

## INQUEST response to Lampard Inquiry Terms of Reference

November 2023

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question.<sup>1</sup> This includes work around the Hillsborough football disaster and the Grenfell Tower Fire.
2. We have conducted research and analysis on issues arising from our work with families bereaved after deaths in mental health settings. This includes the deaths of detained patients, voluntary patients and those who have died while under the supervision of community mental health services. INQUEST was also a member of the advisory group to an inquiry conducted by the Care Quality Commission (CQC) into the way in which deaths in NHS settings were investigated. As part of this inquiry, INQUEST arranged a Family Listening Day for the CQC to hear directly from families affected, many of whom had died in mental health settings including the Linden Centre in Essex.
3. INQUEST welcomes the conversion of this Inquiry to a statutory one, and hope the evidence brought to the Inquiry will enable much needed learning and accountability in the provision of mental health care. There has been considerable anger and anguish over the many preventable deaths involving Essex mental health services and the failure to enact systemic change. Many families have not previously engaged in this Inquiry process because of concerns about its limited powers and scope. Therefore, it is important the Lampard Inquiry hears the voices of all affected families and adopts a Terms of Reference (ToR) which respects their experiences. This would both encourage and enable not only the participation of the bereaved in the Inquiry process, but also harness their positive contribution to the quality and credibility of its outcome.

### *Proposed Terms of Reference*

4. *Data*. Firstly, we believe an addition should be made to the ToR to ensure the Inquiry's ability to investigate possible trends in the data on deaths of individuals under the care of NHS Trusts in Essex. Data on the number of deaths should be captured by the Inquiry and disaggregated by protected characteristics including age, gender, race and ethnicity, as well as details on the location and type of death. Data on whether restraint was used should also be noted. This would strengthen the

---

<sup>1</sup> For more information on INQUEST's work on mental health related deaths, see our 2023 Family Consultation Day report on deaths of people with mental ill health, a learning disability or autism, [www.inquest.org.uk/Handlers/Download.ashx?IDMF=6f8b416f-adce-4c5e-9a9b-3c435f71d767](http://www.inquest.org.uk/Handlers/Download.ashx?IDMF=6f8b416f-adce-4c5e-9a9b-3c435f71d767), our 2016 report on the CQC Family Listening Day, [www.inquest.org.uk/Handlers/Download.ashx?IDMF=244b96e0-d733-4ada-b171-897847a1adad](http://www.inquest.org.uk/Handlers/Download.ashx?IDMF=244b96e0-d733-4ada-b171-897847a1adad), and our 2015 report 'Deaths in Mental Health Detention: an investigation system fit for purpose?', <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=92fa356f-8335-4c6a-a273-62aad802284c>

# INQUEST

Inquiry's ability to identify any patterns or concerns. We believe the relevant text from the ToR should be amended as follows (INQUEST proposed text emphasised):

*"The Inquiry will investigate [...] the circumstances **and related data** surrounding the deaths of mental health inpatients within this timeframe"*

5. *Repeated issues.* Secondly, we believe the ToR needs to better enable the Inquiry to identify repeated issues and failings which can emerge following the death of an individual. INQUEST's casework shows the prevalence of repeated issues identified as contributing to someone's death, and we believe the Lampard Inquiry should enable focus on this to effectively assess whether NHS Trusts in Essex were or are carrying out their duty of care. We believe the relevant text from the ToR should be amended as follows (INQUEST proposed text emphasised):

*"The Inquiry will investigate [...] serious **and repeated** failings related to the delivery of safe and therapeutic inpatient treatment and care"*

6. *Staffing.* We note the Inquiry will examine the culture, leadership, management and governance of staff. However, we believe it needs to also investigate issues around the recruitment of staff. Many INQUEST cases highlight issues with the over-reliance on agency staff who are not always adequately trained to care for an individual's complex mental health issues. We believe the Inquiry should also include the following ToR:

*"The Inquiry will investigate [...] **the recruitment, training and management of mental health workers and professionals who are in direct contact with inpatients under the care of the NHS Trust(s) (Essex)**"*

7. *Inquests and inspections.* We believe it is important the response of the Trusts is examined with respect to their conduct during a coroner's inquest, including inquest disclosure, duty of candour and the conduct of a Trust's legal teams. We also believe the Inquiry should investigate how effective independent inspections and regulation has been in identifying and preventing concerning practices on the part of NHS Trusts in Essex. We believe the relevant text from the ToR should be amended as follows (INQUEST proposed text emphasised):

*"The Inquiry will investigate [...] the response of the Trust(s) to investigations, inspections, **inquests** and reports (internal and external) including to any recommendations, and their conduct throughout these processes, and the quality of independent inspections and regulation."*

8. *Family engagement in post-death processes.* In addition, we believe there should be an additional ToR focussed on the experience of bereaved families. Given the need for bereaved families to be a central part of this Inquiry, we think it important another ToR is added to explore their experiences of post death legal processes, such as investigations, inquests and prosecutions.
9. *Recommendations.* With regard to Inquiry recommendations, we believe it is critical that the Inquiry's eventual recommendations are taken seriously by the relevant organisations in order to ensure positive change for mental health care follows.

# INQUEST

INQUEST's work has shown just how easy it is for inquiry and other important recommendations made following state related deaths to be ignored.<sup>2</sup>

10. We would encourage the Lampard Inquiry to follow the practice of the Manchester Arena Inquiry: alongside general recommendations, the Manchester Arena Inquiry Chair made specific Monitored Recommendations to be monitored and reviewed during the course of the public inquiry, stating, "*I intend to scrutinise what has been done in response to the Monitored Recommendations and use all of the powers available to me, if required, to achieve transparency and accountability.*"<sup>3</sup> The Chair then heard evidence on the progress of implementation of the inquiry's recommendations and the organisations' approach to learning. This Inquiry could also consider the approach taken by the Covid inquiry to adopt 'interim recommendations'.

## *Amendments to scope of the Inquiry*

11. *Timeframe.* We believe the inquiry should investigate the circumstances of deaths in Essex over a longer period of time. The Inquiry currently proposes to investigate deaths until 31 December 2023. However, we believe the Inquiry should allow for deaths that occur during the course of the Inquiry and up to the publication of its Final Report to be investigated, so far as practicable. This is to ensure the most recent evidence on NHS Trust(s) in Essex can be incorporated into the Inquiry's findings.
12. *Community deaths.* The intended scope of the Inquiry states that it will investigate the deaths of inpatients. In order to effectively investigate the complete provision of mental health care by NHS Trusts in Essex, we believe it is important community mental health deaths are added into the scope of the inquiry. We therefore propose the following text is amended as follows (INQUEST proposed text emphasised):

*"those who died following any mental health assessment provided by a relevant Trust where the decision was not to admit as an inpatient (this includes but is not limited to any death following a review in A&E, or an assessment under section 135 and 136 of the Mental Health Act) **and any individual under the care or supervision of community mental health team(s) in Essex.**"*

---

<sup>2</sup> For more information see INQUEST's briefing on the case for a National Oversight Mechanism, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b480f898-7fbd-4c9c-a948-50dd3fad3a04>, June 2023

<sup>3</sup> Manchester Arena Inquiry Volume 2: Emergency Response, Volume 2-II Report of the Public Inquiry into the Attack on Manchester Arena on 22nd May 2017, para 21.47, pg. 162