



Lampard Inquiry Newsletter – Autumn 2026

Welcome to the Lampard Inquiry newsletter.

We have created this newsletter to keep you updated on the Inquiry's progress and upcoming activity.

Hearings

Upcoming Public Hearing: 5th- 22nd October 2026

The Inquiry will hold its next hearing at the Civic Centre in Chelmsford. [You can now register online to attend](#). This public hearing is an opportunity for the Chair to hear further evidence on two areas examined during the July 2026 hearings. These are:

Emergency Response and Resuscitation

The Inquiry will hear further evidence about the issues that have emerged in relation to emergency response and resuscitation.

Professor Jasmeet Soar, a national and international expert in cardiac arrest treatment, guidelines and outcomes, will provide expert evidence. The Inquiry will also hear evidence from EPUT, other NHS trusts, NHS England and the Care Quality Commission.

Observations and the Use of Technology

The Inquiry will hear further evidence about observations and the use of technology in mental health inpatient care, including how systems such as LIO (formerly known as Oxevision) are used and the arrangements and safeguards in place for their use overnight. This includes expert evidence from psychiatrist Dr Chess Denman.

All evidence gathered relating to observations and the use of technology, and emergency

response and resuscitation, will help the Chair to decide whether any interim recommendations are needed. These could address ongoing patient safety concerns in mental health services in Essex and, where appropriate, nationwide.

Previous Hearings

6th- 23rd July 2026: In July, we held the first of our 'thematic hearings' - focused on the theme of Observations and The Use of Technology and the issue of Emergency Response and Resuscitation. A summary of the evidence heard during the July hearing is available in [Counsel to the Inquiry's Closing Statement](#).

Past hearings can also be found [here](#).

Work is well underway to prepare for further substantive hearings at the beginning of next year.

Themes and Issues

Through its evidence gathering and investigations, the Inquiry has identified a number of key themes and issues. Individual cases that illustrate these themes have been grouped together in 'clusters'. You can find a list of these clusters at [Statement of Approach - Investigating Illustrative Cases - The Lampard Inquiry - investigating mental health deaths in Essex](#). These are being kept under review as our work continues.

Thematic teams are bringing together and carefully analysing all evidence from families, staff, organisations and experts. This is helping the Inquiry build a better understanding of systemic issues, which will inform future recommendations for change.

Where further information is needed, the Inquiry continues to seek evidence from relevant people and organisations using its legal powers to do so, where appropriate.

Experts are also being appointed to provide independent insight into specific areas. Together, this work will help ensure that the hearings are informed by a thorough and wide-ranging body of evidence.

Staff Evidence

Through its dedicated Staff Team, the Inquiry continues to gather focused evidence from current and former staff who worked in mental health inpatient services in Essex during the period being investigated. Staff evidence is helping the Inquiry examine how services operated in practice and deepen its understanding of the key issues under investigation.

Visit our [Staff Witnesses FAQs](#) page for more information about emotional and legal support.

Family Evidence

The evidence shared by bereaved families and friends remains at the heart of the Inquiry's work. It has been central to identifying key themes and issues which have shaped the Inquiry's work programme and approach, in line with its Terms of Reference. This includes evidence provided through written statements, oral evidence at hearings and pre-recorded evidence sessions held in April and May 2026.

The Inquiry is grateful to everyone who has shared evidence, often about deeply personal and difficult experiences.

Family Q&A Event

On 17 September 2026, the Inquiry Team hosted a Q&A session for family Core Participants at the Civic Centre, in Chelmsford. The session provided an opportunity for families to speak directly to members of the Inquiry Team, ask questions and hear about various aspects of the Inquiry's work.

We will update the FAQs section of our website on these matters, after the October hearing.

Case Summaries

Case summaries are documents that summarise details of particular cases. These bring together the concerns raised by families, along with other information relevant to the Inquiry's investigations, such as evidence from other organisations involved, and previous findings.

The Inquiry has now disclosed draft case summaries, in relation to 112 of its 147 illustrative cases, to those who are factually connected to each case and has invited them to share their views. This means around 76% of illustrative case summaries have been shared with families, NHS trusts and other organisations involved in those cases for comment. The remaining draft case summaries are expected to be disclosed in the Autumn.

Case summaries help the Chair identify common themes and issues across multiple cases, understand what action has been taken by organisations, and consider whether further changes may be needed.

More information is available in the [Chair's Open Letter to Families](#) and our [Statement of Approach – Investigating Illustrative Cases](#).

Corporate Evidence

The Inquiry has issued 582 requests for information to organisations either under Rule 9 of the Inquiry Rules 2006 or Section 21 of the Inquiries Act 2005. While most information has been requested voluntarily through the Inquiry's evidence gathering process, the Chair has also issued 18 Section 21 notices, using her statutory powers to require organisations to provide information or documents.

The Inquiry's legal team continues to review and assess evidence from organisations. This work supports its investigation of the key themes and issues that will be examined at future hearings.

Beyond the Inquiry

The following developments relate to organisations and services that may be of interest to those following the Inquiry's work.

New Interim Chair Appointed At EPUT

Jackie Craissati has been appointed Interim Chair of Essex Partnership University NHS Foundation Trust (EPUT). She succeeds Hattie Llewelyn-Davies, who died in May 2026.

Concerns Raised About EPUT Leadership

A Care Quality Commission (CQC) assessment found that leadership at EPUT needs to improve. The assessment identified concerns including staff confidence in speaking up and how serious incidents are reviewed. Campaigner and Core Participant Melanie Leahy said the findings reflected concerns previously about leadership and organisational culture at the Trust. [Read the full CQC assessment report for EPUT.](#)

Lampard Inquiry Referenced During Nottingham Inquiry

The Lampard Inquiry was referenced during closing submissions to the Nottingham Inquiry, where the importance of learning from other reviews and inquiries into mental health care was highlighted. Reference was also made to the role inquiries can play in supporting organisations to implement recommendations and demonstrating how change will be delivered. A [transcript of the closing submissions](#) is available on the Nottingham Inquiry website.

Thirlwall Inquiry Publishes Final Report

The [Thirlwall Inquiry has published its final report](#) into events at the Countess of Chester Hospital. It identified serious failures in leadership, governance and safeguarding, including missed opportunities to act on concerns and protect babies from harm.

The report makes recommendations aimed at strengthening patient safety and accountability across the NHS.

Although it examined maternity and neonatal care, the report raises wider issues that are relevant to the Lampard Inquiry, including

how organisations respond to concerns and ensure that lessons lead to change. The Inquiry will be examining the report with care.

Support and Wellbeing

Please be aware that the hearings may contain descriptions of death and suicide, from the start and throughout, which some people may find distressing. Please visit the support section on the Inquiry's website for information about how those engaging with the Inquiry can access support.

Social Media

Follow the Lampard Inquiry on [X](#) and [YouTube](#) for updates.

Contact

For questions that are not answered on the website contact:

contact@lampardinquiry.org.uk

For press enquiries, contact:

press@crestadvisory.com

Helen Gibson, Secretary to the Inquiry