Statement of Approach

Investigating illustrative cases of those who have died

Introduction

1. The Lampard Inquiry's Terms of Reference [TOR] require it to "*investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex… between 1 January 2000 and 31 December 2023*".

2. The Explanatory Note in relation to scope, which was published at the same time as and accompanies the Inquiry's TOR, states that "*[t]he Chair is minded to identify a sample of cases, representative of the issues, that will be investigated in detail in order to draw wider conclusions*". For the avoidance of doubt, the use of the word sample should not be taken to reflect a statistically derived selection of cases from the Inquiry's List of Deceased. Rather, sample should be understood in the context of the purpose of investigating illustrative cases as set out at paragraph [5] below.

3. In his Opening Statement at the September 2024 Hearing, Counsel to the Inquiry explained that this approach would provide a sensible and proportionate way forward, and indicated that the Inquiry would be looking into the deaths of all those whose families and friends had been granted Core Participant status, to the extent possible and appropriate.[1] The Inquiry intends to do so, analysing each case to the extent that is necessary and proportionate to enable the Chair to make recommendations for change in relation to systemic issues.

4. This statement of approach sets out:

    a. the factors the Inquiry intends to consider in order to select cases for investigation;
    b. how it will identify and explore the issues and themes raised by those cases in accordance with its TOR;
    c. how the Inquiry will approach the gathering and testing of factual evidence; and
    d. how families, providers and other agencies can engage with the Inquiry's investigations.

[1] Opening Statement of CTI at the September 2024 Hearing, 9 September 2024, p.29.

5. The purpose of this exercise is three-fold. It is:

    a. To allow for a proportionate and timely investigation, in accordance with section 17(3) of the Inquiries Act 2005, into the nature of serious failings relating to the delivery of safe and therapeutic inpatient treatment and care with reference to the Inquiry's TOR;
    b. To explore and assess systemic issues by reference to individual cases and the extent to which providers took into account and acted upon relevant recommendations made across the relevant period (and after, where necessary) by investigatory bodies and/or individuals; and
    c. To assist in the formulation of recommendations by this Inquiry, and the delivery of the Chair's report, to improve the provision of mental health inpatient treatment and care in Essex, and nationally.

6. This statement of approach does not address the approach to the evidence of Core Participants with lived experience of inpatient mental healthcare in Essex during the relevant period. Further communication on this will follow, however the evidence of all those with lived experience and/or those who have evidence to give to the Inquiry which relates to matters of current practice will be taken into account alongside illustrative cases where relevant to issues within case 'clusters' (see below).

7. The cases of those who have died which will be examined for the purpose set out at paragraph [4] above will be known as 'illustrative cases'.

8. All illustrative cases will be investigated in accordance with the Chair's statutory duties and relevant Inquiry protocols. Notwithstanding the principles set out below, there may be occasions where the Chair, in exercising her discretion, departs from this proposed approach.

Inquiry approach to the selection of illustrative cases

9. In order to explore issues and themes relevant to its TOR, the Inquiry intends to consider the following factors when selecting illustrative cases:

    a. The extent to which any illustrative case provides evidence necessary for the Chair to meet her TOR[2];
    b. The representation of care by relevant trusts and providers, across the period under investigation;
    c. The representation of a range of patients, taking into consideration factors such as mental health condition and presentation, the

[2] Also taking into account the Chair's Explanatory Note on Scope and how she is minded to interpret the TOR.

location and type of unit at which care was received (if admitted), age, other protected characteristics and any co-occurring needs (such as physical health conditions and neurodivergence); and

d. The representation of issues that have been raised by families in their accounts and/or identified by the Chair within her discretion as relevant to the Inquiry's TOR.

10. Having regard to these factors, the Inquiry has identified the following categories of case to form part of its sample of illustrative cases for further investigation:

    a. Cases where a family member or friend has been granted Core Participant status in respect of someone who has died;
    b. EPUT (and its predecessor trusts) and NELFT cases where CAMHS patients have died;
    c. Cases which formed part of the 2021 EPUT prosecution by the Health and Safety Executive (HSE);
    d. Cases involving an Essex-based mental health inpatient care provider and a neglect finding at an inquest in relation to acts / omissions of that provider regarding mental health inpatient care;
    e. Cases involving an Essex-based mental health care provider where a Coroner issued a Prevention of Future Deaths report to that provider regarding mental health inpatient care; and
    f. Such other cases as the Chair considers, in her discretion and with regard to section 17(3) of the Inquiries Act 2005, ought to be included [TOR5, TOR6].

11. It should be noted that in addition to f. the Chair, in her discretion, may add or remove a case from the sample, should she consider it appropriate to do so.

12. At present, and having included all known cases which fall into the categories identified at paragraph [10] above, the Inquiry proposes to examine around 145 deaths as part of the illustrative case sample. Notification letters will shortly be sent to all those with whom the Inquiry has contact and/or for whom next of kin or family contact details are held by key stakeholders where their cases have been included within the Inquiry's illustrative cases. Lists of relevant cases will also be shared with providers.

13. The Inquiry appreciates that many of those who died had long and varied engagement with mental health inpatient services and with other healthcare providers and services, which may extend beyond the matters which the Inquiry has been established to investigate. In respect of each of the illustrative cases, the Inquiry's focus will be on matters which fall within its TOR.

Overarching approach to investigations

14. A dedicated team within the Inquiry has been established to gather and review materials in relation to the illustrative cases (the Inquiry's Investigation Team).

15. As is set out in further detail below, where there have been comprehensive previous investigations into clinical failings or related issues, the Inquiry does not intend to rehearse or reinvestigate these matters.[3]

16. Where there have been findings or admissions of failings in other proceedings, such as criminal, civil, inquests and/or regulatory proceedings, the Inquiry does not intend to re-open or re-examine these unless there are compelling reasons to do so, or the Chair within her discretion considers it appropriate.

17. The Inquiry proposes to approach illustrative cases by building upon evidence already received from families, providers and key stakeholders. It will analyse previous investigations and consider what further evidence may assist the Chair to meet her TOR. Whilst the Inquiry intends to avoid duplicating previous investigations, it may re-examine matters where previous processes lacked systemic scope or independence.

18. At appropriate times during the Inquiry's investigation of illustrative cases, the Inquiry will liaise with families, key stakeholders and others (at the discretion of the Investigation Team) as to further investigative steps. However, decisions in this regard will ultimately be for the Chair within her discretion.

19. The Inquiry recognises that where there have been inquests or other relevant earlier proceedings, there may have been limits as to their scope and breadth. This means that broader systemic issues across illustrative cases, providers, and periods of time may not have been previously or adequately considered.

20. In these circumstances, the Inquiry intends to focus on these systemic issues. In so doing, the Inquiry proposes to explore systemic accountability for any failings identified across the relevant period and the extent to which the issues have either been remedied or repeated.

21. The Inquiry may also consider the extent to which providers have acted defensively and/or with candour in dealing with families in these cases.

22. Each illustrative case will contain its own unique facts and features. As such, the Inquiry intends to adopt a flexible approach to its investigations. The nature, extent and focus are likely to depend on a variety of factors, including the availability of material, specific areas of concern identified by the family or

[3] For example, by way of an Article 2 inquest which resulted in a narrative conclusion.

by others, and in particular the extent to which the Chair considers further detailed investigation is necessary in order to meet the TOR.

23. In line with the principles set out below, the Inquiry proposes to seek within its initial phase of investigation the following evidence, if not already in its possession, in respect of the illustrative cases:

    a. Records of Inquest and/or death certificates;
    b. Prevention of Future Death reports (if made) and any responses;
    c. Evidence of the relevant provider's approach to Prevention of Future Death reports, including in cases where a report was ultimately not issued;
    d. Post death investigations including, but not necessarily limited to, internal investigations conducted or commissioned by providers, and reports from external investigators or oversight bodies (including the police and the HSE). This will generally include seeking the provider's response to any reports and/or any complaints from families; and
    e. Any relevant material or admissions of liability in respect of civil claims.

24. It is proposed that targeted requests for materials will then be made, where necessary and proportionate, to examine issues relevant to the Inquiry's TOR. This may include, but is not limited to, requests for the following:

    a. Focused extracts of individual medical records;
    b. Relevant policies and procedures;
    c. Witness statements given in previous judicial, inquest or regulatory proceedings; and/or
    d. Expert reports relied upon in claims or previous proceedings.

25. The Inquiry intends to consult its Independent Assessors and instruct independent experts, where necessary.

Approach to previous investigations and findings

26. The Inquiry proposes to review previous investigations and findings including, but not limited to:

    a. Inquest conclusions and findings, considering formal Records of Inquest and matters of concern identified and subject to Prevention of Future Death reports;
    b. Criminal proceedings resulting in conviction, such as the HSE prosecutions of EPUT;
    c. Civil proceedings and settlements;

d. Internal and external reports (such as Serious Incident or Patient Safety Incident Reports) conducted or commissioned by relevant providers; and
e. Findings from regulatory and oversight bodies, such as the Heath and Care Professions Council (HCPC), Nursing and Midwifery Counsel (NMC), General Medical Council (GMC), Parliamentary and Health Service Ombudsman (PHSO), Local Government and Social Care Ombudsman (LGSCO) and the Care Quality Commission (CQC).

27. As part of this review, the Inquiry intends to prepare a 'Case Summary' for each illustrative case. This will summarise family witness statements where provided, any previous investigations and findings, and identify further key evidence. It will be disclosed in accordance with the process set out below.

28. The purpose of the Case Summary is to identify relevant matters for the Inquiry's consideration and to establish whether (and the extent to which) those matters are, or are likely to be, subject to factual dispute. It will also identify any potential criticisms of individuals or organisations at an early stage.

29. Where there have been findings of fact in previous proceedings, the Inquiry does not intend to challenge these, unless there are compelling reasons to do so. This would not prevent further exploration of issues identified in any such findings, or the exploration of new concerns. However, the Inquiry is not able by law to determine questions of civil or criminal liability.

30. The way in which the Inquiry will use each of the above materials is discussed in further detail below.

Inquest proceedings

31. It is proposed that findings in a Record of Inquest will generally not be re-examined by the Inquiry, unless there are compelling reasons to do so; such as the emergence of new and cogent evidence not previously before the Coroner, or where there is other evidence which suggests that the evidence presented at the inquest was unreliable.

32. However, the Inquiry will not necessarily be limited by findings reached by a coroner or a jury. There may be cases where findings set out within a Record of Inquest do not fully reflect the circumstances of the case; for example, where the Record of Inquest records either simply 'suicide' or the factual mechanics of death, without comment on any failings in care. The Inquiry may carry out its own assessment of those matters. In this way, the Inquiry will not be limited by any previous inquest findings.

33. It is proposed that a similar approach will generally be followed in respect of concerns subject to Prevention of Future Death reports.

34. There may be cases where it is clear to the Inquiry that a coroner or a jury has not been able to examine adequately, or determine, particular issues in relation to one of the illustrative cases; this may be because the case was looked at in isolation. Where applicable, the Inquiry intends to consider systemic issues which have not been explored in a particular illustrative case.

35. The Inquiry recognises that there are cases where families have raised concerns about the effectiveness and adequacy of coronial investigations. Where concerns as to the adequacy of inquest findings are raised, it is proposed that these will be considered on a case-by-case basis.

Criminal proceedings

36. The underlying factual basis outlined in criminal proceedings will generally be relied upon by the Inquiry when considering the circumstances of deaths that were subject to prosecutions.

Civil proceedings

37. In a number of cases, the Inquiry is aware that there have been civil claims, admissions of civil liability by providers, or settlements in relation to alleged failures in care.

38. Where a claim has included or sought to rely on expert evidence, the Inquiry proposes to obtain that expert evidence. The Inquiry further proposes to rely on admitted or proven failings, unless there are compelling reasons not to do so.

Internal and external reports (such as Serious Incident or Patient Safety Incident Reports) conducted or commissioned by relevant providers

39. In the majority of illustrative cases, the provider will have conducted or commissioned some form of investigation. From its initial review of the illustrative cases, and the evidence from family witnesses, the Inquiry has noted that these investigations vary significantly in detail, quality and impartiality. Further, there are a number of cases where the findings of an internal investigation have been challenged by the family and/or have been inconsistent with findings made by external investigators, or coroners.

40. It is proposed that the extent to which matters contained within these reports can be relied upon will be addressed on a case-by-case basis and regard will be had to any other external and/or independent reports in determining this.

Findings from regulatory and oversight bodies

41. The Inquiry intends to consider findings made by regulatory and oversight bodies, such as the CQC during its inspections of relevant providers. The value of these reports may vary depending on their timing and the location which has been assessed. Reliance may therefore be considered on a case-by-case basis.

42. There may also be cases where disciplinary findings have been made by healthcare professional regulators, such as the HCPC, NMC or GMC. Here, where findings have been made in accordance with the principles and rules of civil evidence and on the balance of probabilities, the Inquiry intends to generally rely on these in the same way as findings from an inquest or civil proceedings.

43. To the extent necessary, investigations by the PHSO and LGSCO may also be considered.

Expert evidence

44. Where there have been alleged or established failings in care and/or clinical conduct, it is proposed that consideration will be given to the scope and nature of any expert opinion evidence that may be required.

45. Potential previous findings that may be relied on are detailed above, but may include those of a coroner or jury, the civil courts, the CQC, and findings from professional healthcare regulators (particularly in respect of individual staff).

46. In deciding whether expert evidence should be obtained by the Inquiry in respect of the illustrative cases, the Inquiry intends to take the following approach:

    a. Cases will be grouped together by relevant issue, as 'clusters', in accordance with the principles set out below;
    b. An assessment will be made of whether the relevant issue within that cluster falls within the scope of, and requires, expert evidence;
    c. An assessment will be made as to whether previous investigations or findings of fact can be relied upon to form the basis upon which any expert evidence or assessment can be obtained;

d. An assessment will be made as to the extent of any previous expert evidence and its reliability (in particular whether it has formed the basis of any previous findings in respect of care); and
e. Where there are gaps in the expert evidence, the Inquiry will consider instructing a suitably qualified expert to provide evidence as to the relevant standards and any failings in respect of that cluster.

47. The Inquiry will follow the process set out in its Protocol on the Role and Instruction of Experts when seeking to obtain any expert evidence in respect of the cases and/or issues under investigation. It will also have regard to Rule 10 of the Inquiry Rules 2006 at hearings, meaning that Core Participants will be in a position to provide questions and engage with any expert opinion.

Clustering of cases by themes and issues and further investigation

48. Once sufficient initial evidence has been obtained, the Inquiry proposes to link and group illustrative cases together by common themes and issues. The grouping will be at the discretion of the Chair, with input from others (including Independent Assessors), as appropriate. Each group will be known as a 'cluster' of cases. A list of clusters, based on the evidence gathered and work undertaken by the Inquiry so far, is annexed to this document. This list and the overview of each cluster will be kept under review, and may be subject to change, as the Inquiry's investigations progress. The following issues will also be considered across all clusters, with reference to each thematic issue:

    a. Therapeutic care and compassion;
    b. Patient engagement and capacity;
    c. Family engagement and the receipt and passing on of information;
    d. Record keeping (by individuals);
    e. Staffing and training, including the use of bank and/or agency staff; and
    f. Ward culture.

49. The inclusion of a case in one particular cluster will not prevent it being considered in respect of another.

50. Once cases are in their provisional clusters, the Inquiry proposes to:

    a. Focus on identifying systemic issues across those illustrative cases;
    b. Assess compliance with and/or responses to previous recommendations and Prevention of Future Death reports;
    c. Consider whether any further evidence is required from providers and/or individual witnesses in respect of key issues, including those

with lived experience and/or those who can give relevant factual or contextual evidence;

d. Assess the need for expert evidence to comment on potential failings in care (as above); and
e. Identify relevant provider and/or other third-party (including regulatory) witnesses with whom issues relating to accountability can be examined. The Inquiry will seek to use illustrative cases to explore the operation of systems, policies and procedures. These witnesses will therefore likely include senior staff members, such as medical directors from within the Trusts and those responsible for overseeing internal investigations.

51. The need for further evidence (including evidence of national relevance) will then be considered on a cluster-wide basis.

Disclosure and engagement with Core Participants and third parties

52. The Inquiry recognises the importance and value of input from bereaved families in relation to the Inquiry's investigative process. It is for this reason that the Chair directed that evidence be obtained from families at an early stage about their concerns in respect of the care received by their family member. This evidence has helped the Inquiry identify key areas of concern and focus its work. It is, however, also important that the Inquiry maintains its independence. The Inquiry intends to take the following approach to disclosure and engagement in respect of the illustrative case sample:

    a. Those who form part of the factual nexus of an illustrative case - either as a family member, provider or outside agency - will be provided with a copy of the initial Case Summary prepared by the Inquiry, along with copies of relevant documents referred to within that summary (where appropriate, necessary and proportionate in line with TOR 10,the Inquiry's Privacy Information Notice, the Chair's Statement of Approach on Redaction, Data Protection and Privacy and Restriction Order No.12), on a confidential basis. They will also be provided with a form, in which they will be invited to comment on particular issues, such as whether there are any factual inaccuracies and/or areas for further exploration, as well as the proposed case cluster(s) which that case has been provisionally identified to fall within.

    b. Should families, providers or any outside agency wish to provide further relevant documents to the Inquiry, these should be identified and the purpose for proposing to provide them explained in the return of the above form. The Inquiry will then consider what further evidence ought to be obtained, from whom, and make the

appropriate requests. Case Summaries may be updated, and again disclosed to those involved.

c. Once the Inquiry has finalised any Case Summary, taking into account steps a. and b. above, that Case Summary will be disclosed to both the family, providers and/or outside agencies who are factually connected to the case and Core Participants whose cases are proposed to form part of each cluster. Disclosure of underlying documents relevant to the Case Summary to Core Participants within each cluster will take place where appropriate, necessary and proportionate in line with TOR10, any views expressed by the family, the Inquiry's Privacy Information Notice and other statements mentioned at a. above. Again, this will be done confidentially.

d. Finalised Case Summaries will also be disclosed to *all* Core Participants, whether or not factually connected to the individual illustrative case cluster. Underlying documents relevant to the Case Summary will not generally be disclosed to these Core Participants. However, in accordance with the principles contained in TOR10, the Inquiry will consider on a case by case basis any further representations in respect of underlying documents where disclosure to individual Core Participants is sought.

53. If safeguarding concerns emerge during the course of the Inquiry's investigations action will be taken in accordance with the Inquiry's Safeguarding Policy, where appropriate.

Next steps

54. This strategy will be kept under review and timelines will shortly be provided to those involved.

55. The manner in which illustrative cases are investigated will also be kept under review and may vary according to each cluster or case.

56. Whilst the Inquiry will generally seek to publish Case Summaries and take account of their contents in reaching any findings of fact and recommendations in any report, not all illustrative cases or clusters will be subject to further oral evidence and/or hearings.

57. Consideration will be given to whether there are significant and material factual disputes which need to be resolved in order to adequately meet the TOR, and whether expert opinion ought to be sought in accordance with the process set out at paragraph [46] above.

58. It is intended that broader issues which are likely to arise across more than one cluster relating to culture, staffing, management, governance structures and processes (including the responses to any adverse findings or criticisms made following internal or external scrutiny) will be dealt with at an oral hearing with appropriate corporate witnesses. Further information about which will be provided in due course.

Conclusion

59. The Inquiry is aware of the importance and urgency of its task. This statement of approach therefore sets out a process that, whilst being appropriately thorough, allows for its TOR to be met (and for recommendations to be made for lasting change) with all due expedition.

26 January 2026

Annex to Statement of Approach: Investigating illustrative cases of those who have died

List of Clusters (to be kept under review)

Cluster	Overview
Assessment and admission	Cases where an individual died following assessment (Mental Health Act and other) by an Essex Trust where the assessment did not lead to inpatient admission. This cluster also includes cases where there was a failure to assess in an appropriate time, or at all, and cases where admission was impacted by a lack of available beds, the need for an out of area placement and/or the use of partial hospitalisation.
Environmental risk and ward safety	Cases, including but not limited to ligature deaths, where death was linked to issues relating to the management of the physical inpatient environment and ward-based risk assessments. This will include deaths subject to the Health and Safety Executive prosecution in 2021 and absconsions from inpatient units. It will also consider the impact of staffing and acuity of inpatients where relevant to ward safety.
Sexual safety	Cases where significant concerns arise in respect of sexual safety whilst a deceased was a mental health inpatient (including on leave). Areas for consideration will include the adequacy of systems to ensure safety and the investigation of allegations. It is not intended that findings of fact or as to the veracity of any allegations will be made.
Safeguarding	Cases where serious concerns arise in relation to safeguarding and how risks relating to the deceased were managed outside the ward environment. This may include but is not limited to financial, sexual or other exploitation, neglect and/or abuse.
Observations and the use of technology	Cases where there are significant concerns relating to the carrying out of observations, including the use of surveillance technologies, such as Oxevision.
Co-occurring health conditions and older adult care	Cases where significant concerns arise in respect of the appropriate management of co-occurring or health conditions, with a particular focus on older adult inpatient care.
Neurodevelopmental disorders	Cases where significant concerns arise in relation to the inpatient care and treatment of those who had a suspected, differential or confirmed clinical diagnosis of one or more neurodevelopmental disorder(s), including but not limited to Autism Spectrum Disorder (ASD) and/or Attention Deficit Hyperactivity Disorder (ADHD).

Substance misuse	Cases where substance misuse and/or addiction is a significant feature and concerns arise in respect of its impact on the way in which deceased individuals were assessed, diagnosed, treated and/or discharged from inpatient units.
Medication	Cases involving significant concerns about the use of medication where related to the safe delivery of inpatient care and treatment. This cluster of cases will touch on issues relating to how medication was administered, prescribed or controlled, and whether other therapeutic interventions were considered.
Restraint	Cases involving significant concerns about physical (manual / mechanical) environmental or chemical restraint which was used in inpatient settings on individuals with mental health needs.
Emotionally Unstable Personality Disorder (EUPD)/Borderline Personality Disorder (BPD)	Cases where there are serious concerns in respect of the assessment, diagnosis, and/or management of Emotionally Unstable Personality Disorder (EUPD) or Borderline Personality Disorder (BPD), and this is directly relevant to potential failings in inpatient assessment, care, treatment and/or discharge.
Child and Adolescent Mental Health Services	Cases where the deceased was under the age of 18 and assessed and / or admitted for mental health inpatient care or treatment by Child and Adolescent Mental Health Services (CAMHS). This cluster of cases will focus on the adequacy of age-appropriate care, treatment, transfer to adult services and support.
Perinatal care	Cases involving significant concerns where specialist perinatal psychiatric care was or should have been provided during the perinatal period, including where referral to a mother and baby unit was considered and / or took place.
Leave	Cases involving significant concerns where an individual died whilst on a period of authorised leave (either section 17 or informal) from an inpatient mental health unit.
Discharge	Cases where patients died within 3 months of discharge from a mental health inpatient unit and significant concerns arise in relation to the decision to discharge, the adequacy of care planning, liaison, and/or aftercare planning in the community.
Information sharing, record keeping systems and inter-agency communication	Cases involving serious concerns regarding a) information sharing between and within trusts; b) the adequacy of and accessibility to information recording systems; and/or c) the adequacy of communication, coordination and information sharing between mental health inpatient services and external agencies.

CQC cases	Cases referred to the CQC and falling within the terms of their regulatory oversight and duties.
Culture, candour and accountability	Cases which involve significant concerns as to the quality, appropriateness and adequacy of the Trust's response to individual deaths and broader thematic issues and action taken over the relevant period. This cluster of cases will include the following areas: • Quality of internal investigations; • Falsification of records; • Culture (at all levels) and compassion fatigue; • Candour and engagement with families post death; and • The adequacy of responses to critical findings and external concerns, including Prevention of Future Death reports.