

The Lampard Inquiry

2000 deaths in Essex

The Lampard Inquiry into the deaths of 2000 mentally ill patients in the care of NHS Trusts in Essex between 2000 and 2023 is now seriously underway and public evidence has begun.

Baroness Kate Lampard, the chair, is a lawyer who has significant NHS experience having been Chair of the South East Coast Strategic Health Authority. She also played a major role in the Saville Inquiry.

Evidence from families of those deceased was heard last year and will provide the backcloth to the evidence that will follow in the coming months. There are three NHS Foundation Trusts directly involved. Essex, North East London and Hertfordshire

This full public Inquiry is a restart as an earlier non statutory Inquiry had to be abandoned when only 14 of 14,000 staff agreed to give evidence.

What prompted the inquiry was a Channel Four documentary in 2006 which exposed major shortcomings in mental health services in Essex by an undercover journalist and which prompted prolonged and angry pressure from patient groups for a full public inquiry.

This led eventually to over 100,000 people signing a petition to Parliament resulting in a debate in the House of Commons.

Over the last twenty years there had been numerous critical reports about the services from Coroners, CQC, Ombudsmen, the police and others as well as prosecutions by the

Health and Safety Executive [based mainly on ligature failures] which led to a major fine of £1.5m. Numerous staff had been reported to health regulators over this period and some struck off.

There had, some alleged, been “a litany of failure”. The Trusts involved had responded to many of these criticisms over the years but they had clearly lost the trust of the wider public and in particular the relatives of patients who had died. A public Inquiry had become inevitable.

Whilst it is focused on Essex (Colchester, Clacton, Chelmsford, Harlow, Billericay, Rochford and Basildon) it will have major implications for all mental health services including those provided by the private and independent sector.

The chair has made it clear that she will use all the legal powers she has to call for evidence and has not sought an assurance from the Attorney General that witnesses who give evidence will be protected from later criminal charges. However, witnesses with “living experience” may be granted anonymity.

This is a really serious inquiry with dozens of lawyers involved including many Kings’ Counsel. It is not going to be cheap! The

Inquiry has appointed a number of expert advisors including psychiatrists, mental health nurses and statisticians.

The great and the good in the field of mental health will no doubt be called to give evidence but the Inquiry has said it will make up its own mind about what properly describes good mental health services.

The resourcing of mental health is not mentioned explicitly but many witnesses will no doubt want to raise this issue in their evidence as well as commenting on the acute patient demand currently being managed by mental health services.

The performance and competence of health regulators will also come under scrutiny.

The CQC had at one point demanded improvement but never made any enforcement orders in Essex.

In his opening statement Counsel to the Inquiry provided a short history of psychiatry as well as an indication of the areas of most likely interest.

Mental health policy had moved towards a foundation in community care and embraced specialisation. Inpatient services had been reduced, perhaps by too much.

Expert witnesses would talk about risk. There were no risk-free options for decisions about discharge or leave. At times a focus on risk management had dominated the provision of treatment and care.

What is not yet clear is whether the Inquiry will focus on a grand strategy for the future of

mental health services or limit itself to criticism of today.

Time will tell. If the evidence supports the view that many deaths were avoidable it is, to use the words of the Chair, "deeply shocking".

Some of the areas Counsel has already said will be covered include;

- Assessment at time of admission
- Assessment in Accident and Emergency Departments.
- Ongoing ward assessments
- Diagnostic experience and competence
- Patient/staff interaction
- Decisions about drug or psychological therapy
- Recreation and leave for patients
- Transfer between providers
- The involvement of patients and relatives in treatment decisions
- The value and competence of multidisciplinary teams
- Record keeping
- Relationship with patients and relatives when they have concerns.

-Ligatures and absconders.

Interestingly the Inquiry has said it will also review the use of IT and biotechnology in mental health.

I would have added a review of services for difficult to handle patients who soak up so many resources and a really serious search across all mental health services for

evidence about what has been shown to work.

Mental health treatment needs a stronger evidence base.

The list is of course endless but it demonstrates the detail into which the inquiry will go in the “search for the truth”.

Other NHS Trusts do not need to wait for a final report in 2027. They can read the evidence today, learn what they can and take action.
