

The Lampard Inquiry

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There is nothing more we can do.

The Lampard Inquiry has recommenced hearings focused on the evidence from families about the care their deceased relatives received, or lack of it.

Most of the stories are distressing, which is why the Inquiry has a specialist team available to provide Emotional Support for witnesses and observers.

In most cases the Trust's involved seem to have done their best but could have done better!

They were dealing with patients with very complicated lives.

In today's NHS world everybody is busy and overstretched dealing with today, but they do have to find time to read and reflect on these patient stories and ask themselves the question "Could it happen here?"

I set out below an extract of one family story drawn directly from the evidence presented to the Inquiry.

"Terry knew he was mentally ill and was really struggling. He wanted help but it was not there for him.

He needed therapy. He simply needed somebody to talk to. Medical staff just told him to keep taking the antidepressants and anti-psychotic medicines.

His mental health problems were repeatedly dismissed by the Trust once he had been stereotyped as a "druggie."

He lived alone so when he texted family members to say he was contemplating suicide they contacted the police to do a welfare check.

The family had to find their way around the police, ambulance, mental health services and A and E. They saw the traumatic episodes of psychosis and other severe mental health symptoms he

suffered from. In their view he needed inpatient care [via section if needed] but this never happened.

He led a chaotic lifestyle with drug habits and repeated attempts at suicide.

When he was admitted to hospital, he was usually quickly discharged either to the care of "nobody" or his GP. On one occasion he begged staff not to discharge him as if they did, he would try to take his life again.

He was told that security would be called if he did not leave.

Relatives claim to have tried to speak to the doctors or nurses, but they were always too busy. On the one occasion the staff did talk they told us that "there was nothing more they could do."

This latter point is telling. Mental health services do not have the capacity to solve the problems of everybody with chaotic lifestyles that may put them at risk.

Next, Trusts will be required to offer counselling to everybody who plans to Sky Dive or make a parachute jump?

Inpatients beds are limited.

The large asylums have all closed and the police have moved on to deal with what they regard as other, more important, priorities.

Some of the deaths being investigated by the Inquiry might have been prevented if a fully integrated social network of care was operating.

NHS Trusts are only part of this network.

Sometimes the response *“There is nothing more we do”* is uncomfortably true.

We will have to hope that Lampard recognises this.

Social safety and care networks are simply not strong enough to deal with all the demands placed on them.

The government should either invest or lower their expectations of what can be achieved. Apportioning blame will achieve little.

NOTE: There were over 6000 suicide deaths in England and Wales in 2023.
