[14] at paragraph 89, per Lord Walker, that that there is "often no clear dividing line" between the positive operational duty and the systems duty "below the national level": *Morahan* at [30](2)(b). We are here concerned with cases below the national level (i.e. in the region of Essex) and thus, in our submission, this observation is particularly apt.

20. In *Savage* at [50], a case concerning a self-inflicted death by a person who was mentally unwell and, most pertinently, a death within the scope of this Inquiry, Lord Rodger observed that the systems duty meant that the hospital *"had, for example, to employ competent staff and take steps to see that they were properly trained to high professional standards" and their "systems of work…plant and equipment…had to take account of the risk that detained patients might try to commit suicide."* From the perspective of the CPs represented by HJA, *Savage* is an extremely significant case. Not only does it provide guidance from the House of Lords, but it also evidences a pattern of failures that has persisted in SEPT (now EPUT). It contributes to demonstrating the inadequate framework in place to address and prevent recurrence of such failures. As set out in HJA's Opening Submissions and the chronology **attached** thereto, Carol Savage died in 2004 under the care of SEPT.

21. The facts of *Savage* have a strong resonance with the evidence to date and the Inquiry will be well aware of factors such as:

    a. The use of Oxevision equipment and systems for monitoring patients;

    b. The common themes emerging as to staff training / competence in resuscitation and in addressing physical health concerns in elderly patients, to name but two examples;

    c. The change in risk assessment model to be used by the NHS in April 2025 (which begs the question as to why this needed to be changed having regard to the model / practice in place before, indicative of a systemic issue);

    d. The Mental Health Bill and serious impetus for legislative change which is ongoing.

22. The Inquiry's understandable determination not to 'lose sight of the wood for the trees' and to keep its focus on systemic issues of concern is precisely that which engages a timely consideration of Article 2 now.

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[14] [2009] 1 AC 588

ARTICLE 2 ECHR: THE INVESTIGATIVE DUTY AND ITS APPLICATION TO THE INQUIRY

23. As to the investigative duty to inquire into and explain the circumstances of a death, this is further divided into the substantive duty to investigate every death as an aspect of the framework duty and the procedural obligation that arises in some cases where there is the possibility of a breach by an agent of the state of one of the substantive operational or systems duties.

24. In the latter instance, there is a duty to carry out an enhanced investigation i.e., to initiate an effective public investigation by an independent official body: Morahan at [30](3): the enhanced investigative duty.

25. It is submitted that the mere fact that there has been an inquest in the case of some of the deceased whose families are CPs does not automatically mean that the duty has been discharged. The Inquiry ought to keep an open mind in this regard, as there has been compelling evidence that in some cases, the information before the Coroner and was erroneous or incomplete, including internal investigations carried out by NHS Trusts. It would be an invidious task to parse all the of the inquests and determine which ones need further investigation. Instead, it is submitted that robust investigation of all of the HJA CPs' cases, which it is understood will be illustrative cases, will not only assist the Inquiry in meetings the TOR but ensure that the duty will be met insofar as it is engaged in these cases.

26. Clearly, the Inquiry can avail itself of evidence from those cases and inform itself of the Coroner's conclusions. Few CPs seek a finding on cause of death; instead, most CPs seek robust findings as to the wider circumstances leading up to their loved one's death, the adequacy of the state's response in each case, and of its framework to prevent such deaths. They seek accountability in the form of public hearings. It is is necessary for this Inquiry to come to its own conclusions in each case.

27. The HJA CPs acknowledge that there have been inquests in some cases and not in others. Of those cases where inquests were held, a proportion were Article 2 inquests, but the Inquiry cannot automatically assume or concede that those Article 2 inquests properly discharged the procedural duty as this depends upon how the inquests were conducted. **Appended** to this skeleton is a table showing the status of HJA CPs in this regard. Where a patient was detained at the time of death, it is more likely that an Article 2 inquest was held[15]. It is not submitted that this Inquiry should routinely go behind the findings in inquests or civil proceedings; those findings are legitimately part of the picture which the Inquiry ought to consider. However, the Inquiry must focus on the evidence available now, not all of which was or would have been available at the inquests in question and focus on its own TOR as informed by the operation of

[15] Albeit we do not have full instructions on this point and thus provide a breakdown of detained and other cases to assist the Inquiry to the best of our knowledge at this time.

Convention rights. Further it must be alive to concerns about and limitations of some of the inquests, an issue which has already been ventilated in evidence and which no doubt informs the caveat in the draft Investigative Strategy in this regard.

28. As was submitted by the Equality & Human Rights Commission to the Grenfell Inquiry and as we submit is apt here:

The scope of human rights obligations is a key consideration for the Inquiry in deciding whether to make interim recommendations, what these and the final recommendations should be, and how the Inquiry should now proceed.

29. As to the enhanced investigative duty which may well be engaged due to the arguable breaches of the state, Popplewell LJ address the issue of when that enhanced duty arises in Morahan in the following terms:

"75. Lord Bingham's formulation in Middleton v West Somerset Coroner[16] identifies the duty as arising when there is a sufficiently arguable breach by the state of one of its substantive obligations ("it appears that [a substantive obligation] has been or may have been violated")…This threshold is a low one because to impose a more onerous burden would run the risk of the coroner determining, in advance of the full evidential picture, what the outcome of any inquest might be. Nevertheless it must amount to more than mere speculation. There must be a real evidential basis which makes the suggestion of a breach of a substantive obligation by the state a credible one".

"102. Nor do I regard that threshold of arguability as any different from the relatively low threshold which arises outside the category of cases giving rise to an automatic duty, where there is, for example, an arguable breach of the positive operational Osman duty in the particular circumstances of an individual death. The latter arises where, in the words of Burnett CJ in Maguire, a breach can credibly be suggested…These different expressions (grounds to suspect, legitimate suspicion, possibility, potential, more than fanciful, credible suggestion) are, in my view, simply alternative ways of expressing a single concept of a single threshold of arguability. It is a concept which is similar to the domestic test for summary judgment, keeping in mind that in the article 2 investigative duty context the test often falls to be applied at an early stage when the evidence is all in the hands of the state authorities (a factor also taken into account in the summary judgment jurisprudence: the court must take into account not only the evidence actually placed before it on the application for summary judgment, but also the evidence that can reasonably be expected to be available at trial: Royal Brompton Hospital National Health Service Trust v Hammond[17]… "

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[16] [2004] 2 AC 182
[17] [2001] Lloyd's Rep PN 526

PROCEDURAL IMPLICATIONS OF THE FOREGOING

30. Arid submissions on the law without a clear focus as to what needs to be changed, and what participants want, assist no one. Thus this section addresses what it is that the HJA CPs ask the Chair to consider doing. It is, in reality, a modest request.

31. Accordingly, it is submitted that the Inquiry must embed into its strategies suitable means for giving meaningful consideration as to whether there has been an arguable breach of the positive duty either by way of the operational duty or the systems / framework duty. It is already looking at these matters in the sense of examining the concerns of CPs which may give rise to further investigation revealing a breach of the operational duty or systems / framework duty. Further, it is to examine evidence from the NHS Trusts themselves and to receive expert evidence the gravamen of which will surely touch upon potential systemic breaches again pointing towards a breach by agents of the state of Article 2 ECHR.

32. There should be a baseline for findings in respect of each of the deaths which form illustrative cases with clear conclusions as to whether there have been arguable state breaches in respect of those cases and, if so, to hold the investigation in such a way that is sufficient to examine the circumstances of the death and to hold those involved (whether because they contributed to the death or whether because they were involved in the circumstances leading to death) to account. The investigation into the circumstances of each of those deaths should take into account the concerns and questions of all of the families who are engaging with this Inquiry and have CP status. As currently envisaged in the draft Strategy, there is little time for CPs to comment on case summaries and this is a vital juncture at which their input is needed. It is also a critical point at which the Inquiry should give active consideration to ECHR and, in particular, Article 2 as set out above.

33. This has an important impact on disclosure, which is a major concern referred to in submissions on the draft Investigative Strategy, and on the way in which witnesses are questioned i.e., without overly narrowing down the areas of questioning. There have been examples of excellent questioning by the Counsel to the Inquiry ('**CTI**') to date, which would be fully Article 2 compliant in any event. However, crucially and disappointingly, all questioning has been conducted without exhibits. Further, because of a lack of disclosure from the Inquiry, each witness has only been able to comment upon those documents which happen to be in their possession (and this differentially affects witnesses). The key is to ensure parity in the handling of witnesses and CPs. The effective way forward is to aim for Article 2 compliance across the board; this is beneficial to the Inquiry as it supports the fulfilment of the TOR and means that a robust and thorough investigation will be carried out, without seeking to rehearse matters that do not need to be rehearsed or to unpick findings that do not merit being unpicked.

34. Where answers can be given, they should be given. We underline, on behalf of those whom we represent, exactly what was said in our Opening Statement, paragraph 50:

"***First**, our clients want the truth. Our clients will assist the Inquiry with their own evidence. Yet there remain significant issues touching on their own care, or their loved ones' care, life or death, which trouble our clients. Our clients have learned some horrendous truths touching on these matters, but there remain silences, omissions, gaps, and unanswered questions. For answers, we look to this Inquiry and ask the Chair to use the full breadth of her statutory powers to compel evidence and air it in public.*" (emphasis in the original)

35. Our clients have set these out some of their questions in witness evidence[18] and would be pleased to collaborate further as to this during the investigative stage. In our submission, their questions must be put to the relevant CP (usually the Trust) by way of a rule 9 request, and the Trust's response must be shared with CPs. The response must be candid and made with the input of those who have first-hand knowledge of the issues – a response designed to minimise perceived governance and reputational risks will not suffice in the circumstances to meet the duty of candour. Any failure to respond (or respond adequately) must be treated by the Inquiry with the seriousness it deserves – perhaps by calling the witness to give oral evidence or using its powers under the Act to compel evidence, as the case may be. Where the issues ought to be treated by way of oral evidence, then that evidence must be listed to be heard.

36. Where – exceptionally – answers cannot be given as they have not been established through an appropriately robust investigation, families should be informed that this is the case and be provided with sufficiently informative and satisfactory reasons for it. There will be some cases, it is of course understood, in respect of which not every question will have an answer. That is always so. That should not, however, detract from the Inquiry's duty to comply with ECHR.

37. Taken as a whole, it is submitted that the draft Investigative Strategy as presently drafted is not suitable to discharge the Inquiry's obligations under the TOR and the ECHR. Greater CP involvement and engagement is necessary in order to fulfil both. Whilst it is presently understood that there will be separate streams of work as mentioned by CTI in his opening remarks, it is not yet clear what they will be, how they will interconnect, what the overall timeframe will be and what the overarching roadmap to concluding the Inquiry is. It is of course possible that taken together those elements will meet both the TOR and ECHR, but at present it is impossible for the HJA CPs to comment or to have confidence that this will be the case. However, the law is clear: the onus is not on the HJA CPs; rather, the onus is on the Inquiry to determine for itself whether there is an arguable duty or duties under the ECHR. In our submission, that threshold is unequivocally met.

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[18] See, for example: Witness statement of Sally Tyler §§74, 97, 101, 110, 116, 167, 170; Witness statement of Ralph Taylor §§6-9, 56, 59-62, 69-71, 74, 78-80, 93. 98, 100, 106, 109, 111, 112-114, 117, 120, 127, 130, 132, 135, 136-137, 147, 152, 155-156, 185; Witness statement of Y10 §§36, 83; Witness statement of Jane Stanford §220; Oral evidence of Craig Scott (transcript 20 October 2025) p101 lines 4-6, p30 lines 17-21 (etc).

38. In our submission, the Inquiry's ECHR duties require it to:

    a. make rule 9 requests of the NHS Trusts in each Illustrative Case where the CP has outstanding questions they want answers to, forward those answers to CPs and determine whether oral evidence is required, in consultation with CPs;

    b. ensure that there is full and timely disclosure to further the duty of candour;

    c. ensure that those who experienced less than full Article 2 inquests (e.g. where there was no inquest or no Article 2 inquest) get a fuller examination into their loved one's treatment and decision making surrounding it;

    d. ensure that experts are instructed in good time, on the full range of issues, and informed by CPs' suggestions & concerns at all stages – not merely following clustering (as currently envisaged in the draft Strategy paragraphs 45 and 49).

39. As to CPs' procedural expectations more generally, the Chair has our submissions made jointly on behalf of former patient and family clients and Core Participants represented by Bindmans, HJA, Irwin Mitchell and Leigh Day dated 29 May 2025 as well as the contents of the application made jointly by RLRs which led to the listing of this hearing on 8 December 2025.

OTHER CONVENTION RIGHTS

40. No doubt the Inquiry will have already given thought to Article 8 in the context of its redaction and information sharing strategies, and to Articles 3, 5 and 14 as well. In respect of Article 14, we note that there will be expert evidence on neurodiversity and that this may well be relevant to a class of patients who would be considered to be disabled within the meaning of section 6 Equality Act 2010 i.e. that they would possess a relevant protected characteristic to be taken into account. There may well be others.

41. If and to the extent relevant we or other RLRs can provide submissions on the wider ECHR rights that may be engaged in this Inquiry we would be pleased to receive permission for the time to be taken in doing so.

ELEENA MISRA KC

ACHAS BURIN

ANNAHITA MORADI

REBECCA HENSHAW-KEENE

JAKE LOOMES

Counsel instructed by HODGE JONES & ALLEN