BEFORE BARONESS KATE LAMPARD CBE

IN THE MATTER OF:

THE LAMPARD INQUIRY INVESTIGATING MENTAL HEALTH DEATHS IN ESSEX

OBSERVATIONS ON BEHALF OF INQUEST
TO THE DRAFT STATEMENT OF APPROACH
INVESTIGATING ILLUSTRATIVE CASES
OF THOSE WHO HAVE DIED

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1. INQUEST is grateful to the Inquiry for requesting observations on its Draft Statement of Approach to investigating illustrative cases of those who have died. INQUEST would be grateful for clarification as to whether this Investigative Strategy represents the totality of the Inquiry's investigation roadmap, or whether it is a strand of the same? We have the following short set of observations to make in relation to the draft on the basis that it is one strand of the overall investigation roadmap.

2. First, in relation to Paragraph 9, in which the Inquiry has provisionally identified categories of case to form part of its sample, and specifically in relation to cases involving an Essex based mental health inpatient care provider, INQUEST asks why the Inquiry is only looking at cases where there was a finding of 'neglect' (which for coronial purposes requires there to be a gross failure to provide basic care) as opposed to all cases in which the Coroner/ Jury have made findings that an act/omission by the Provider has contributed to the death. In such cases, for example, there could have been findings of gross failures even if the legal test for 'neglect' is not met.

3. Given the Inquiry is looking here at inpatient deaths, all the deaths that were not natural should have had an inquest process that at least sought to comply with the Article 2 ECHR investigative duty and therefore should have been capable of identifying and recording

critical findings that either probably or possibly contributed to the death. INQUEST is concerned that if this category of deaths are excluded from investigation, then the Inquiry may miss illustrations of important causative themes that did not amount to neglect.

4. INQUEST understands that there may well be practical constraints in relation to obtaining and reviewing all the Records of Inquest for inpatient deaths across the time period within the Terms of Reference but would welcome further expansion of the Inquiry's rationale in relation to this category and can also engage with the Inquiry in relation to methods for the selection of relevant cases, including through requests to coroners, or through INQUEST's own case load.

5. Further, it is not currently clear from the draft Statement of Approach whether the Inquiry will be including all cases that fall within a particular category at paragraphs 9(a) to (f). For example, will all deaths of CAMHS patients be considered? Will all cases where the Coroner has issued a Prevention of Future Death Report under the CJA 2009 or a Rule 43 Report under the previous legislation be considered? If not, how will cases be selected from within these categories?

6. Second, in relation to the "overarching approach to investigations", INQUEST welcomes the proposal at Paragraph 16 that the Chair may re-examine matters where previous processes lacked systemic scope or independence, also referred to at Paragraph 33. As highlighted in the evidence to the Inquiry by Deborah Coles[1] and in our previous written submissions,[2] we ask the Inquiry to consider whether previous Trust investigations have had sufficient systemic scope or independence, and whether some previous inquests have lacked systemic scope.

7. In relation to Paragraph 17, INQUEST asks the Inquiry to provide clarity as to when and how liaison with families and others will take place in order to ensure that the experience and expertise of families informs the investigation of relevant cases from an early stage and that importantly, families understand when they will be contacted and will be given sufficient time to input meaningfully.

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[1] Oral evidence of Deborah Coles, 12 May 2025, p.48:12-23, 53:16-55:15
[2] Written submissions on behalf of INQUEST, April Hearings, p.4 §15 to p.6 §24

8. INQUEST's experience across decades of working with bereaved families is that this will be a very traumatic process for families and must be approached sensitively. The Inquiry must adopt a trauma informed approach and appreciate that families are likely to be at risk of re-traumatisation, not only by the Inquiry examining their own loved one's experiences, but also by having shared with them the experiences of others.

9. Third, in relation to Paragraph 20 of the Investigative Strategy, INQUEST welcomes the Inquiry's consideration of defensiveness and lack of candour and urges the Inquiry to make public findings in relation to these important topics. The national profile and significance of this Inquiry means that other Trusts will be aware of its work and monitoring its findings and if there is to be meaningful cultural change in Essex and nationally, then issues of transparency and candour should be identified at the earliest opportunity.

10. In relation to the evidence that the Inquiry intends to seek regarding the illustrative cases (Paragraph 22 and 23), INQUEST asks for further details and clarification as to the approach to be taken. For example, whether the Inquiry intends to obtain and hear evidence directly from staff members involved in a person's care and how any further expert evidence obtained by the Inquiry will feed into the illustrative cases?

11. In relation to Paragraphs 30 to 34 of the Investigative Strategy (dealing with inquest proceedings), it is noted that the findings in a Record of Inquest will not generally be re-examined by the Inquiry, unless there are "compelling reasons to do so" (Paragraph 30). INQUEST considers that it would assist Core Participants to understand what criteria the Inquiry will be applying in considering whether there are such 'compelling reasons'.

12. The Inquiry recognises that "there are cases where families have raised concerns about the effectiveness and adequacy of coronial investigations" and notes that, where these are raised, these will be considered "on a case by case basis" (Paragraph 34). INQUEST encourages the Inquiry to examine the underlying materials in such cases wherever possible, and to provide clarity as to how it intends to exercise its discretion where such concerns have been raised.

13. Fourth, in relation to the provision of a 'Case Summary' at Paragraph 26 and the disclosure protocol at Paragraph 51, it is submitted that as a minimum, where INQUEST have supported a bereaved family within any cluster, that with the permission of the family,

INQUEST should be provided with a copy of the initial case summary in order to assist with whether there are any factual inaccuracies or areas for further exploration. In this way, INQUEST will be able to assist the Inquiry with its investigative objectives.

14. INQUEST also raises the concern that the Inquiry's current approach at Paragraph 51 is inconsistent, in that for some Core Participants, (like INQUEST) case summaries will not be provided at all until they are published, whilst some families who are within multiple clusters will receive multiple summaries.

15. Fifth, in relation to the grouping of the illustrative cases into "clusters", it is not clear from the Draft Investigative Strategy whether there will be engagement with Core Participants around the "common themes and issues". INQUEST would welcome further clarity on this topic and is of the view that such consultation is essential to ensure that the relevant themes and issues are identified.

16. Although INQUEST welcomes the sharing of the Draft Investigative Strategy, we remain concerned that the Inquiry has not yet set out with any clarity its overarching investigation roadmap with clear guidance as to how the 2026 hearings will be utilised or structured. We had understood from CTI's opening in July that the Inquiry would provide its disclosure plan, alongside a timetable of further disclosure to allow Core Participants to plan their work and resources in advance but this has not been provided despite the indication it would be distributed in August.

17. INQUEST's own experience through managing their caseload supporting bereaved families, which seeks to bring together information about a death, including material from post-death investigations, family members and other sources, is that it is an incredibly time consuming and intricate task with the need for constant and sensitive communication with the families and other parties. Given the Inquiry's Investigative Strategy is currently only in Draft, we are concerned as to how any evidence of any depth relating to the illustrative cases could realistically be ready to be heard before the hearing windows in February and April 2026.

18. We will address these concerns and other procedural matters in oral submissions on the 8th December, but in the meantime welcome conversations between the Inquiry team and Core Participants to clarify the points raised above.

Anna Morris KC
Garden Court North Chambers
Lily Lewis
Garden Court Chambers

Charlotte Haworth Hird
Bhatt Murphy Solicitors

1st December 2025