WITNESS STATEMENT OF SOFIA DIMOGLOU PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **Ms Sofia Dimoglou** (**DOB:** [I/S], of [I/S] [I/S]) am the daughter of Valery Dimoglou (born on 15th August 1939; died on 9th October 2015.)

2. I am making this statement from a combination of own my own memory of events, knowledge, belief and having access based on my memory of events, from having seen my late mother's records / other disclosure and the evidence placed before the inquest (into my mother's death), which was held on 8th September 2016.

Diagnosis

3. The mental health difficulties of my mother, Valery (who I will refer to as 'Val' or 'mum' throughout my statement) were evident from early adulthood, with post-natal depression following the birth of her children – including me - being one of the first identifiable points of concern. I recall that Val struggled significantly with her mental health for as long as I can remember, with ongoing issues around pre-menstrual tension (PMT/PMS) which could make her volatile and anxious at times. Her divorce in the 1970s alleviated some stresses but also meant that as a single parent of four children, she had to work very hard to survive economically. Nonetheless, much of our family life was happy and adventurous, thanks to Val.

4. Supporting evidence confirms that Val had experienced childhood trauma, lived in an emotionally unstable household, and was affected by her mother's depression and suicide ideation (Letter dated 20th June 2014 from North Essex Partnership University Trust (NEPFT) (Dr **PB** Clinical Psychologist) to Dr **A** (Consultant Psychiatrist of Old Age) pages 1 – 4 of Extracts of Medical records with comments). This history likely predisposed her to mental health issues later in life. She received Cognitive Behavioural Therapy (CBT) from her GP in the late 1980s or early

1990s, coinciding with major life stressors, including housing instability which often triggered depressive episodes.

Nonetheless, Val mainly lived a vibrant, successful, and happy life, raising four children and a dog.

5. The same letter from **PB** to Dr **A** also notes that *"Val first became depressed in 1997 when she was asked to attend an employment tribunal at Williams and Griffin…"* and that *"Val would withdraw completely from the family…isolating herself in her bedroom…switching to elation and spontaneous activity."*

6. According to Dr **[I/S]** psychiatric report dated 8th August 2016, at page 4, he notes that *"…It is reported that in March 1998 (age 58), she sustained back and neck injuries in a RTC. She experienced issues at work and was suspended in November 1998. Her GP regarded her as 'depressed' from this point"* and she *"…reportedly 'settled' for redundancy around June 1999, remaining angry and bitter about this"* with it *"…suggested that "at the time it sounds like she was depressed…"*

7. We could see that Val was being bullied at work and this added to her depression; she was a brilliant employee, managing the restaurant in Williams and Griffin department store in Colchester for many years, but a mixture of ageism and new staff who wanted rid of Val led to her leaving – not her depression.

8. *"…In September 1999…she was referred to mental health services by her GP…and…seen…as an outpatient in May 2000, and was diagnosed as suffering from severe depression. She was discharged from the clinic in December 2002, apparently asymptomatic. She was being prescribed an antidepressant, citalopram…"* and *"…seen for a number of years by a local consultant psychiatrist, Dr* **[I/S]** **[I/S]** *..treated for depressive order (exclusively on an out-patient basis) …"*

9. We never felt that 'severe depression' or 'depressive disorder' were actual meaningful diagnoses, and these were not fully explained to Val, who continued to complain that she waited so long for any help and that she did not really want to be on pills, as he was anti-drug and only drank alcohol in small amounts at Christmas.

10. Outside of this, I am not aware if she had contact with any other formal mental health services before this.

11. Val's first contact with NEPFT (now EPUT) according to Dr [I/S] (Consultant forensic psychiatrist) report at page 5, was when her *"…GP referred her to services in December 2008…"* which was prompted by a depressive episode related to housing difficulties she was experiencing, increasing instability in her mood and probably most impactful, following the death of her close friend [I/S]

12. I do remember that around that time, Val's mental health deteriorated as she had moved back to Colchester to a lovely house after living in a flat by the seaside that was not good for her (no garden/felt trapped upstairs), but she was still unsettled some years later. CBT had previously helped her visualise where she could live when she needed to move, but without this she spiralled and she would not let us pay for private therapy when the NHS only offered her anti-depressants, and minimal talking therapy. She really suffered from regret and housing was often central to her sense of feeling that she did not belong or was in the wrong place.

13. Following a GP re-referral in May 2009, Val was transferred into the care of Dr A [I/S] Consultant Psychiatrist of Old Age, in 2009, as she reached the age of 70. Dr A initially treated Val's depression with medication although she did receive a short course of therapy, which sounded cognitive-behavioural in approach.

14. Val held a lot of hope in Dr A and was often overly deferential to doctors, believing they had the knowledge to help her, though this opinion changed a lot in her final years, when she realised how she was left to cope so often without real support.

15. In mid-2013, Val reached what I would describe as a crisis point in her mental health. I remember due to this crisis Dr A agreed to refer Val for talking therapy with Clinical Psychologist PB

16. Val had been waiting for a referral by Dr A for approximately 3 months, even though she had told him that she was desperate, and that the anti-depressants not only did not help her but made her feel worse. She had made it clear to him that only talking therapies would help her. It is important to note that Val could not afford private therapy, and in any case did not have the capacity to seek out a therapist who would suit her; she believed whole-heartedly in the NHS and in the fact that her National Insurance contributions helped to fund a health service committed to making people

better. She would never have allowed us to pay for a private therapist – her working-class pride and independence By this time, her presentation was very bad, and I was extremely worried as whenever I would see her, (I live in Sussex and she was in Essex so it would be every fortnight or so, weekly in the summer holidays, but my sister lived close by.) I would find her shaking and stressed and not making sense. She had been on anti-depressants and said that it was not helping her and that she wanted and needed help to talk to mental health professionals to deal with how she was feeling. I, therefore, had to get involved and went to Val's doctors surgery, as the referral that was to be made by Dr **A** was taking far too long. I remember clearly that this was on a hot summer's day at the end of July or early August, and we had spoken about how desperate Val felt, as we walked our dogs.

17. When I went to the doctor's and asked why the referral to therapy was taking so long, I only managed to speak to the receptionist and was told to *"just wait"* for the referral. I made a speech about how seriously lacking the mental health services were and insisted that Val's doctor (who did not agree to speak to me) do more to push Dr **A** to help Val or do something else to help her as I felt she was in crisis.

18. In October 2013, Val was eventually referred by Dr **A** to **PB** (Clinical Psychologist, Older Adult Psychology Service, NEPFT) for an assessment for therapy. Val's mental health had deteriorated sharply due to delays in her being assessed.

19. On 6th December 2013, after more than half a year of acute depression and complex side effects to the anti-depressants she was on (Venlaflaxine), Val first met with **PB** **[I/S]** together with her trainee **[I/S]** Val according to **PB's** **[I/S]** letter to Dr **A** dated 20th June 2014 at pages 1 – 4 of the extracts of medical records with comments, during the assessment *"…explained that her mood worsened in August 2013 when she felt trapped in her house. She spent time ruminating about a lost opportunity to buy a bungalow nearby and regretted staying in a house she felt she could not manage. Her depression was compounded by noisy neighbours and she felt there was no peace. During the summer Val spent 6 weeks lying on the sofa under a blanket, only rising to take the dogs for a walk. Although she was no longer doing this when we met in December, her mood was clearly low. Val was keen to proceed with therapy and an appointment was made for 11th December 2013..."* At this meeting Val did not feel confident or well enough to ask if the trainee would leave but said later that had she been alone with **PB** she would have been more open about her desperate plight.

20. On the morning of 7th December 2013 Val was involved in a deliberate car crash, after expressing suicidal ideation in her assessment with PB the day prior. The medication she had been taking to help her sleep, and the Venlaflaxine anti-depressants, had the impact of exacerbating her suicidal feelings, and most likely had created them. The suicide attempt resulted in Val sustaining serious burns, damage to her foot, a fractured hip and her precious dog Plum being killed, whilst her other dog Tommy survived.

21. Val was initially taken to Ipswich Hospital, and then Addenbrookes Hospital for burn treatment and an operation on her hip before being suddenly transferred to Colchester General Hospital on Christmas Eve, with no warning.

22. On 8th January 2014, Val was transferred to Henneage Ward, at Kingswood Mental Health Centre. She was discharged in August 2014 but was readmitted on 10th October 2014 due to renewed suicidal ideation, following a conversation with a neighbour, where she asked for tablets to commit suicide. She remained in inpatient care until her death on 9th October 2015.

23. Val struggled with depression throughout her adult life and I suspect that she may have had bipolar disorder, although this was never formally diagnosed.

24. In terms of Val being diagnosed with depression, this likely was a diagnosis by her then GP, Dr [I/S] at Wimpole Road Surgery in the 1990s and later reaffirmed by NEPFT in 2000 during an outpatient appointment as noted in a letter from Clinical Psychologist, PB to Consultant Psychiatrist, Dr A, dated 8th June 2015 at pages 5 – 6 of the extracts of medical records with comments, where it states *"…Scores on Beck Depression Inventory remain in the 'severe' range for depression."*

25. Assessments by NEPFT acknowledged that Val at times had hypomanic symptoms and elation cycles consistent with mood instability. A possible diagnosis of borderline personality disorder was also mentioned in her medical records under her care of Dr A However, despite repeated requests, no conclusive diagnosis of bipolar disorder was ever made; in fact, there was a range of suggestions of types of depression: 'depressive disorder'; 'depression; 'borderline personality disorder' but these were never explained or presented as a clear diagnosis.

26. She was prescribed Lithium by Dr A or by Dr C at one point, which stopped her being able to write. This caused further concern for me and the family, as I recall asking Dr A why Val was on Lithium if she had not been formally diagnosed as bipolar and I was never provided with any reasonable explanation. It was like a punishment for us for questioning Dr A regarding his lack of diagnosis, and for asking for a second opinion by Dr C though he was also uncommunicative and cold towards us.

27. Val was on so many different drugs, which was affecting her already deteriorating mental health. NEPFT would give her diazepam three times a day when she was an inpatient on Henneage Ward. She was also on Venlafaxine, which did not help her mental health and weighed heavy on her. I had expressly requested that Val be taken off Venlaflaxine permanently, as she was convinced that it caused suicide ideation, but she was put back on it though she had told the staff at Henneage Ward that she did not want it. I know this because I was with her when she made this clear, but the toxicologist report and the medical records show that she was given it again without consultation with the family. Val had also signed something saying she wanted us to have a say in her treatment, but I do not recall this being given to us as part of the medical records.

28. My mum was anti-drugs and didn't drink. Therefore, in my mind, giving an elderly person so many anti-depressant drugs was wrong, and yet nobody would have a conversation with me about all these medications she was being prescribed.

29. I also recall saying to Dr A that Val might have [was having manic] depression/be bipolar, but Dr A disagreed. This was when I asked for a second opinion, which was provided by Dr C when he assessed Val on 8th October 2014. He never really provided a diagnosis but lithium was added to the drugs Val was given, with no explanation.

Assessments

Assessment with PB (Clinical Psychologist) on 06 December 2013

30. As I have mentioned above earlier in my statement, Val was assessed by PB [I/S] along with her trainee following a referral from Dr A I was not present at this assessment. Page 1 of the care plan progress note contain details of

what occurred during assessment, including Val describing that she was *"…feeling in a "phase of depression at the moment…"* and that *"…she has had several phases in the past which have been "on and off" but feel more regular now…"* It was agreed during the assessment that Val would be seen again on 11th December 2013 to *"…continue the assessment with a view to offering Valerie psychological therapy using a CBT approach."*

Assessment with PB (Clinical Psychologist) on 16th January 2014

31. Val attended a further assessment with PB where at page 2 of the care plan progress note, it confirms that Val was now *"…on Henneage Ward following discharge from Addenbrookes and Colchester General Hospital following a car accident on 7th December 2013"* where she was *"…very tearful…and described feeling 'in agony'…"*.

32. During the assessment PB discussed Val's bereavement and guilt at the loss of Plum, whom she had cared for, for 12 years. Her feelings at being on Henneage Ward was also discussed, as Val felt "…*I used to be so strong…"*. Val also discussed that she regretted surviving her suicide attempt, with her not wanting the *"…firefighters to pull her out from the car…"*. Val also raised fears of not wanting to go back to her house and not attempting to when she had the chance. PB discussed with Val about possible aims and arranged a further appointment with her for 20th January 2014.

33. In total, Val had 45 sessions of therapy with PB In her letter to Dr A on 8th June 2014, she stated that by August 2014, Val's goals centred around developing a shared formulation of how her difficulties developed from her early life experiences, family history and attachment style, alongside understanding and managing her mood swings and her interpersonal difficulties had been met. PB went on to state that she was determined to now focus on the next phase of Val's therapy, relating to her depression and suicide risk.

Assessment with Dr A (Consultant Psychiatrist) dated 7th October 2014

34. Dr A assessed Val, with my brother-in-law in attendance, through his outpatient clinic at Kingwood Medical Centre. Dr A during this assessment admitted that Val *"…had a very protracted admission under…"* his *"…care"* and *"…did not really seem to be making much progress on antidepressants and at her request had come off them completely approximately two to three months ago. She was*

discharged to her home address with support from…Home Treatment Team, the Community Health and the Psychology Department."

35. Dr A noted in his letter to Dr [I/S] that Val had a *"…precipitous decline in her mood following her receiving a letter from the RAC demanding more than £5,000 payment and threatening court action…"* He remarked that Val *"…appeared a good deal more depressed in clinic" than he could remember…"* and prescribed a low dose of olanzapine and arranged for her progress to be reviewed in two weeks.

Assessment with Dr C (Consultant in Psychiatry Old Age) on 8th October 2014

36. Val attended an assessment with Dr C in which I was also in attendance. The purpose of the assessment was that I wanted a Val to have a second opinion in relation to her mental health issues. At pages 3 – 4 of the care plan progress note it notes the issues that were to be discussed, which included *"…bi polar disorder, risk of suicide and lithium treatment…"*

37. During her assessment, Val reported a longstanding history of low mood, with depressive episodes often lasting months and recently worsened by receiving a distressing letter. Though she had experienced recurring suicidal thoughts, particularly since a serious attempt in December, she explained to Dr C that she had no active plans and cited religious and familial reasons for not acting on them. She further explained that her thoughts have been a consistent theme in her life, shaped by her upbringing and her mother's own mental health struggles.

38. Dr C noted that Val's presentation suggested depression, but she was socially appropriate and not acutely distressed and that there were indications of mood instability and hypomanic features, though not consistently severe or disruptive enough to confirm a bipolar diagnosis.

39. Dr C also documented that Val's past treatment with antidepressants had mixed results, and the Olanzapine, she was taking may help stabilize her mood. Dr C also discussed taking Lithium, but Val declined.

40. Dr C given Val's history and fluctuating symptoms recommended ongoing monitoring by her mental health team and psychological support to help manage what he considered to be Val's moderate to high suicide risk.

41. Following this assessment, Val really wanted her care to be transferred from Dr A to Dr C. Val confirmed as much in a letter to Dr A dated 12th October 2014, which is at page 10 of correspondence with North Essex Partnership Trust.

42. Val explained in this letter to Dr A that after her assessment with Dr C they *"…discussed the possibility of [Val] being given a fresh start and transferring…treatment to Dr C …to help…move on from the terrible events of last year."* Val pleaded to Dr A saying that *"…she was hoping to turn a new leaf and put the past behind…and to do all I can to achieve this…"* and that she was *"…desperate to find a reason to live and hope that working with someone new may just help…"*

Assessment with Dr A (Consultant Psychiatrist) dated 1st April 2015

43. Val underwent a review with Dr A [I/S] (Charge Nurse), WM (Ward Manager) and members of the Home Treatment Team, who were also present. It was noted during this review that Val *"…feels anxious at times…"* and *"…expressed that lithium in her opinion was causing her to have a tremor and this caused shaking making it difficult to write…"* and that *"…she feels the venlafaxine causes her to feel anxious…"* Following the review the plan was that *"…Ward Manager to refer to non-psychosis pathway team…"*.

44. We did not really understand any of this, or have it explained to us. Val and the family began to feel that we were being shut out of discussions about Val, though she had made it clear she wanted us involved. The drugs increased, the therapeutic activities and talking therapy decreased. Experts at the Lampard Inquiry Dr Ian Davidson (Consultant Psychiatrist) and Maria Nelligan (Registered Nurse) on 8th May 2025 highlighted how essential it is to keep communicating with family, but we had very little from them, so many 'lost' invitations to meetings, so often ignored.

45. Val started meeting us outside, and asking us to drop her outside the ward, said it was not worth coming in, and we certainly did not feel welcome after we asked for the second opinion for the diagnosis. Also, Val had drawn attention around this time (or earlier) to the notice board in the office at Henneage Ward which had clearly written next to the names of the inpatients how they had tried to commit suicide. Val advocated for the patients in many ways and insisted this be changed as members of the public

or delivery people would go into this office, and it was humiliating for patients to have this deeply personal information written up on display.

Assessment with 439 Ipswich Road, Rehabilitation and Recovery Ward on 5th August 2015

46. Val was informally assessed at 439 Ipswich Road by nursing staff. Pages 8 – 12 of the extracts of medical records with comments, detail this assessment, including Val explaining that she had a long-standing history of depression and anxiety dating back to 1997, with a serious suicide attempt 17 months prior involving a deliberate car crash, resulting in the death of her pet dog.

47. Val acknowledged that Henneage ward had helped her manage her mental health and reported improved mood stability. The assessment notes that although Val had a past history of suicidal ideation and emotional dysregulation, that she denied current risks and was engaging in community leave and social activities. Therefore, the fact they considered her mental state was stable, cooperative, and forward-looking, ultimately, she was not accepted for rehabilitation at 439 Ipswich Road, as no specialist inpatient needs were identified.

48. In fact, this whole assessment was a cynical farce, putting my mum through an 'informal' assessment for a placement the trust and its employees knew she was not suitable for – there were young people in this facility, and it would have never been offered to Val. I went with her to look at the building from the outside and knew at once it was just an exercise in pretence.

49. On 15th July 2015 at the annual review, I saw the team chaotically discuss this placement in front of Val, arguing with each other, some staff saying categorically it was not suitable for Val, others saying she should leave Henneage Ward, Dr **A** saying he would not send Val home, others saying she could not stay…Val saying openly, shaking and upset, with no sympathy from any of the fifteen or so employees there, that she would kill herself if she was sent home. That meeting scarred me for life. I begged Val to let me complain to the CEO or whoever I could but she was adamant I must not do so. It was shambolic but still intimidating – all those staff staring at Val, and not one of them truly competent or joining up the dots of the care of this vulnerable elder.

Assessment with WM (Ward Manager, King's Wood Centre) dated 6th October 2015

50. At 11.30am Val was seen by WM Ward Manager. Val updated WM on her discharge plans and explained that she was *"…desperate to find accommodation…"* During the assessment, WM explained that she had *"…invited one of the commissioners to a CPA meeting on 28th October at 10am as they…requested information around discharge plans…"* Upon hearing this information *"…Val became visibly anxious…and confirmed that she is feeling very anxious at the moment"* explaining *"…triggers for any suicide plans are still in her home…"*. Due to Val's *"…obvious anxiety…agreed to place Val on level 2 observations with 4 checks per hour around her safety and suicide ideation…"*.

51. Do not underestimate the power of this incident. This cruel woman – supposedly the Ward Manager responsible for the care of my mum – deliberately lied to her about the Commissioners wanting to know when she was leaving, hoping it would scare her into discharging herself. It does not matter how she continues to equivocate about this vile act (as she did in the Inquest) WM aided by the Matron (M) was determined to get Val out of the Kingswood Centre even if it meant her suicide. This is evidenced in the note she gave to my mum actually stating that the Commissioners were coming to a meeting about Val's discharge; this note was beside Val in her glasses case when she died – she clearly wanted us to know that this was the reason she had given up all hope.

Assessment with Dr A (Consultant Psychiatrist) dated 7th October 2015

52. Dr A attended and assessed Val at 10.30am, where according to page 31 of the Psychiatric Report Commissioned by Colchester Major Crime Team dated 8th August 2016, *"…Ward staff reported that they…overheard a conversation when Valerie was telling someone about thoughts / plans to kill herself by crashing her car when she is discharged*

Since then she has been on level 2 obs. Has been viewing property without any success. She has shown reluctance to be discharged. A Commissioners meeting has been planned. Has been stable while on the ward but risk of completed suicide after discharge in the community.

Seen. Reported frustration around finding property but she is hopeful to find one. Stated that she will be able to cope after discharge without the support she is getting on the ward. But upon questioning stated that she does feel hopeless about it to the point of contemplating suicide. Denied any thoughts of self-harm / suicide while on the ward. Discussed medications – she is not keen on any change / increase in rates due to side effects.

Plan. 1. Reduce obs to level 1. 2. Continue with current management. 3. Carry on looking for property…"

Concerns with assessments

53. Firstly, I would like the inquiry team to seriously investigate both **WM** and Dr **A** **[I/S]** for their assessments of Val on both 6th and 7th October 2015, which in my view played a large role in why Val felt she had no choice but to take her own life.

54. Val on both 6th and 7th October 2015, as you can tell by the assessment notes was very distressed and suicidal, given that she was adamant that she did not want to be discharged home. **The WM** knowing this information, lied to Val by stating that a commissioners meeting was being scheduled for the purpose of discharge planning.

55. As the assessment note clearly states, this news shook Val to her very core as being discharged back to her home had clear and obvious suicide triggers for her. **The WM even** compounded the situation by putting the lie in writing, which I have a copy of, where she explained to Val that she had *"…invited the commissioners for a CPA meeting on Wednesday 28th at 10am to discuss discharge plans."*

56. I have since learned through the inquest that the commissioners were never considering discharging Val and did not have the authority to discharge Val due to pressures to free up beds in Kingswood.

57. We will be haunted forever by the despicable note written by **the WM** to scare my mum into leaving Henneage Ward. Val got her to write it down because, like us, she believed the scandal of it would be massive, would expose **the WM** for the bully she was, and would bring about change in the Kingswood Centre, where Val came to realise how people in danger of death by suicide were treated as an annoyance once they outstayed the short stay offered by the Trust. However, no-one seems to care – not even in the Inquest, **when the WM** agreed she should not have said what she did to

Val and should not have written that note, knowing that the Commissioners do not get involved in discharge matters. We did not discover the note until Val's death, but it is also evident from the medical records that **the WM & M** were pressurising Val to leave at every opportunity.

58. Secondly, I am also perplexed and angry considering that Val was practically begging Dr **A** on 7th October 2015 that she did not want to be discharged home and expressed clear signs of suicidal ideation, that he considered and agreed it appropriate clinical management to decrease observation levels from level 2 to 1. Val was clearly distressed and did not feel she could be away from the ward and the support it offered her, especially given that she felt the pressure that NEPFT were about to discharge her back to her home with the help of the commissioners.

59. I genuinely believe that **the WM** and Dr **A's** assessments played a major role in Val ultimately taking her life on 9th October 2015. 'A Commissioner's meeting has been planned' is also noted in **Dr A's** assessment, as if that is a discharge procedure, when it is not. The constant harking back to Val looking for somewhere to live when she is openly suicidal is staggering – expecting a depressed patient to go house-hunting, as if she could envisage a happy life – or any life – in a new home when she said every day that she would kill herself out of hospital. The duty of care to protect life must come before the quota of beds and the policy to move people out.

60. Another aspect of the assessments that I am concerned with and want the inquiry team to investigate is that before October 2015, there were 6 weeks where doctors at Kingswood weren't available. The doctors were away on annual leave, I believe, and there was nobody to talk to.

61. I recall Dr **C** was on holiday and someone took over and therefore, there was no continuous care for Val. It was all very ad hoc. Whoever was there would sign anything. She was assessed as safe even though as we now know she was on suicide watch just two days before her death.

62. As a family we were never informed that she was ever on level 2 observations / suicide watch. This goes against all NHS/Trust policies even in the time frame we are discussing – you do not need to be a trained clinician to know that if a patient is openly discussing suicide family should be informed.

63. It is my absolute belief that the Ward Manager **(WM)** and the Clinical Manager/Matron **(M)** deliberately kept it quiet about Val being suicidal because they were hell-bent on getting her out, at any cost, and this would have delayed the discharge.

64. In fact, an anonymous 'whistle blower' wrote a letter to the CEO at the time stating that the team had been told NOT to inform the family of Val's assertion that she would kill herself. Why would someone write that if it was not true? The police investigation into the anonymous letter was also disgraceful – none of the staff being properly questioned, and, as with the SIR, **the M** being allowed to sit in on interviews. The police weirdly pronounced the letter 'fake' – what does that even mean?

Failures to arrange mental health assessment(s)

65. Val struggling with her mental health and not being considered for a mental health assessment, was an on-going question we had, as to why Val didn't have a proper diagnosis. We always felt how could those at Kingswood Medical Centre give Val proper care and treatment when she had not been provided with a proper diagnosis that was relevant to her ongoing presentation?

66. My problem with all of this was that we didn't have anyone who would assess Val properly and diagnose her accurately.

67. Additionally, there were occasions where we felt there was a lack of urgency and there were delays in assessing Val, particularly when she needed the care and support the most. Case in point is pages 31 to 35 of the extracts of medical records, where my brother wrote to Secretary of State for Health, at the time Jeremy Hunt, Sir Bob Russell MP, CQC and Colchester NHS Trust Acting Chief Executive, **[I/S]** shortly after Val had attempted suicide in December 2013. In this email my brother details the following:

"…(2) Dr **A** *Val's psychiatrist, had been contacted directly by the Addenbrookes psychiatric team on 27 Dec 2013 and they asked him to act on Val's needs.*
According to Addenbrookes team, Dr **A** *told them Val would be referred to the elderly care team - the mental care worker told my sister this in the week after Christmas, when she called them with her concerns that nothing had been done at Colchester.*

When Sofia finally got to speak with Dr **A** *on 2 Jan 2014, he told her that he had not referred Val - it was not his job - it was up to the ward (though Addenbrookes contacted him and not the ward). Despite Dr* **A** *having intimate knowledge of Val's condition before the accident, the importance of her dogs, and the effect the accident and losing one of her dogs would have had on Val, he only returned Sofia's calls when she threatened to complain about him. He apologised for the poor service and mis-communication. The referral had been made on 3/1, but only because my sister complained, and even then the liaison team at first said they had never heard of Val.*

Dr **A** *eventually visited Val on 3 Jan 2014 and apologised for not seeing her sooner.*

Val or Sofia have received no more contact from Dr **A** *or his team since 3 Jan 2014. Val is displaying suicidal tendencies even now, and is receiving no support or counselling from any psychiatric team, despite telling a number of mental health workers/psychiatrists how she feels. We do not have confidence in Dr* **A** *and he has shown little interest in her care, and the psychologist who worked with Val on 6/12 (the day before her accident) actually had a student in the session, and Val said they used it as a training session, writing notes, with the student asking awkward questions, rather than listening to her. This is all in spite of Sofia flagging up this summer that our mother was very low. The anti-depressants and sleeping tablets have clearly not helped, and may have had an adverse effect.*

(3) She is being moved between hospitals, wards and beds with four or five minutes notice, which is doing little for her state of mind, and with no real explanation why, or concern for her complex after-care needs. Nobody has spoken to Val about her care plan, what she can expect in the coming weeks. She has a fear that she will be told at short notice she has to return to her house, with no downstairs washing or toilet facilities. She does not feel she can cope with this mentally or physically."

68. At this point I was found crying on the stairs by a doctor – everything felt desperate as Val was in physical pain from the car crash injuries but also in mental turmoil from the failed suicide attempt, having killed her dog and being disabled from the injuries. Absolutely no-one addressed Val's mental state and **Dr A** was only a matter of

metres away but not only did not visit Val until I threatened to repot him but refused to speak with us.

69. This set the tone for Val's care, and he was never more than a drug-giver, as far as I could see, with some half-hearted stock-phrases to feign concern for Val, till the very end. That final assessment came from him when he was technically not her main Doctor (not that Dr C showed any interest in her either), after he had been on leave and had not concerned himself with her open suicide ideation, and he made no effort to contact us about how she was, or to instruct others to do so. How could he agree that she could be on twelve hours' leave straight after being on fifteen-minute observations for saying aloud that she would kill herself at home?

Admissions

2009

70. In 2009, Val was not an inpatient at King's Wood Mental Health Centre, she was treated by NEPFT as an outpatient.

8th January 2014

71. Val following a suicide attempt on 7th December 2013, was firstly admitted to Addenbrookes hospital, after a short emergency stop at Ipswich Hospital, before being transferred to Colchester General Hospital after her burns and fractured hip had been treated.

72. I visited Val regularly during her admissions to both Addenbrooke and Colchester General Hospital and I saw up close, Val's worsening and deteriorating mental health, as it had been her intent to end her life along with her two dogs Plum and Tommy and surviving the crash, she felt severely guilty. Due to Val's presentation, I sought assistance from her psychiatrist Dr A However, this was not forthcoming, despite my pleas.

73. I complained that Dr A and NEPFT did not care about Val's mental state after the accident. It was as a result of my complaint, that Dr A made the decision to admit Val as an informal patient to Henneage Ward at the Kingswood Medical Centre

on 8th January 2014, which is an inpatient admission ward for older adults and formed part of NEPFT (EPUT).

74. Val was admitted as an informal inpatient until 13th August 2014. So approximately, 8 months spent as an inpatient. I recall that in her hospital time Val was often moved very suddenly and at night. All of this was very stressful for her. They would do everything quickly without involving us as a family.

75. I remember Val would feel whilst she was an inpatient that at any minute, they could send her home without discharge planning and/or discussion with her or her family, which is against all policies and which has been discussed in the Lampard Inquiry, notably on 8th May 2025.

76. Things always felt instant and without collaboration with Val or with the family. She was taken across the car park on a bleak midwinter night to the Henneage Ward from the main Colchester Hospital; my elder brother managed to be with her at that time at very short notice as he was the only one who lived close enough and did not have childcare to consider in the dead of night. See Pablo Dimoglou's email at this time, mentioned above.

10th October 2014

77. From 13th August 2014, Val had been discharged from Henneage Ward. Following discharge, she was initially coping and managing well. However, her mood deteriorated with a re-emergence of suicidal ideation which led to a further inpatient admission on 10th October 2014. The trigger for this event was a letter she received from the RAC regarding her crash the previous year.

78. Having considered Val's inpatient care plan at page 42 of the extracts of medical records, it also sheds light as to the additional reasons for her re-admission to Henneage Ward at this time, noting that Val *"…appeared to be doing very well in the community with support from home treatment and* **her CC** *but her mood deteriorated, experiencing high levels of anxiety and expressing this by what Val describes as 'moaning' noises. According to home treatment they were concerned after Val missed two appointments – one with home treatment and one with* **her CC** *were worried Val was disengaging from the services*

…A neighbour expressed her concern when Val asked her if she knew the best way to kill herself – Val agreed to an informal admission to hospital…"

79. Val agreed reluctantly. I got a call at work [I/S] from the neighbour, who was concerned that Val was planning to kill herself and had to dash to Colchester. The medical records make it look as if the home treatment team were helping Val but she had little to do with them and did not trust them.

80. [I/S] was supposedly the care co-ordinator, but we had not had any meetings with her and the one time I did meet her, by chance, she clearly had no rapport with Val and no interest in her. She told Val that she had to leave hospital as she had her own house and she should not expect a council property as she was not entitled to one (although the council had allowed Val to apply, as they took into consideration her inability to live in the house where she had first had the serious suicidal thoughts.) Her notes were often blunt and unkind – one of the medical records suggesting Val was not hygienic, though Val was very clean and tidy.

81. Val remained an informal inpatient from 10th October 2014 until she took her life on 9th October 2015. Most of this period involved very little therapeutic care, and lots of discharge planning, without our involvement as a family and without Val's cooperation as a patient.

Observations about admissions

82. When Val was first admitted in January 2014 to Henneage Ward, the process was extremely sudden and, in my view, poorly managed. She was transferred from Colchester General Hospital without any prior warning or preparation, which left her confused and distressed. At the time, she was already in considerable physical pain from burns sustained in a recent car accident, which meant she was highly vulnerable, both physically and emotionally.

83. The abrupt nature of the transfer and the complete lack of communication with her beforehand made it very difficult to keep her calm and contributed significantly to her heightened distress. I believe the impact on her mental health was serious; she was already in a fragile state, and the way the admission was handled exacerbated her anxiety and confusion. It felt as though the process prioritised logistics over Val's well-

being and failed to acknowledge her need for reassurance and involvement in decisions about her care.

84. This came after her sudden move on Christmas Eve from Addenbrookes Hospital to Colchester General Hospital and then another sudden and unexplained move from a ward where Val could talk to people to a room on her own where she thought she would go mad from isolation and distress. We had had to complain about staff allowing someone to visit Val without her permission, breaking data protection laws, and Val felt she was being punished for this.

85. A further concern relates to a later occasion when Val was re-admitted to Henneage Ward on 10th October 2014, without being sectioned under the Mental Health Act, even though there were serious warning signs about her mental state. She had told a neighbour that she wanted to know the best way to kill herself, had been missing appointments with the home treatment team, and had disengaged from mental health services.

86. Whilst I appreciate that Val had a fear of being sectioned i.e., she was afraid of being put to electric shock treatment. I feel that no one explained the options of potential sectioning and whether that would have been more beneficial for Val than an informal admission. I accept that we didn't want sectioning to be triggering her and making her worse but if someone had explained to us better, we would have been able to make better decisions.

87. There should have been serious consideration to sectioning Val, as it seemed clear to me that she was at significant risk, and yet the response lacked the urgency or protective intervention that the situation warranted. I remain concerned that this failure to act more decisively left Val without the safeguards she needed during a highly vulnerable period, and it raises serious questions about how risk was being assessed and managed in her case.

88. Given these red flags, I was deeply concerned that she was not detained for her own safety. The lack of clear policies over voluntary patients in mental health facilities is still shocking. The Rabone v Pennine Care NHS Foundation Trust Supreme Court Ruling of 2012 should have been something that all Trusts were aware of and should have protected patients like Val, especially as the ruling was in 2012 – enough time to instigate policies and close enough that it should have been a topic spoken about widely, given the media coverage.

89. Rabone established that NHS trusts have a duty to protect voluntary mental health patients from a real and immediate risk of suicide, regardless of whether they are detained under the Mental Health Act. This duty, based on Article 2 of the European Convention of Human Rights, is an 'operational duty' to take reasonable steps to prevent the death of an individual at risk.

90. We assumed that all patients would be looked after equally and that the preservation of life was paramount. However, we grew to realise that care plans were often slapdash and that on that final day Val's voluntary status meant that checks were almost non-existent.

91. The Rabone case, despite the sacrifices made by the parents of Melanie Rabone, is almost unheard of in the NHS, and even in the Inquest, the coroner pooh-poohed my questioning if NHS staff were aware of this crucial ruling which requires NHS trusts to take proactive steps to protect voluntary mental health patients from harm.

92. In light of Rabone, I am left questioning whether the Trust fulfilled its duty of care and adequately assessed the real and immediate risk to Val's life. It appears that the threshold for protective intervention was inappropriately high, and that her vulnerability and expressed intent were underestimated. This omission not only exposed her to serious harm but also undermines confidence in the consistency and effectiveness of the admission and risk management processes.

Ward Environment

Initial impressions of ward environment

93. While Val was an inpatient, I visited her regularly, at least once a week and sometimes more if I was in Essex, and not at work. The frequency in which I visited Val was the same for both her first and second admissions to Kingswood Medical Centre. I found that I would visit Val more often during the summer months and in school holidays as I lived about two hours away.

94. My impression of Kingswood Medical Centre was that it felt mainly clean, and the building was modern. I also felt that parts of the ward were cheerful places to be, including the section where Val would play Scrabble. There was natural light in this space.

95. When I attended during the day, it wasn't awful. It has a very small outdoor space for people to smoke, but it was very small and not really big enough for smokers and non-smokers to be comfortable. It was also closed for many months due to some construction work. Considering the fact that nature is known to help with mental health recovery, I found this surprising. The indoor area was not spacious though and I would describe it as just serviceable.

96. I found during Val's second admission that Henneage Ward at Kingswood Medical Centre, that the demographic of the patients had changed, which led to a quite noisy environment, whereby other inpatients who appeared to have dementia would be constantly shouting.

97. I do remember Val telling me she had an issue with different genders using the same toilets. She did not like this idea and thought there should be clear delineation for the genders.

Safety of ward environment

98. In August 2015, my mum was the victim of a robbery, whilst she was an inpatient at Kingswood Medical Centre, which calls into question the safety of the ward environment. A person took her bag, which had a lot of money in it, through a window that the person opened from the outside to get in.

99. The window of Val's room was close to the pavement and next to a busy road. My mum's bag was eventually recovered, and I understand that the perpetrator was prosecuted for their offence. The fact that NEPFT didn't tell us that Val was robbed was disappointing and it summed up my impression that Henneage Ward didn't feel totally secure: the window was faulty and this was only flagged up because of the robbery.

100. The way **the matron** dealt with the robbery was seriously lacking in compassion – she seemed concerned to avoid admitting that Val's room was insecure and we only found out about the robbery as Val was shaken up when my sister visited her. The medical notes at the time actually show **the matron** turning from the robbery to how the house hunting was going, putting more pressure on Val at a traumatic time.

Privacy and dignity

101. A disturbing issue that occurred on the ward, that Val raised at the time she was an inpatient, was that NEPFT staff would write on a wall, that was visible to inpatients, the manner in which inpatients had tried to kill themselves. There was a door to an office, but it was sometimes left open and there was a window on the door, which inpatients could see. That I recall impacted her mental health massively, as her sense of justice was disturbed. My mum complained about it and eventually they stopped writing about the methods of suicide attempts.

102. Whilst steps were taken to eventually stop the method of suicide on the boards being visible to inpatients, I do feel that for NEPFT to have allowed staff to write such in the first place, meant that inpatients privacy and dignity, was not respected. Furthermore, I found that staff would sometimes discuss about private matters in front of other people, which led to a lack of privacy. You could also see what was going on with other patients, as there was not much space where they could discuss things privately, with one room that staff would use to discuss inpatient matters.

Did ward meet Val and inpatient needs?

103. Henneage Ward did meet Val's basic needs, as for example she had her own room and it was good that she had a space of her own, which gave her privacy when she required it.

104. Additionally, she was able to occasionally have a bath, which was nice for her, as she hated showers. In relation to her nutrition Val was never malnourished or starving, as she was able to make her own food to her liking and taste. However, a serious safety concern was that Val was allowed to take in cans of food – she liked canned fish – and knives to cut up her food. She also had bleach, as she like to keep the sink in her room spotless and she would bleach her tea towels. While we did not want to report Val for having these items, it was shocking to think they could be brought in quite freely – no searches were made of voluntary patients returning from leave, which is good in terms of dignity but concerning in terms of safety.

105. I feel as though Val's recovery was assisted whilst on the ward, when she was able to partake in activities. She did get quite involved with some of the things. For example, she loved playing Scrabble with other inpatients. She also did a writing

activity class, which helped her, and she loved the newspaper and news discussions. The staff who led these activities were brilliant, and Val did bond with them.

106. Henneage only had a courtyard outside space, which was inadequate and didn't assist Val's recovery. People would always smoke there and she didn't like that, as she couldn't get out in nature there.

Staffing Arrangements, Training and Support

Individual staff concerns

107. I can honestly say that I had concerns about almost everyone who provided Val with inpatient care at Kingswood Medical Centre on both occasions that Val was admitted. Firstly, I was shocked and horrified that no staff knew and/or understand the **Rabone v Pennine Care NHS Foundation Trust [2012]**, Supreme Court case and the judgments wider implications on mental health care.

108. **WM** who was the ward manager on Henneage Ward, was horrific in how she treated and dealt with Val and me. She had absolutely no compassion in her dealings and every interaction we ever had, centred around Val leaving and being discharged, rather than focussing on her overall mental health well-being. This culminated as I have mentioned earlier in my statement, in the callous and untruthful manner in which she wrote a note to my mum, stating that commissioners had been invited to attend the next care programme approach (CPA) meeting to discuss discharge from the ward in order to 'free up beds', which caused my mum increased anxiety.

109. The commissioner would have never been involved about any inpatient leaving and would not have involved themselves in individual cases. The note was clearly a lie and this still remains shocking that a ward manager could lie like that. I would like the inquiry team to investigate **the WM** on the matter of the note she presented to my mum, which I reiterate played a major role in my mum taking her life. **The WM's** behaviour here and on countless other occasions, to me, seemed to go against all the training I would imagine a person in her position would undertake.

110. **M** who was the Clinical Manager/Matron on Henneage Ward was also another staff member that I have serious concerns about. During all my

dealings with her relating to Val, she wouldn't listen to anything I had to say and/or take things on board. We found that we always had a hard time finding out who could be held accountable/responsible or who we could go to, to make things happen in relation to Val's treatment and care.

111. As mentioned above in paragraph 82, M never contacted us about Val's care and did not tell us that Val had been robbed and the police called, until my sister asked what happened as Val told her. Even when Val was most distressed M would press her to say when she was leaving.

112. Val told us that the WM & M were bullying her but it was hard to get evidence until we found the note from WM by her when she committed suicide and in the medical notes which we got months later, when the tone of M's approach to Val is apparent: cold and focused on getting her out, not because she was well enough to leave but for the bed. There are many instances in the medical notes which we saw after Val's death where it is actually recorded that Val is telling M that she feels suicidal and then M tells her that discharge planning is happening.

113. The CC I also have concerns about. She was a NEPFT Care Coordinator who was assigned to Val's care but whom throughout, we never met in person, apart from one chance meeting in a doorway, when she was very dismissive of us. She was one of the members of staff on Henneage Ward that was pushing for my mum to be discharged from their care. She had an issue with the fact that Val owned a house but didn't want to be discharged there, due to the suicide triggers that house posed her.

114. [I/S] was also a Care Coordinator that we also did not meet and was invisible.

115. I have serious concerns about **Dr** A **(Consultant Psychiatrist) and Dr** C **(Consultant in Psychiatry Old Age)** from the very beginning of their involvements in Val's care. I did actually intend to complain to the GMC about Dr A but never managed to due to all the stress.

116. He was never willing to speak to us as equal human beings but always spoke in a patronising way, without clear explanations or respecting our need to fully understand the processes.

117. He gave Val heavy medication totally unsuitable for her and was scornful when Val said that Venlaflaxine gave her the initial suicide ideation, despite it being listed as a possible side-effect. Val had a deferential attitude towards doctors, believing that they knew what was best, and that if we questioned them, she might be 'punished' somehow – sent home, for example.

118. We had dealt with NEPFT arrogance and ineptitude when my elderly Dad had been admitted to Colchester general Hospital following a serious incident – wrongly diagnosed – and we basically had to stay by his side and then take him home for fear that he would not survive the shocking care, so we children were less confident about NEPFT generally).

119. Every time I wanted to complain about Dr **A** Val would ask me not to as she was worried that it would make her less likely to get help. From that first summer 2013 when Val was desperately waiting for therapy to the period after her crash when he made no attempt to talk to her, and right to the very end, Dr **A** seemed disconnected, disinterested and unwilling to discuss any aspect of Val's care with us.

120. In the horrendous care review on 15th July 2015 I saw him floundering, promising Val that she would not be asked to leave until she was well enough (no doubt prompting staff to say she was well when she was not), while also saying he did not want her to be institutionalised. I could see that Val liked his softly spoken tone, but he really did not seem to have a plan in mind for her care, and he promised her something he could not give – I saw the look of horror on many of the faces in that meeting.

121. Also on 15th July 2015, in that same meeting I asked if Val was allowed to drive again as she had been planning on buying a car, which I was uneasy about. He said she was allowed, and I was shocked by this (Val told me off for asking and would have been angry had he said 'No'. However, in the medical records of that meeting it was either omitted or changed to saying she could not drive as the law states this. This giving false hope seemed characteristic of Dr **A's** psychiatry, along with a cavalier attitude to the very real dangers not only of overloading medication but of a patient taking their own life in the community, and the impact of someone dealing with that.

122. I thought to myself, imagine if I wasn't attending this meeting to support Val, how would she cope with 15 medical professionals in one room staring at her and providing contradicting opinions and views about her ongoing care.

123. Val killed herself with pills at home in what must have been a terrifying, painful and lonely death, but many voluntary patients have the opportunity to kill themselves in a more public way – in front of trains, or, as with poor Melanie Rabone, by hanging in a public place. Dr **A** seemed unconcerned with this aspect of allowing leave so soon after Val had been on 15-minute observations (for the first time ever, I would like to add) when he agreed that she could go on leave for as long as he wished in the day without informing us of any of what happened in those last days.

124. When we asked for a second opinion as there had been no real diagnosis and the prescribing of medicine seemed random and not connected to Val's needs, Dr **A** **[I/S]** just went quiet but it seems as if he was still in charge. He was there on 15th July 2015 (review) and he was the one who took Val off the 15-minute observations although he and **Dr C** had both been off for some weeks in the summer and he had lost touch with Val's needs.

125. It became confusing to us as Val's family and to Val herself who was actually in charge of her care. The ward and clinical staff – **the WM** and **M** – seemed to have the most immediate power, but the psychiatrists loaded Val up with drugs and seemed to have the final say in matters of leave. **Dr C** was totally ineffectual and uncommunicative – we never ever had an explanation of why Val was on Lithium and she was not taken off it, despite our requests, as she could no longer write, due to how it made her shake.

126. I cannot believe that both of these doctors adopted such a superior and unapproachable manner when their job was to help such vulnerable patients. Dr **C** made no connection with Val at all.

127. Dr **A** despite using a template letter when writing about her, at least seemed to have some regard for her; this makes it even more shocking that he did not protect her at the end when she had openly said she would kill herself.

128. The next day, when she told him she would not commit suicide was too close, and it is well known that people who seriously want to kill themselves test the water with lies and pretended wellness to take the opportunity. Neither **Dr A nor Dr C** seem to recognise this.

129. One of my strongest complaints against Dr A (and Dr C who would have been part of this) is the over-subscribing of drugs to my mum, Val. The toxicologist report lays out the drugs in Val's body and the toxicologist spoke to me and said that most of the drugs were things that she had been prescribed over time and he was surprised at how much she had in her. He explained that older people do not expel the toxins etc from the drugs and so minimal doses are recommended.

130. I was furious to find out from the medical records that Val was put back on Venlaflaxine without our permission after we had categorically said she must not take it; she had also been given a lot of diazepam, supposedly to help her to meet up with family. Dr A had prescribed Venlaflaxine for years – Val was convinced that "*the zopiclone would have made her suicidal",* as Dr A himself wrote. The mixture of the two was lethal for Val. Val was clearly not really herself for some time towards the end, dosed up on a cocktail of drugs even before her overdose. Neither doctor got in touch after Val's death. Maybe this is standard, but it felt awful.

131. There remains a lack of clarity over whether Dr C ever really became Val's main doctor: *It appears that Dr* C *was Ms Dimoglou's inpatient consultant between 3 November 2014 and 1 April 2015…* See paragraph 125. And 127: 2015…*At a ward review on 23 March, attended by Dr* C *it was recorded that:…"I have today spoken to Val regarding change of consultant due to service redesign…*

132. What was the diagnosis? Never one thing – there seems to be a sliding scale of possible diagnoses : *…CPA meeting: 15 July 2015…Ms* [I/S] *…Ms Dimoglou suffers a depressive illness with a secondary diagnosis of unstable personality disorder…"* along with all the other ones. How could anyone be 'stable' when given so many drugs which most definitely impacted Val's moods and behaviour adversely.

133. There were issues with staff not filling out care plans properly and the inquest highlighted untruths told by charge nurse (CN1) and CN2 **(Charge Nurse)**, whom Val despised and who acted and behaved as though he had no real responsibility for the patients in his care. He is the one who basically lied about calling Val on the day she died. He clearly did not as we checked with the phone companies and there had been no missed calls and no voicemails could be left though he said he left one.

134. In fact, shockingly, we found out through the medical records that Val's number was not correct – so even if they had called, they had the wrong number. This is beyond

belief, considering Rabone. CN1 was also involved in this chaotic leave plan and it was galling to see him speaking a rehearsed and insincere speech at the inquest, pretending to care about Val to cover his own incompetence with leave plans.

135. [I/S] who I recall was an Irish nurse on Henneage Ward, was very nice and pleasant to deal with. She was brilliant with Val, especially when they held the news discussion sessions, and she spoke with patients as if they were real and good people. She left suddenly, we never knew why.

136. PB was also very nice, and my mum liked her a lot. I would say that whilst PB was likeable, she was ineffectual. She allowed herself to be taken off Val's case in 2015 when Val began talking about suicide even though up until that point her sessions with Val had been helpful.

137. I think PB had a constant battle with the psychiatrists under mum's care (Dr A and Dr C), in that as a psychologist, PB was able to get my mum to talk about her feelings and concerns, whereby it seemed that the psychiatrists main concerns were to prescribe my mum as many anti-depressant drugs as possible, even at the detriment to health, given the impact of the side effects.

138. Also, the drugs definitely made Val more anxious and less able to express her feelings. When she came off them in the summer of 2014, she said she could not bear feeling so numb, and she was good for a while.

General staff concerns

139. In general, a concern I have is that I don't feel that staff on Henneage Ward were trained about care plans. They treated voluntary inpatients, who were not under section, like they can just come and go as they wish, with no duty of care. There was absolutely no knowledge of the Rabone case, and I suspect that is still the case. There was an increasing number of 'bank' staff, and a lack of one-to-one therapeutic conversation. The ward began to feel as if the staff did not like being there and were not fond of the patients. I saw some confrontation between patients and saw staff frustrated by patients, and quite abrupt with them.

140. From the medical records I have managed to obtain to date, there appears to be gaps and jumps in Val's care plan. There are care plan entries surrounding her death which are missing. For example on the day she died (9th October 2015),

someone had written her telephone number down incorrectly. Furthermore, there was no record of NEPFT calling Val and they lied about this but were able to prove via call logs that Val was not contacted when they said she was, which forced them to admit that they didn't ring the correct number. It beggars' belief how NEPFT (EPUT) could have noted the wrong number for a vulnerable and suicidal patient.

141. Another general concern I want to bring to the inquiry's attention involving staff, relates to an anonymous letter someone, who I believe worked for NEPFT wrote saying that they knew Val was going to kill herself. The head of the EPUT was written to directly with a handwritten note informing her that the ward manager did know that Val was intending to kill herself but to tell staff not to tell family. This was clearly an attempt at whistleblowing to show the dangers in the Trust in relation to mental health care.

142. The police investigated this anonymous letter but sadly and incompetently stated that they could not glean anything from that it that would assist their investigations; insinuating that the letter held no significance.

143. Details of this anonymous letter can be found at page 232 of the inquest bundle and also at page 5 of the Report to her Majesty's Coroner, Serious Crime Directorate dated 17th August 2016.

Meeting with EPUT on 13th February 2018

144. On 13th February 2018, I had a final meeting with EPUT. I can only describe this meeting as the most shocking meeting to date. In attendance at this meeting I had with EPUT was who I believe to be possibly Andy Brogan, and woman representing EPUT and a transcriber named **[I/S]**

145. During this meeting, I was told categorically that Val was not depressed or mentally ill when she took her own life, and that staff confirmed this. This was after the coroner ruled that Val took her life while under a mental health diagnosis. At the end of the recording (1hr 55) they say that Val was let out of hospital because depression comes and goes and at that time Val was not depressed.

146. I believe that much of this nonsense was led by **the Matron and the Ward Manager** as they wanted it to look as if patients can be suicidal one day and the next day, they are safe to go on leave for 12 hours without family knowing any of it. Or they are

covering their own backs in a trust which was purely driven by the need to free beds, so minimising the distress of a patient means they deny all responsibility for them once they leave the building.

147. I would like the inquiry to obtain the minutes of this meeting which was confirmed to me was being taken, so I can confirm more specifically who all those in attendance.

Care Management and Plans

148. Val was hardly involved in the plans for her care, including its formulation and implementation. During her first admission to Henneage Ward, she was told when she was discharged that there were things that needed to be done. But these were more like superficial conversations about her care, rather than obtaining her views and discussing details of any care plan and how it would work in practice.

149. I do recall that there were some meetings about care plans, in which I attended but there was always very little scope for Val and/or as a close family member to have an opinion that would be taken on board and implemented. We were merely just told by staff what was going to happen rather than any meaningful involvement.

150. I have also not seen any evidence that NEPFT (EPUT) asked either Val or us as a family about the decisions that were made for her care plans. I do remember that they have a written policy that families should be involved at every stage of a inpatients care.

151. When Val was first discharged from Henneage Ward, in August 2014, we may have been told informally about care plans and provided some leaflets but were never formally consulted and/or actively involved in Val's care plans for discharge. The medical records make it look as if there was a community team working with Val but in reality, Val did not want them in her house.

152. I would very much have liked to be consulted and involved in the formulation and implementation of the care plan when Val was initially discharged but I was denied that privilege by NEPFT, despite there being scope to do so.

153. The care plans towards the end of mum's life would always mention preparing her for discharge, whilst simultaneously confirming that she was actively suicidal. How does that make sense?

154. We would constantly mention to Dr A and other staff that we did not want mum on Venlafaxine, given her age and the impact the side effects of the drug was having on her, yet many care plans towards the end of her life, detailed that she continued to be prescribed the same, and the toxicology report dated 13th October 2015, confirms she had it in her blood stream.

155. Overall, I feel that the care plans were dangerously ineffectual. Occasionally however, I was invited - often with little warning, considering I live in Sussex, and had a job and child/dog care to deal with to a meeting, by NEPFT like at the Care Programme Approach meeting which took place on 15th July 2015 CPA (Care programme approach) care plan meeting. This seemed to take place every several months, but I can't truly recall how often these meetings occurred.

156. To be honest, even being in the meeting there was no negotiating with NEPFT, as our views fell on deaf ears. It always felt as though they were always doing the talking. We never saw any actual effective changes coming out from these meetings that would positively affect Val. The meetings were more an insight into how they were not coordinated. i.e. one clinician / medical professional would be saying one thing that was totally at odds to what another clinician / medical professional would be saying, which led to confusion and contributed to a lack of diagnosis and un-joined thinking in relation to Val's care.

157. I do feel that the level that my family was involved in Val's plans was inadequate, given that NEPFT's policy specifically say that they should involve family but they just didn't include us in Val's care and treatment. When mum was suicidal and she was threatening us about killing herself, we should have been involved. But I think they ultimately didn't involve us, as they're convinced that lay people don't know enough to have an opinion, until you threaten to complain higher up the chain. Even worse, I believe that we were deliberately not told how bad Val was as they wanted her to leave, whatever the consequences.

Treatment

158. I have considered Dr [I/S] (Consultant Psychiatrist) report dated 08 August 2016, and below are details of all the diagnoses and treatments Val received over the years:

2000

159. *"…Ms Dimoglou…seen…as an outpatient in May 2000, and was diagnosed as suffering from severe depression…was…prescribed…antidepressant, citalopram…and…receive a short course of therapy which sounded cognitive behavioural in approach…*

2009

160. *…Dr* **A** *in July 2009…diagnosed…recurrent depressive order…and prescribed venlafaxine…in place of citalopram…*

161. *…reviewed on 17 November 2009…and recommended she continue to take venlafaxine for at least 12 months…*

2011

162. *…Dr* **A** *reviewed Ms Dimoglou on 16 August 2011…finding no change…noting the absence of "morbid ideation" …advised that she continue to take venlafaxine long-term…*

2012

163. *…Dr* **A** *reviewed Ms Dimoglou on 21 February 2012…noted that she remained "in excellent spirits and is free of all biological and cognitive indicators of an affective disturbance…and…discharged…from outpatient care, back to the care of her GP…she had taken venlafaxine continuously for over two years by the point of discharge from psychiatric services in 2012…*

2013

164. *…Dr* **A** *reviewed her on 04 October 2013 "a sudden and rather catastrophic decline in her anxiety and depression since August…no obvious provocation…I know in the past she did very well with cognitive behavioural therapy…and rather than alter her medication at present I think this treatment modality is probably indicated at this stage…advised that Ms Dimglou continue take venlafaxine (150 mg daily), and he referred her to* **PB** *for consideration of CBT…*

2014

165. *…At a later meeting (7 May 2014),* **PB** *is recorded as having:…"identified through the first session of assessment that VD was exhibiting depressive symptoms but at this moment believed her to be low risk. VD acknowledged some suicidal ideation…is not able to determine if this was either an impulsive or planned act of suicide…"…*

166. *…At a meeting on 19 February…"Dr* **A** *advised that from his professional role, it will be in her interest to be on the antidepressant. But daughter thinks otherwise. Valerie feels the zopiclone would have made her suicidal"…*

167. *…On 2 April "issues about building up home leave were discussed* **PB** **[I/S]** *.developed a programme of graded exposure to her home with her"…*

168. *…On 9 April: "daughter thinks that the diagnosis of depression might not be right. They think she also had manic-like episodes in the past…Daughter wants Val to be taken off venlafaxine to another anti-depressant…Daughter requested second opinion"…*

169. *…30 April: "currently on a home visiting regimen with the psychologist"…*

170. *…7 May: "Valerie has not been able to stay more than one hour in the home…Probable diagnoses depressive illness, emotionally unstable personality traits..."…*

171. *…A professionals meeting took place on 7 May attended by Dr* **A,** **PB** *and* **CN1** *charge nurse, among others*

172. *…Dr* **A** *noted that VD'S daughter had asked whether her mother has bi-polar illness…* **PB** *believes that VD does exhibit strong emotional reactions to*

certain triggers that might be construed as hypomanic…[Dr **A** *noted that VD does not have a formal diagnosis of bipolar disorder…*

173. *…A letter from Sofia included; "we would now like to formally request this second opinion…to ascertain a clearer view of Val's illness, with a mind to a definite diagnosis…This would be in the hope of surer path to more effective medication…"…*

174. *...4 June: "wants a second opinion before starts taking lithium…Not keen to commence the lithium". It seems she was prescribed venlafaxine and mirtazapine (two anti-depressants)…*

175. *…11 June..* **PB** *envisaged weekly basis…therapy sessions at that point, to be kept under review…*

176. *…9 July: "Valerie thinks she has a diagnosis of bipolar affective disorder despite being told that she does not meet the diagnostic criteria. Valerie more has emotionally unstable personality"…*

177. *…A professionals meeting took place on 6 August, attended by Dr* **A,** **PB** *and others. It appears that Ms Dimoglou had been involved with the Home Treatment from early February 2014, but that: "…she is on no treatment at present…Valerie has her own accommodation; however, she associates this with the cause of her depression and suicidal thinking. The concern is that if she was to return home, she will…act again impulsively and make further suicide attempt…Dr* **A** *…quoted as saying: "potential diagnosis of borderline personality disorder. She was depressed when she was admitted but she is not depressed now…All agreed that she continues to present as a high risk of suicide when discharged and this may always be present. There is therefore a need to take some positive risk taking…Discharge to be at home address..* **PB** *to continue with weekly sessions…*

178. *…Ms Dimoglou was discharged from Henneage on 13 August 2014…the discharge summary gives the diagnosis as 'recurrent depressive disorder, current episode severe'. She had not taken any medication since around July. This has been described as "an informed decision made by Ms Dimoglou due to adverse side effects"…*

179. *…Dr* **A** *reviewed Ms Dimoglou on 7 October, accompanied by her son-in-law.." and noted that she "…would probably be better served with a low dose of*

olanzapine which as well as having antidepressant effect is also a mood stabliser and tranquilliser…"…he prescribed olanzapine 2.5 mg…

180. *…On 8 October, Dr* **C** *…assessed Ms Dimoglou…and…explored…with Sofia…a diagnosis of bi polar disorder…and…that the areas of risk are concerning suicide…"thinks has increased suicidal ideas when on zopiclone and venlafaxine in the past – blames the zopiclone…is at quite high risk of suicide long term. Diagnosis of bipolar disorder and recurrent depression not well established…Possible bipolar II. Lithium seems possible pragmatic treatment"…*

181. *…15 October:…Olanzapine was increased to 5 mg and diazepam 9 mg daily was prescribed…It appears she was also being prescribed venlafaxine 150 mg daily…(On 22 October, the dose of Olanzapine was increased to 7.5mg and the diazepam reduced to 6 mg daily.)…*

182. *…At a ward review on 29 October attended by Dr* **A** *and Ms Dimoglou amongst others…the dose of olanzapine was (to 10 mg once daily) and the plan was for "Ms Dimoglou to be transferred to Dr* **C** *as from 3 November 2014 as per previous request and agreement"…*

183. *…31 October:…Diazepam dose reduced to 4 mg daily. It appears that Dr* **C** **[I/S]** *was Ms Dimoglou's inpatient consultant between 3 November 2014 and 1 April 2015…*

<u>2015</u>

184. *…A professionals meeting took place on 23 February attended by Dr* **C,** **PB** *and others…Ms Dimoglou was being prescribed olanzapine and diazepam…*

185. *…At a ward review on 23 March, attended by Dr* **C** *it was recorded that:…"I have today spoken to Val regarding change of consultant due to service redesign…*

186. *…CPA meeting: 15 July 2015…Ms* **[I/S]** *…Ms Dimoglou suffers a depressive illness with a secondary diagnosis of unstable personality disorder…"*

187. *…She was assessed by Ipswich Rd on 5 August, and on 11 August the staff nurse concerned completed her report…"Current diagnosis: suspected mental and behavioural disorder…venlafaxine 37.5 mg…discussed her plans to live independently and travel…"*

188. *…An 'inpatient care plan' apparently completed on 19 August includes the following:"…Val has had thoughts of ending her life and has some kind of plans in mind but said she wouldn't carry them out whilst on the ward…One-to-one therapeutic time to be offered on a daily basis by her allocated nurse…Risk around suicide ideation should be explored…Val…has stated that the highest risk will be upon discharge and being home alone but she has also said that being home in her current home could be a risk…Is experiencing high levels of anxiety around meeting with staff and discharge planning…"*

189. *…As of 2 September…her psychotropic medication comprised: olanzapine 10 mg, diazepam 2mg, lithium carbonate (modified release) 400 mg, and venlafaxine 37.5 mg daily…*

190. *….Notes of a ward rounded attended by Dr* **A** *and Dr* **C** *on 9 September state: …diagnosis "ICD 10 suspected mental and behavioural disorder"*

191. *…Friday 9 October 2015…Ms Dimoglou was being prescribed olanzapine 10 mg at night, diazepam 2 mg at night, lithium carbonate 400 mg at night and venlafaxine mg in the morning…"*

<u>Overall views on diagnosis and treatment</u>

192. Overall, I don't think the medications were ever appropriate for Val. I have major issue about counselling being stopped. Val always said that she needed that talking time and they never gave her and/or me a reason for stopping it.

193. When Mum first crashed the car, I encouraged them to lower the dose of the medication and to take her off the venlafaxine because it was dangerous. But in hospital they were giving her hefty doses. I would have been happy with her coming off medication, as can be seen by how many times I mentioned it to Dr **A** and Dr **C** but to no avail., they would not discuss it with me at all.

194. Additionally, Val should have had a proper diagnosis and should have kept on talking therapy. In my view, NEPFT should have been trying desperately to manage Val to come off the drugs and not constantly prescribe her drugs. In reality she was just left to her own devices.

195. When Val came home after her first discharge from Henneage Ward, she came off the venlafaxine and she felt much better for it. I made NEPFT put down in writing that Val must not again be put on venlafaxine and we also insisted that we wanted to be involved about changes in Val's medication.

196. It wasn't until Val died that we learnt she was on venlafaxine again. Val also said at the time, that she wanted family to be informed about changes to her medication but again they NEPFT didn't tell us.

197. I would like to mention the toxicologist report. I talked to Senior Forensic Toxicologist, who I believe to be **[I/S]** at the time of the inquest, and they explained to me privately in person that it's so rare that a person at my mum's age could be on so many drugs. He said that old people shouldn't be on so many drugs because they don't have the capacity at their age to get rid of the toxins the drugs produce. He further confirmed that Val had dangerous levels of medications in her bloodstream, not just from the overdose.

198. Another overall observation and concern about Val's treatment was that there was no security about Val taking her medication, she could just take it away with her when on the ward, as I do not recall the administering of her medication was ever monitored. However, my major concern was that Val had a lot of drugs in her and we were adamant venlafaxine was not suitable for her but yet NEPFT insisted on putting her on this medication along with the lithium.

199. Val clearly had a toxic build-up of all the medication she had been prescribed and taken and I reiterate that there was no supervision when administering drugs to inpatients which is extremely dangerous and shocking.

200.

201. I would like to add that whilst Val had been given the drugs, they didn't make sure she actually took them. Therefore, when she was going out on leave she was building up a little pharmacy of drugs that she was going to take to eventually kill herself.

202. If as a family we had been informed the days leading up to her death, that she had been place on increased observations (from level 1 to 2) due to her suicidal ideation and insistence that she would kill herself if let off the ward, then my sister would have gone to her house to check and look for any buildup of medication that she

had stored in her house and would have been able to prevent her taking her life on 9th October 2015.

Safety

203. Val's safety and that of other inpatients could have been compromised as she was able to harm herself, although she chose not to do so. That is because Val was able to have in her room on the ward knives and 6 tins of sardines. Both were unchecked and self-harm could have been possible both from the perspective of Val harming herself and other inpatients harming themselves by potentially having access to Val's knife and tin which had sharp edges.

204. Val did raise concerns regarding her safety, when she was burgled and someone entered her room through her window and stole her bag. I am unsure if NEFPT changed the window after the incident but easy access to the window was like that for a long time. The burglary was reported by Val likely to **the Matron** at Henneage Ward and the police were contacted and investigated the matter. From memory, my mum's bag contained approximately £400. Once the police investigated, they managed to locate the bag two weeks later and to identify the culprit. I remember that the staff at Henneage Ward were so unsympathetic about it and lacked in empathy towards Val, pressing her on when she was going to leave rather than dealing with the faulty window.

205. I also had a safety concern, with my mum having access to bleach, as she used to do her washing in her room. She was in the habit of using bleach when washing.

206. I also have concerns that I didn't feel there was no clear programme/ policy of leaving the ward for inpatients. They could just come and go as they please, albeit they were voluntary inpatients. I do not feel that the risk assessments were robust enough given the suicidal ideation that Val presented, particularly in the last month of her life. Note Rabone ruling, mentioned earlier.

207. In terms of observations, I feel that Val's safety was not considered. NEPFT placed her on level 2 observations, just 2 days before her death, which requires checks every 15 minutes, because she was overheard on 7th October saying she would kill

herself, if she was allowed off the ward. Yet, Dr A and NEPFT, deemed it wise to downgrade her observation level to 1 and to also allow her to leave the ward for twelve hours on a cold October day – from 9am to 9pm - which she had never done before. She told them she was going somewhere they could have checked and, had they really known her, they would have realised never happened on that day. Val was clearly testing how observant they were/how seriously they took the leave plans.

208. Val was talking about suicide all the time especially in the April 2015 and running up to October 2015, therefore to my mind she should have been monitored more strictly.

209. Val's leave plans were also very ad hoc and inconsistent. No one knows consistently where she was. They have blank pieces of paper for observing people leaving and the forms aren't electronic. It should have been impossible for them to make a mistake about her phone number and any leave should have been copied or sent to a designated family member. But we were never told anything. This shouldn't be that hard to do these days with technology.

Leave, Absconsion and Awol patients

210. Val had several instances of leave throughout 2015. Most of the time, she left accompanied by one of us. Either family members and/or the staff would have known we were collecting her and returning her to the ward. Later on, she was allowed to leave without us needing to go in and collect her; she would simply come out to meet us.

211. We believe there should have been a process whereby staff checked with Val who she was planning to be with and verified this by calling that person. That kind of basic due diligence did not appear to happen. Henneage Ward was not that big so this would not have been an arduous task as many patients did not go out at all.

212. The handling of leave requests was extremely inconsistent. Occasionally, notes included what she was wearing and when she was leaving, but most of the time, the notes were blank or extremely vague. There was little to no involvement of family in these decisions, and we were not kept in the loop. This has been highlighted over and over again as a failing of this trust.

213. Val deliberately told staff false information to test whether they would check on it and they didn't. This revealed serious gaps in oversight. The leave notes appeared to be completed in a way that allowed backdating or doctoring; they were just scraps of paper with minimal content.

214. In relation to whether my family members or I were informed that leave had been granted for Val on 9th October 2015, I can categorically say, absolutely not. We were not told that leave had been granted that day, nor were we informed that she had been placed on increased observation just two days earlier on 7 October 2015. Had we known, we would have been far more alert and could have taken steps to intervene.

215. It was particularly alarming because she had never taken such a long (12-hour) unaccompanied leave before. That fact alone should have raised red flags, especially given that it was the anniversary of a previous suicide-related incident. No one connected these crucial details.

216. Records indicate that Val had told staff she had been there a year, which should also have prompted a fuller assessment. This also suggests that Val was hoping that someone would realise she was in danger of self-harm and would have kept her in the ward, or that she was testing them.

217. I would like to also state that the leave plan was poorly filled out and, crucially, included the wrong phone number for Val. We can point to this specific error in the documentation. During the inquest, it became clear that staff gave conflicting accounts about whether they attempted to call Val. One person claimed to have left a voice message, but there was no record of a call being made.

218. We were shocked that they allowed a 76-year-old woman, recently on suicide watch, to leave the ward unaccompanied on a cold autumn night. No one checked who she would be with, and we strongly believe that if the care plan had been followed and we had been informed, this could have been prevented.

219. At the beginning, when Val was an inpatient, we collected her directly from the ward. But later, she would just meet us in the car park, with no signing in or out, no face-to-face check-ins. There was no request for us to come in or receive updates.

220. We now know from reading the notes after her death that she was being given diazepam while out on leave, something we were never told. That lack of communication created a huge barrier to understanding her state of mind.

221. Requests for leave were also handled poorly by staff, with communication becoming increasingly limited. When we did try to reach out to the ward, we were usually told everything was "fine," even when it clearly wasn't.

222. I also feel that Val's grant of leave was inappropriate. There was a time when some communication made the leave feel more structured and safer. But from June 2015 onward, things deteriorated. After a meeting in July, August was a period of silence due to staff being away, and by September, we were completely out of the loop, right when Val's behaviour and risk were escalating. It felt like the duty of care was missing. We lived in fear that she could be sent out at any time without our knowledge or involvement.

223. My views about Val's leave fluctuated. Some days were pleasant, where Val would come out with us, walk the dog or do some gardening. But toward the end, she became increasingly reckless. She often appeared vacant or said strange things. We now understand this may have been a result of the medication (diazepam), which we were never told about.

224. I do not feel overall that the periods of leave were beneficial, as Val was taking medication to be allowed out, but the drugs made her more unwell.

225. There was no continuity of care. Staff changed frequently, and it became clear after her death that we were unaware of many significant developments. The lack of consistency and communication made it difficult to voice concerns or feel heard.

226. Prior to the day she died, there were no previous incidents of Val failing to return from leave, nor were there any attempts to abscond. Her death was a complete shock and the lead-up to it unlike anything that had occurred before as it felt as if the hospital had severed communication with us, until Nicola got the call that Val was half an hour late from leave – at 9.30 pm.

Transfer

227. I want to clarify for the record, that Val first became an inpatient in January 2014. She had previously been cared for in the community as an outpatient and had not been transferred elsewhere at any stage whilst an inpatient on the two occasions at Henneage Ward.

228. Val was only transferred for the physical injuries she suffered and was not transferred to another inpatient ward. She continued to attend Broomfield Hospital in Chelmsford for her burns.

229. Val went to Ipswich General Hospital at first after her car crash, where she attempted to take her life and they took her to Addenbrookes the same day because of the burns she sustained and her broken hip. It was from Addenbrookes due to her physical injuries, that she was then transferred to Colchester General Hospital and then to Henneage Ward in the Kingswood Centre, a psychiatric facility in the grounds of Colchester General.

Discharge and Continuity and Treatment in the Community

230. Val was not admitted to Henneage and/or any other inpatient facility for the purpose of her mental health in 2009. Val's first admission to Henneage Ward at Kingswood Medical Centre was in January 2014, followed by a second admission in October 2014.

231. In 2015, Val felt the ward environment had become more intense, particularly due to an increase in patients with dementia, which deeply unsettled her because her own mother had dementia. Around August 2014, conversations increasingly focused on her discharge, even though there was no clear evidence that she was well enough to go home. Her care appeared to break down during this period.

232. It was claimed and incorrectly so, that the local Clinical Commissioning Group was pushing for her discharge due to the length of her stay, but we have no evidence that this came directly from the CCG. **The WM** told Val this, and during the inquest, she at first denied it, but Val had kept a note showing she had been told this, indicating dishonesty. Val felt pressure to leave and was distressed by it. At the July 15th meeting in 2015, there were clear disagreements among professionals. Dr **A** said he would not force her to leave, while others implied otherwise.

233. There were conflicting views among the professionals. [I/S] representing the hospital, did not agree with the discharge plan, while others like Dr A appeared more sympathetic but lacked authority. Val sensed the institutional machinery pushing for her discharge, and this confusion severely affected her mental state.

234. Val was told about the discharge but was not meaningfully involved. There was no clarity, just constant uncertainty around if and when it would happen. Her care coordinator, [I/S], had very little contact with her, and we (her family) were not involved. The discharge was terrifying due to the absence of a clear plan. Previous care coordinators like [I/S] were also unknown to us. Conversations were vague and contradictory. Staff, including the Matron even told her she would be discharged after Val told them she felt suicidal, which was completely inappropriate and deeply alarming.

235. There was no discharge date communicated to us and no real planning involving the family. This lack of involvement left us unsettled and unprepared. There was also no fixed discharge date. It was always vague and uncertain. This lack of clarity was deeply unsettling for Val and for us.

236. We were told a discharge plan existed, but any information shared with us was vague and insufficient. We were left in the dark on key points.

237. I have serious and significant concerns about the discharge decision, process and communication. In 2015, it was even worse than 2014. There was no engagement with the family by the care coordinator [I/S], and Val's housing situation was ignored. She could not return to her house as it was a major trigger, yet the team resisted her move to council housing, even telling us she didn't have the right to access it. The council, by contrast, was supportive. The hospital's approach was cold and lacking in empathy and focused on moving her out without considering her needs. They said unkind and dismissive things, missing the critical fact that her home environment was traumatising her.

Care and support as an outpatient

238. After Val's 2014 discharge, there were some visits from the team, but we (the family) were not involved. Val didn't want people in her house, and it's unclear if she was taking her medication during that period. The outpatient plan wasn't explained to

us. We don't know how successful it was. We do know that Val told the team she didn't want certain people – CN2 especially - in her home, but there was no flexibility.

239. I believe she was receiving CBTat some point before the crash in 2013, but possibly through her GP, not her psychiatrist. Some of it may have taken place when she wasn't speaking to me, which happened sometimes. She was also on antidepressants.

240. Val's care in the community was primarily through her CC and [I/S] CN2 and possibly [I/S] earlier on. There was a team that visited a few times during the two-month period in 2014, but they liaised only with Val and not with us.

241. The support did not align well with the discharge plan. Val didn't receive the consistent or flexible care she needed. There was no follow-up to check on whether she was taking her medication.

242. Additionally, face-to-face contact during this period was minimal. The team visited only once or twice, if that, and Val often rejected further visits.

243. The community treatment did not work well for Val. She felt unsupported and misunderstood. She also felt bullied. One example being a report written by [I/S] the CC that falsely claimed her home was unclean, which was simply untrue and deeply hurtful. It suggests that staff were writing misleading records instead of addressing Val's real issues. The CC only seemed concerned with telling Val she had to go home and that she was not entitled to other housing when in fact she was. It was left to other, nicer, people to help Val, though it was supposed to be [I/S] the CC's job.

244. The support Val received in the community was inadequate and poorly delivered. Staff didn't engage with us, and what they wrote in records often did not reflect the reality. Val was isolated, unsupported, and distressed, both emotionally and practically. The system failed to understand her triggers, her reluctance to be in her home, and the need for coordinated care. There was no continuity, no proper oversight, and no compassion in the delivery of community-based support.

Engagement

245. Val's involvement in decisions about her care and treatment was minimal. Most of the time, she was simply told what was going to happen. This was not true involvement, it was more about informing her after decisions were made. Toward the later stages, she was on so many medications that she became confused and disoriented, which made meaningful participation impossible.

246. The care team should have included the family in decisions, especially when Val couldn't fully advocate for herself. Unfortunately, they did not. There was no effort to involve or consult us, even when it was clear that Val was not in a position to make fully informed decisions.

247. I do not consider that Val's and/or the families level of involvement was appropriate. Val should have been involved to the extent she was able and when she wasn't, her family should have been more closely involved in supporting her care. This was especially important during her second admission, where decisions were made around her discharge despite her being mentally unwell and expressing suicidal thoughts. The lack of appropriate involvement showed a fundamental failure in care planning and safeguarding.

Staff, healthcare and other professionals communication

248. Our involvement was essentially non-existent. We were sometimes informed of what was happening but rarely invited to participate in decision-making. There were a few individual staff members who were more open and willing to share, but this was inconsistent and entirely dependent on the person.

249. We tried to share background and concerns, but there was no structured opportunity to do so. For example, I asked to be present at all meetings, but wasn't consistently informed when they were taking place. The traumatic July 15th meeting in 2015 (which was crucial) I only found out about by chance a few days beforehand. If I hadn't heard in time, I would have missed it, which could have had serious consequences.

250. We were not listened to. Our concerns about Val's safety, especially the risk she posed to herself, were either dismissed or overshadowed by the focus on discharging her.

251. Information was also provided sporadically and inconsistently. Some staff, like **one nurse,** were approachable and helpful, but overall communication was disjointed. At times, conversations happened in passing, not formally. Others, such as **the WM,** **the Matron** and **CN1** as well as the two psychiatrists, **Dr A** and **Dr C** were unhelpful and added to our sense of frustration and exclusion.

252. I have major concerns about how we were involved. There was no regular communication. Meetings weren't scheduled in a way that included us, and when we tried to stay involved, it felt like we were being kept at arm's length. The entire second admission felt like it was centred around preparing for discharge, not recovery or safety. This left us feeling powerless and fearful for Val.

253. Whilst Val was an inpatient, we were able to routinely contact and visit her. She was also able to contact us.

254. During Val's first admission from January to August 2014, it was somewhat easier to get information, and we could speak to staff when we visited and get a sense of how things were going. But during the second admission, communication deteriorated. We weren't told about her medication or any long-term plan, and it was much harder to understand what was happening.

255. I would surmise that we had concerns regarding communication. The lack of information sharing from staff made it incredibly difficult to understand Val's treatment, her progress, or what plans were in place. Our ability to support her was limited by how little we were told.

Concerns and Complaints: Quality, Timeliness, Openness and Adequacy of Responses

How to raise concerns

256. We were given a leaflet at some point, possibly by **[I/S]** one of the nurses. It may have contained information about how to raise concerns, but it wasn't

explained to us in any detail or in a proactive way. There was no follow-up or encouragement to use it.

Concerns

257. Val and the family raised several concerns, both informally and formally:

- There were concerns about Val's safety, particularly regarding her risk of self-harm and the lack of adequate observation.
- We were very concerned about the ward environment, including a burglary that occurred and a board that exposed confidential patient information, which Val could see and be distressed by.

- There were complaints about the staff's conduct, especially certain individuals who we felt were not professional or responsive.

- We also complained about the clinical decisions, particularly the excessive medication, lack of diagnosis, and pressure to discharge her when she wasn't well.

- In early January 2014, an email was sent (by my younger brother) to the Health Secretary raising concerns, including about Dr **A**

258. Throughout Val's care, I raised concerns repeatedly, particularly about the medication and absence of a clear diagnosis. I asked for a second opinion, but was told the only option was another psychiatrist in the same building, which didn't feel like a real alternative.

259. I informally complained about **the CC** , someone I never properly met but who was involved in decisions. I also raised several concerns in the 15th July meeting, including about medication, discharge pressures, and issues like the DVLA not being properly informed. None of that was reflected in the meeting minutes, which felt like deliberate omission.

260. We received an anonymous letter, which is mentioned in the police report, which seemed to support the idea that there were systemic issues at the hospital.

261. I also had ongoing concerns about community care, especially the lack of contact and communication with us. I also raised concerns about the lack of coordination, staff not knowing her situation, and the same issues of over-medication and failure to diagnose. There was never a clear response. Some of these issues were mentioned to clinicians, and some, like the January 2014 email, were more formal.

Complaints

262. In general, complaints were not handled properly. Our concerns were not taken seriously or responded to appropriately. Key points we raised were often left out of formal records, including meeting minutes. There were delays and inconsistencies in how things were followed up. We had the impression that some staff were under pressure from *"higher up"* to push for discharge and were not acting in Val's best interests.

263. Overall, there was a lack of transparency and accountability. My repeated concerns about medication and diagnosis were ignored.

After Val Died

264. We were misled into thinking Val was still in hospital that day, based on an earlier conversation with Val herself – we would speak each morning before I went to work. Nicola also spoke with Val that morning and Val said she was staying on the ward. Later, about 9.30pm, Nicola (my sister) received a call saying that the hospital had called to say Val had not come back from leave and that she was going to my mother's house. The moment my sister told me Val had left hospital; we both feared the worst and we instinctively knew she would have tried to kill herself.

265. I was in Sussex and started driving back, already knowing in my heart that something terrible had happened.

266. After Val had died, it was very unclear and badly handled. I was the one who had to ring Henneage Ward to tell them Val had died. Nicola was at the house, waiting for the police. There was no proper outreach or explanation from the hospital. After they found out, communication went quiet, and we didn't hear anything from them the following week.

267. We did not receive any support as one would expect when a loved one has just died. No family liaison officer, no counselling, no practical or emotional support. I had to call them myself just to say, *"I cannot believe you didn't offer us anything."* We had to push just to get any response. It felt like they were in a state of panic, not because they cared, but because they were trying to protect themselves.

268. We were treated very appallingly after Val died and there was no concern, sympathy or empathy shown by staff. Nobody from NEPFT Reached out to us and while **PB** did attend the funeral and was kind, she was the only one who made any humane gesture.

269. Staff like **the Matron** and **the WM** were dismissive and defensive, clearly trying to cover their tracks, it felt like. I definitely do not believe the claim that they called Val when they said they did, as there were no such calls. Neither did they call us to offer sympathy until after I had pointed this out.

270. From the moment Val died, we were given a list of things to do for them to meet their reporting obligations, but no support for us as a grieving family. Meetings were cancelled at the last minute. Records took months to arrive, and it felt like everything was designed to delay and deflect.

271. The whole experience, from start to finish, was shocking and traumatic.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

272. A number of investigations and reports were prepared as a result of the aftermath of Val's death.

Serious investigation report prepared by **[I/S]** (Clinical Manager/Matron, West Adult Inpatient Services dated 1st February 2016

273. The SIR concluded that the exact reason why Val took her own life on 9 October 2015 remains unknown and may never be fully understood. While her early posting of a birthday card to my daughter (October birthday) suggested possible premeditation, no change in her behaviour or presentation alerted staff to any immediate risk, though it should have done.

274. The report continued that Val was an informal patient with capacity, and staff were following leave protocols at the time. However, there were shortcomings in the documentation of her leave on the day of her death and inconsistencies in communication regarding her observation level.

275. The SIR recommendations were that:

- Staff should be made aware of the concerns raised, particularly around documentation and communication.
- The In-patient Leave Policy and Procedure should be reinforced, ensuring staff complete leave plans with clear risk assessments and care planning.
- Relevant staff should meet with report authors to review findings.
- Any outcomes from the Coroner's Court should be shared with the ward team, and all resulting actions must be implemented.

276. We were far from impressed with the SIR report due to factual inaccuracies, fabrications and the conclusions (no inclusion about Rabone, amongst other glaring omissions) and had no faith in the serious incident investigation. Therefore, NEPFT commissioned Verita to carry out an independent quality-assurance review of the serious incident investigation to determine if it was fit for purpose and conducted in line with trust policy.

<u>A quality assurance review of a trust internal serious incident investigation into the suicide of Ms D prepared by Verita and dated July 2016</u>

277. Verita findings included amongst other things the following:

278. There was unclear documentation of Val's leave plan on 9th October 2015 and inconsistent communication among staff regarding her observation level.

279. There was no evidence to suggest that staff could have reasonably foreseen or prevented Val's actions based on her presentation and known history. Although I still disagree with this.

280. That key learning points involve the importance of accurate, detailed record-keeping and consistent communication across care teams.

281. Verita also recommended the following as a result of their findings:

282. That NEPFT should reinforce staff adherence to the In-patient Leave Policy, ensuring all leave plans include thorough care planning and risk assessments.

283. That NEPFT should improve communication protocols around changes in observation levels to avoid misinterpretation.

284. That NEPFT should share the coroner's findings with the care team and implement any required actions and to implement a clear version control system for investigation reports to ensure final documents are properly identified and filed.

285. Verita concluded that all recommendations should follow SMART principles and be prioritised to support meaningful improvements in patient safety and care quality.

Psychiatric report prepared by Dr [I/S], (Consultant forensic psychiatrist) dated 08 August 2016

286. Dr [I/S] prepared a report at the request of Detective Constable [I/S] Serious Crime Directorate, Colchester Major Crime Team. This report was to consider the overall clinical care provided to Val, including prescription of medication and clinical care provided by Dr [A] consultant in psychiatry of old age.

287. He concluded that amongst other things that in his opinion *"…none of the... diagnostic categories could have been reliably ascribed in Ms Dimoglou's case. I am not convinced that there is strong enough evidence to record a manic or a hypomanic episode, and her recorded presentation during the two years from 2013 does not in my view reveal the presence of hypomanic symptoms on repeated occasions. In 2014, Dr* [C] *noted symptoms compatible with hypo/mania, but that 'it does not seem very well-established that they are persistent, or that they interfere Ms Dimoglou's life to a significant degree. It appears that he did not rule out the possibility of a diagnosis of bipolar II disorder, but that he did not actively support it either. Recurrent depressive disorder was in my opinion the correct diagnosis…"*

288. For the record, I do not fully agree with Dr [I/S] conclusion that Val was not bipolar and it is my belief that Val would not have died by suicide that day if the staff had taken more care of her.

Concerns

289. During the inquest, which was a stressful and emotional time for my family and me. I recall that many of the staff were laughing while we were so stressed. That was very disrespectful.

290. It also came to our attention that an anonymous letter which is also referred to in the police's report to the coroner dated 17th August 2016 was received. The anonymous letter confirmed that Val had stated on the eve of her death that she was going to kill herself and the staff all knew and yet they allowed her to leave. Not only did they allow her to leave, but they also allowed her to leave for 12 hours unaccompanied. The letter also said that staff were told not to inform the family.

My views / reflections

291. Let me start my closing comments to my statement by going back to the very real Valery I spoke about in my commemorative statement: full of zest, adventure, love and fun; a lover of nature, and fascinated by humanity. A girl full of dreams of seeing the world, a mother devoted to her family and determined to give all four of us children – and our dog – the best of life. Certainly, she was complex and I haven't really touched on how she suffered, how she came to feel that she had failed in many ways, or how she had been denied or missed opportunities in life. But we wanted her to know how much she had accomplished, and what a brilliant person she was, and we did our best to do this, right to the end.

292. What really hurts, and what I can still cry about every day, is that so few people really and honestly tried to help her, even when she plucked up enough courage to ask for help. If it was their job to help her and they didn't, society itself should feel ashamed of letting that happen; no-one who lacks compassion for the mentally unwell should work in that field; no—one who is driven by numbers of free beds can say they have an understanding of mental health.

293. One of the great ironies in this investigation into the mental health services of EPUT, is that the Kingswood Centre is built on the area that was once Severalls

Hospital, feared by many, including Val, as a place with forced electroconvulsive therapy and lobotomies. Although some asylums were just that – places of safety to keep people from harm and to offer them a home until they might be safe in the world again - Severalls suffered from a reputation of being uncaring. Val was fascinated by such history, and by which asylums nurtured patients, allowing them to be creative (such as the schizophrenic artist Richard Dadd, who killed his father), and which bullied and humiliated patients.

294. Val respected society when it chose to look after people who were suffering, and believed that there should be no limit to the time they were looked after, just as a parent always cares for its child, ideally. This is what the good asylums were all about, so it is sickening that we moved to a 'Care in the community' model which is not fit for purpose, forced on to society because the asylums were exposed as cruel places, but the new system not being well thought-out and to this day suffering from a postcode lottery as to whether it is of high quality and if long-term provision to stay in a caring institution still exists. The Griffiths Report of 1988 and Norman Lamb's reforms during Val's treatment in 2015 (ironically all over the media: we appealed to him) tried to iron out the discrepancies, but the issues are still ongoing, now with even further cuts to the welfare budget in favour of warfare.

295. Val and so many of the individuals spoken about in the Lampard Inquiry were victims of an inadequate in-care programme and an inadequate at-home programme. They did not need to die as they did. Suicide is a desperate act of despair, a statement that no-one of Earth is able or willing to help. It devastates families with guilt and grief, and it is the last effort of those with mental health issues to take control of a terrible situation.

296. I know from Val's death, from that of other people I have known, and, indeed, from celebrity suicide (such as Caroline Flack) that society does not take the warnings seriously and that there are not real safeguarding measure in place. The trite 'lessons to be learned' is just played on a loop, as society has not tried to understand the intensity of suicide ideation and so few measures are in place to stop suicide being such an option. The figures are staggering: globally 740,000 suicides – one every 43 seconds – (Lancet Feb 2025) and in the UK in 2023 an average of 18 suicides a day, according to the Campaign Against Living Miserably. Suicide is rarely spoken about publicly and therefore alternatives to ending one's life do not seem real or possible. Val knew this; she did not want to die by suicide but she preferred it to trying to find a way to live when she thought about suicide all the time and dare not try to live with

family, though we offered. Val knew that she needed expert help and that the guilt she felt towards her family for all the worry meant she could not live with us. Being alone exacerbated her suicide ideation.

297. Val used to argue that people with chronic health conditions of the body other than the mind were allowed to be in long-term health care. Brain injuries were somehow not 'mental health'. It is the very definition of mental health that is the problem, though the mind is as physical part of us as any other. The suggestion remains that we should 'pull ourselves together' and not 'indulge' our depression. My last meeting with the shambolic EPUT ended with me being told that Val was not at the time of her death suffering from depression and I felt like I was in a surreal and crazy loop of my own, a Kafkaesque world of incompetent bureaucrats telling me my loved one took her own life on a whim of normal judgement, as if she was predisposed to it.

298. Val was a survivor. She lived through evacuation, poverty, her Dad not fully recovered from the shell-shock he suffered in World War One and her mam, abused by her husband, trying to gas herself and saved by Val. This did not make her more likely to kill herself – she knew that life could improve, even after everything that had happened.

299. I do not think that Val would have crashed her car had her psychiatrist not given her Zopiclone and Venlaflaxine; no one seems to want to hear this. The arguments against the over-prescription of drugs are side-lined, maybe because of the power of the pharmaceutical industry, maybe because of deference to medical experts. Drugs were not the answer for Val, they were the problem. With real, sustained talking therapy and therapeutic activities, Val could have lived to old age with dignity and some contentment, bringing joy to her four children, her five grandchildren, and to many people who knew her.

300. Val could not live with us or with herself. She needed, properly needed, a safe place away from the family, to be looked after by professionals who really wanted her to stay alive. She needed to be valued for who she was, with her depression and her occasional happiness just being part of that. Val needed to be heard and believed when she said suicide was her only option if she was not allowed to stay in hospital. One day she may have been well enough to leave, but not on October 9th 2015, which any kind person could have seen.

301. How could Val have survived when the grief and trauma over killing gorgeous Plum, her Border Collie, was so raw, when she had disabled her amazing independent self and caused so much pain to herself and those she loved? Just remember the facts – she had suicide ideation for some time from the Venlaflaxine and Zopiclone, was left for months with no support, and then after one not fully successful therapy session she actually drove her car head-on into a lorry, and her car burst into flames. That is mentally unwell. That is severe and extreme reaction to drugs. That is a health service that does not see the patient holistically but passes them from pillar to post, exacerbating their feelings of being a burden, eventually using all the time that is supposedly for therapeutic healing to only talk about discharge plans and how it is time to leave care. We just needed time as a family to process the shock and to try to find a solution for Val, and I do not believe that we were given that.

302. I don't think that our society values the lives of mentally unwell people enough to save them, to put the preservation of life over money and convenience. The figures suggest this is a global problem, not that it excuses EPUT for its dereliction of duty of care. Maybe we have lost true humanity altogether: we are seeing now, in 2025, a live-streamed genocide, over 20,000 Palestinian children slaughtered on our screens for almost two years; we know 25 million are starving in Sudan; Ukraine is attacked, the Congo is in turmoil and slave labour exists so we can have smart phones. What is a missed care-plan in all of this, we might wonder. Maybe it is just part of the whole problem of valuing some lives more than others, of putting an economic limit on the care of some, and not others. It is all despicable: our fellow humans know that society sees suicide as a cowardly way out but that they do little to truly stop it. I am shattered by Val's death, especially because she asked so often to be allowed to stay in hospital to get stronger, but was harassed every day in those last months, as the records show.

303. In my own life, the lack of compassion towards suicide is horrendous to experience. I was forced to teach Literature about suicide while Val was trying to find ways to kill herself; now, there is no real compassion or understanding of what this process has triggered for me, and I am denied time off to deal with the resurfacing grief. This is tiny, compared to what Val and the other people who took their lives while under the 'care' of EPUT will have felt when they acted on the belief that they could no longer live.

Recommendations for Change

304. The excuse that we 'can't stop' people from committing suicide is lazy and spurious. Of course more could be done if people were properly cared for – in the community, in well-run institutions which care for people as long as it takes for them to feel strong enough to go back into the world. Helping people to feel valued and valuable – that will help to reduce suicide.

305. The drug culture of mental health care must change. Families are the experts in many ways when it comes to helping family members: this was the reasoning of the Care in the Community, and it is not wrong, though families are not equipped to look after suicidal family members, especially when young children are in the house. I knew that Val was being adversely affected by the drugs – I knew her as drug-free for decades and then saw what the layer upon layer of drugs had done to her, was doing to her. No-one listened. Or they told me I was wrong. Diazepam three times a day? Lithium, which destroyed her beautiful handwriting, and her sense of self; Venlaflaxine, sneakily re-administered despite the suicide ideation it created in Val. And more.

306. Alternatives to drugs such as talking therapies, acupuncture, natural remedies and distracting activities as well as programmes such as voluntary work to help people feel useful and needed could save a lot of lives. We have moved away from asylums which recognised that being alone was not a good thing for many people who ere depressed or mentally unwell. When these institutions went wrong, instead of fixing them, they were closed down. But the problem – the abusive and uncompassionate people who may work with vulnerable people – has not gone. The health service – and EPUT in particular – needs to remove anyone who does not sincerely have the best interests of the patients at heart.

307. There needs to be no economic pressure on Trusts to remove patients to their homes if they are suicidal. The Rabone findings should be in all training to protect voluntary patients fully, and the driving force of all care, everywhere, should be the preservation of life and the well-being of every human in society. Melanie Rabone's parents suffered so much and remortgaged their house in their deep grief to make the point through the Supreme Court that voluntary patients should be fully protected by joined-up care to prevent suicide.

308. Leave plans, care plans, reviews etc should be fully standardised and digital, with no possibility of falsification. Failure to fill these in should be seen as a serious employment misdemeanour, as it would be if I failed to fill in a Child Protection Online

Monitoring System at school. Voluntary and 'sectioned' patients should be treated equally when it comes to preservation of life. There should, of course, be provision for hand-written copies in case of IT failure, which should also be compulsory.

309. Liaison at every level should happen with patients and families unless there is a safeguarding reason why this cannot happen. There should be no way that a ward manager such as **the WM** could prevent family members knowing of their love one's distress and situation. There should be no way that a staff member such as **the Matron** should be able to intimidate and bully a patient without there being easy access to 'whistleblowing' without fear of losing one's job.

310. Families should have online access to records (with the agreement of patients) so they can monitor the care of their loved ones. This should be easy enough in a digital age and would hold people to account.

311. There is an argument that some people are going to kill themselves and we cannot stop them. This is equivocation. Had we been informed of Val's suicide ideation before 9th October 2015, had we been told that she had requested a twelve-hour leave for the first time (other than one Christmas Day with us), Val would not have died that night in the way she did. Nothing anyone can say will change what we know about the shambles of Val's care, seen with our own eyes, evidenced in the medical records and the insulting Serious Incident Report. I hope this Statutory Inquiry is brave enough to speak truth for all our loved ones, so badly let down by EPUT.

312. Whether or not the Lampard Inquiry actually holds anyone to account, or changes things, it is good that mental health services have been scrutinised and that we have been able to voice our anger, frustration and sorrow over what happened with our loved ones, many of them bullied into taking their own lives, all of them suffering deeper than anyone should. All of this when they should have been looked after and convinced that their lives were worthwhile – or at least that this was properly, totally attempted. This is no more than a reasonable expectation of a reasonable society.

Statement of Truth

I believe that the facts stated in this Rule 9 Witness Statement are true.

Signed: [I/S]

Full Name: Sofia Dimoglou

Dated: 12/05/2025

List of Documents

I attach the following list of documents

Provided by client electronically

1. Ombudsman report 15.10.20
2. EPUT apology letter and offer of £500 13.11.20
3. Medical documents received from client
4. Serious incident investigation report and chronology 01.02.16
5. Inpatient Leave Procedure and Policy
6. Care programme approach CPA and non-CPA policy and procedure
7. Client questions for the coroner's office
8. Questions raised by family at a care plan meeting on 27.10.15
9. Recording of NHS SIR meeting 13.02.18
10. Clinical casenote history
11. Correspondence with North Essex Partnership Trust
12. Careplan progress note
13. Professional meeting notes
14. Assessment note, inpatient care note, leave plans, and others
15. Psychiatric report of Dr **[I/S]** for the Inquest

Provided by client as hard copies

16. Extracts of Medical Records with Comments
17. Clinical Notes Pertaining to Final Weeks
18. Inquest Bundle
19. Psychiatric Report Commissioned by Colchester Major Crime Team dated 08.08.2016
20. VERITA Quality Assurance Review of a Trust Internal Serious Incident Investigation into the Suicide of Ms D
21. Letter from NEP to Valery detailing what's covered in recent therapy dated 10.06.2015
22. EPUT records (298 pages missing from total of 822)
23. **WM** Note to Valery re Discharge
24. Note in glasses box