WITNESS STATEMENT OF MELANIE LEAHY PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **MELANIE LEAHY** [I/S] [I/S] am the partner of the late Colin Flatt (born on 30/01/1940 and died on 07/09/2021) **WILL SAY AS FOLLOWS:** -

2. I am making this statement based on my memory of events, and from having seen some of my late partner's medical records and reports written by various agencies, following his death.

3. An Inquest has listed for 17 August to 25 August 2026. Inevitably there will be more evidence to consider in due course and therefore this statement serves as my preliminary statement which of necessity can only be based on the evidence available at present. Once the Inquest has concluded, I would like to submit a further statement to ensure that the Inquiry is presented with all the relevant information and evidence to enable it to meet its terms of reference and ensure an effective and thorough Inquiry.

WHY I AM HERE TODAY

4. Colin was my partner of 19 years. He had been a professional footballer in his earlier years, and subsequently a very successful businessman. Together we were leading a full and happy life. We had both worked very hard all our lives and were looking forward to what would have been for him, his golden years. We had

many plans, including travelling the world together. All this came to an abrupt and brutal end, courtesy of the so called 'professionals' who were meant to provide care and treatment. Colin and I trusted them to give him the medical care that he needed. For reasons that I do not think I will ever understand, he was instead subjected to the most appalling neglect and abuse imaginable over a protracted period of time, which ultimately resulted in his death. I firmly believe that but for the numerous and gross failings in the care and medical treatment that Colin was subjected to, he would be here with me today. I believe (and the evidence submitted to this Inquiry – both the information contained in this statement and the documents listed in the Appendix will confirm this) that those meant to be looking after him, made Colin suffer unnecessarily and wilfully hastened his death.

5. The records, the body maps, and the documents I have submitted show one side of this story. But what I bring to the Inquiry is the other side: what I saw, what I heard, and what I know. I was there. I witnessed Colin's suffering with my own eyes. I know the truth of what was done to him, and I will not let it be denied or buried.

6. Colin was failed spectacularly and in every conceivable way: -
    i. Neither his physical or mental health was ever properly assessed by the clinical or nursing staff entrusted with his care.
    ii. He was placed in environments guaranteed to have a negative impact on his mental health, and it did.
    iii. His very basic care needs were neglected to such an extent that his physical health was inevitably going to worsen, and it did.

iv. His easily treatable physical conditions were at the very least allowed to deteriorate unchecked, if not actively worsened by the incompetence of those meant to be looking after him.

v. There was a blatant disregard for all legal processes designed to protect vulnerable individuals needing care such as the Mental Capacity Act (MCA) and the appointment of an Attorney under a Lasting Power of Attorney (LPA)

vi. He was subjected to inappropriate, excessive, and injurious use of physical restraints arguably amounting to assault and stripped of all dignity.

vii. Excess medication (this is expanded on and evidenced later in the statement).

viii. Safeguarding processes were not triggered, despite obvious injuries and abuse. I was not told the truth. Reports were contradictory, and staff tried to cover up what had happened.

7. The conditions that my poor Colin was subjected to, and the lack of proper care inevitably caused his mild confusion to worsen and then descend into ever increasing agitation and frustration. Instead of providing Colin with the care and treatment he needed, the chosen response of those looking after him, was to chemically sedate him. Once they had embarked on that trajectory, although I did not know it at the time, there was only one direction in which things could go.

8. Colin went into hospital in May 2021 seeking treatment for very minor and easily treatable health issues: earache and fatigue against a background of occasional and mild confusion. At worst he had an ear infection and chronic (as opposed to acute) heart disease. I firmly believe that if he had been given the care and

treatment, he both needed, and was entitled to, he would have been home in a few days or less. Instead, after some 3 ½ months he was dead.

9. I as his partner was at best ignored but more often treated as a 'troublemaker' and someone to be silenced by many if possible and in any event pushed aside as irrelevant. I should clarify here that it was mainly the more senior members of staff that this applied to. Some of the very junior staff were kind and tried to be helpful, but I noticed that they were scared and fearful of the more senior staff when they were around. It was clear from their behaviour when senior staff were around that they must have been told not to have anything to do with me, or something to that effect.

10. These are not wild assertions. I can and will evidence all the above.

WHAT HAPPENED.

11. Colin was 81 years of age when he was first admitted to hospital (and when he died a few months later). The fact that he was 81 might suggest to you that he was a doddery old man. He was not. He came from a family who lived well into their nineties: One of his sister's; Madeline died a week before Colin aged 91, and his other sister Pauline died recently aged 98.

12. After retiring from professional football, Colin had kept his fitness up. He was muscular and very strong. He would regularly go out at 6am on his bike to take our dog Jed out for a walk and/or run. He would carry out all the heavy-duty household chores such as mowing the lawn, cleaning the car and household maintenance. He played golf at least twice a week and drove his own car.

13. It is true that he was sometimes a bit confused, but this was a very mild confusion that was easily managed and did not impact on the quality of our life together. I have photographs of him in the months just prior to his hospital admission in May 2021 that show both his excellent physical shape and the quality of life he enjoyed. A selection of photographs is listed in the Appendix.

14. Colin was a larger-than-life personality, loved and very respected by many. Had he received the care and treatment he needed and was entitled to, I have no doubt that he would have enjoyed some more years of the very happy life we had together. All the evidence that I have collected to date (referenced in this statement) confirms this.

Admission and Diagnosis.

15. On Friday 21st May I called Colin's GP Surgery as I was getting a bit concerned about Colin's occasional confusion. The GP advised that Colin attend the surgery to have some blood tests. This was to be arranged but, in the event, did not happen as events overtook.

16. During the early afternoon of Tuesday 25 May 2021, Colin complained of earache, and feeling excessively tired. We checked his blood pressure which was fine but noted that his heart rate was consistently running at around 35 bpm. As is the case with very fit people, Colin did have a much lower resting heart rate than the average person, but this was now worryingly low. Colin then drove himself to the GP surgery. When he came home, he told me he had been sent home and told to call the 111 service for advice.

17. We called 111. The person we spoke to advised us to call an ambulance so that Colin could get properly checked out in hospital. We followed this advice and called an ambulance. An ambulance came fairly promptly.

18. Colin was taken to Broomfield Hospital Emergency Department. I was unable to accompany Colin due to COVID-19 restrictions in place at the time.

19. I understand that an electrocardiograph (ECG) was done which showed that Colin not only had a very low heart rate but also an abnormal heart rhythm (bigeminy) and acute coronary syndrome (ACS). Despite the occasional confusion which I have referred to above, I note that the doctor who reviewed Colin in the A & E Dept found him to be alert and "with *no confusion.*" This is consistent with my recollection.

20. When Colin left our home, he was fully with it. He understood that he was being taken to hospital, and he understood why. The following day, Colin seemed confused on the phone, and I became concerned that Colin might have a urinary tract infection (UTI). If so and if left untreated, I knew that this would cause/exacerbate any preexisting confusion particularly given that Colin was in an unfamiliar setting i.e. hospital rather than at home.

21. My understanding is that generally on admission to hospital a number of baseline observations are carried out, these include, blood pressure, pulse, temperature, and urinalysis. I therefore assumed a urine test would be carried out as part a routine A& E attendance, so that any infection would be picked up and treated with antibiotics. To the best of my knowledge Colin's urine was not tested in the A&E Department.

22. Colin was transferred to the acute medical unit (AMU) at 5.48pm that evening. I understand that by this time Colin was becoming visibly confused and it was determined that Colin should undergo a dementia assessment.

23. Colin was transferred to Turner ward on Wednesday 26th May 2021. A capacity assessment was carried out which determined that Colin did not have capacity. I asked to attend this assessment but wasn't allowed to.

24. Months later I found out why, during a conversation with my friend [I/S], she told me that I had not been allowed to attend the assessment as it had been carried out by a staff member who was known to a close family member of my friend and who was aware of my campaign.

25. I should explain that I had been campaigning for some years by this time for an Inquiry into my son's (Matthew Leahy) death – I will speak more about this in due course. My friend told me that the staff member who carried out the assessment did not want to be recognised by me. My friend also told me there was a lot of 'tittle tattle' circulating about me. I was both shocked by the lack of professionalism and very hurt by this gossip.

26. I understand that in this situation a Deprivation of Liberty Order (DOLs) should have been sought and in fact I was told that it had, but then subsequently found out that it hadn't.

27. After Colin's death after much effort and fighting on my part (I will talk more about this later) an investigation was commissioned by NHS England and carried out by Niche (an independent organisation). The report is headed 'An **independent investigation into the care and treatment of Colin 2021/ 16905'** and dated

April 2025. This report is referred to as the Niche report throughout the course of this statement and is referenced in the Appendix.

28. In relation to the state of play on the 26th of May, the Niche report (page 37 para 3.59) states: -

"The mental capacity assessment had confirmed that Colin did not have capacity to make decisions about his discharge, but a DOLs authorisation had not been requested at this time; Colin was therefore detained during this episode of care without a legal framework. This was in breach of his human rights under Article 5: 'Everyone has the right to liberty and security of person. No one should be deprived of his liberty save in the following cases and in accordance with procedure prescribed by law;' the procedure prescribed by law in this case would mean section under the Mental Health Act (MHA) or DOLs. A DOLs was required given Colin's lack of capacity but there should also have been consideration of an emergency psychiatric review given the violence and aggression that had been displayed and the associated risk to Colin and also other patients and staff."

29. I understand that later that evening, Colin tried to leave the hospital but was prevented from doing so. He got as far as the hospital atrium and was then 'escorted' back to his room by security officers who then remained stationed at his door. I spoke to Colin on the phone; Colin told me he wanted to come home; that he had tried to leave but had been pushed back and forcibly restrained. He also told me that he had been forced to take a couple of pills (one blue and the other a combination of orange and white).

30. I now know from his medical records that after being taken back to the ward Colin had become very agitated and had been given a sedative (lorazepam). I did not

know this at the time but then subsequently found out that the doctor who had prescribed the lorazepam Dr A was the same doctor who had been involved in Matthew's care. Dr A was the consultant psychiatrist responsible for my son's care when he was an inpatient at the Linden Centre in 2011 and 2012. Extremely unhappy about the care that Matthew had received I had reported Dr A to the GMC. It is inconceivable that Dr A would not have been aware of this. It was the care (or rather the lack of care) provided to my son, and that culminated in his death that was the trigger for this Inquiry.

31. Colin was moved to Terling Ward in the early hours of Thursday 27th May. Colin rang me that morning and told me that he had had some blood tests but still no urine test.

32. I went to the hospital later that day and was shocked to find Colin in the main atrium with four security guards guarding him. I could see a mass of bruises and some skin tears visibly covering both Colin's arms and wrists (the relevant photographs are referenced in the Appendix). Colin was so highly medicated that he did not know who I was.

33. I spoke to Dr [I/S] (the Consultant on the ward) and questioned the use of lorazepam without a DOLs in place. Dr [I/S] told me that he had not prescribed lorazepam and that it must have been given by the night staff. As stated above (paragraph 29) I later found out that Dr A had prescribed the lorazepam, without him even seeing Colin.

34. Dr [I/S] told me that Colin's diagnosis was heart failure. He explained that they had carried out a CT scan of Colin's head as well as a multitude of other tests. I was very worried that infection might be making Colin's confusion and his

consequent agitation worse and so specifically asked whether a urine test had been carried out yet. Dr [I/S] did not answer me and walked out of the room.

35. Colin told me that he was constipated, which I found very concerning as I understand that constipation if left untreated can also lead to confusion in older people. Colin also told me that he was having trouble urinating.

36. The Niche Report states (page 37 para 3.66): -

"*On 27 May it was also documented that Colin was now having trouble voiding urine and that advice would be sought from urology for an alternative to tamsulosin to manage Colin's benign prostatic hyperplasia (Colin had been prescribed tamsulosin prior to his admission and had stopped taking it as he thought it made him feel unwell). The referral to urology was appropriate but this was not actioned until 9 June at 9.55 am, 13 days later. This delay was unacceptable.*"

37. I repeatedly asked staff for a copy of the mental capacity assessment and DOLs authorisation, reminding them that I held a Lasting Power of Attorney (LPA). I explained that I needed this to help me deal with and manage Colin's financial affairs. My request fell on deaf ears. I was told that this assessment was for medical and health needs only. It felt as though staff were doing their utmost to be as unhelpful as possible – making what was already a very difficult time emotionally for me, extremely difficult on a practical level also. The Niche report (page 40 para 3.86) on this point states: -

"….. These responses were unhelpful for ML who should have been fully informed (and involved where possible) in the capacity assessments and DOLs requests for Colin. The MCA Code of Practice (Chapter 7) states: -

'Before making a decision under a personal welfare LPA the attorney must be sure that … the donor lacks the capacity to make the particular decision, or the attorney reasonably believes that the donor lacks capacity to take the decisions covered by the LPA (having applied the Act's principles).' We note 'the attorney must be sure' so the assessment should have been shared (or undertaken with ML present) so that ML understood why the care team felt he lacked capacity."

38. On the same page at para 3.67, the Niche Report goes on to state: -

"…. his urine should have been tested on admission due to the history of confusion. It was documented by the medics that Colin had his bowels open on 27 May, but we can see no reference to constipation being considered as a potential additional cause for the difficulties that he was experiencing. This is relevant as we can see no evidence of Colin's bowel habits being monitored by nursing staff ……... and Colin was found to be constipated three days later."

39. On Friday 28th May Colin was transferred to Bardfield Ward. I was told that this was to await a Mental Health Assessment. On Bardfield ward, Colin was put in a side room with two security guards outside. The room was the worst possible environment for anyone unwell but particularly so for someone like Colin. There was no possible stimulation or means of distraction. The television set in the room was broken and there was no radio. The window (weather wise it was very hot at that time) was made of frosted glass so you could not look outside and only opened two inches. The lighting in the room was excessively bright and the atmosphere in the room was stifling. Although there was air conditioning out in

the main ward, there was nothing in Colin's room, not even a fan. Colin might as well have been in a prison cell. To make matters worse there were some works being carried out outside, so there was the constant and unpleasant noise of hammering and drilling.

40. During his stay on Bardfield Ward, Colin was prescribed and given lorazepam, which seemed to cause profuse sweating and constant itching of his arms soon after he was given it, just adding to his agitation and confusion.

41. On Saturday 29th May, I asked a nurse [I/S] why the Mental Health Assessment that Colin had been referred for had not yet been done. It transpired that a referral had not yet been made as each set of ward staff thought the other was doing it. I understand that a referral was then made that afternoon.

42. On Sunday 30th May, Colin called me and said that his stomach hurt. I guessed that this was probably due to constipation. I spoke to one of the nursing staff and asked for Colin be given some fybogel (a laxative). I explained that this was something that Colin took twice a day at home and so it was inevitable that if he went without it for too long, he would become very constipated, which is exactly what happened. I recall asking for this on numerous occasions thereafter, but my requests were ignored. The fybogel never arrived. I understand from Colin's medical records that he was later given glycerol suppositories but do not know if they helped to any extent or if at all.

43. In desperation I even wrote to Dr [I/S] from Colins GP Practice (the email is referenced in the appendix): -

"I am extremely concerned for his welfare.

He takes a regular fybogel and senna...he has been with them two days and he is being given neither of these medications.

He has a huge hernia and has already had constipation which caused him immense pain and only last week Broomfield had to administer an emergency enema due to the very same issue.

As Power of attorney, I have tried to get his supply to the ward, but he is currently held in isolation, and I am being told no medicines can be brought to the ward.

He needs these medications regularly or he will have a problem.

Please call the ward as a matter of urgency and express your concerns. I do not want his hernia bursting and leading to a life-threatening situation due to the inadequacy of the psychiatric system."

44. I visited Colin later that afternoon and was very distressed by the state I found him in. He was extremely confused and not recognisable in any way as the Colin I knew and loved. I had never seen him like this before. I understand that he had been given more lorazepam. I strongly believe that Colin was being over medicated and that it was the combination of this together with his untreated constipation that was responsible for his extreme confusion and agitation which then translated into aggression. This is supported by the findings in the Niche report (page 42 para 3.105): -

"Colin was transferred to Bardfield ward on Friday (28 May), so did not receive a routine medical review over the weekend. At 7.45 pm on Sunday 30th May Colin was however seen by a FY2 doctor due to right iliac fossa abdominal pain. On examination, the doctor found Colin to be constipated, and suppositories were prescribed. Colin was already on laxatives for constipation, but additional regular or as required aperients were not prescribed despite ML raising concerns about ongoing constipation and Colin having difficulty voiding urine. The medical

records indicate that Colin had his bowels open on 27 May, but we can see no evidence of bowel charts being commenced to show that Colin's constipation had resolved. This is relevant as constipation is linked to acute states of confusion and delirium in the elderly hospital population; also, if someone has dementia, constipation is likely to make their dementia symptoms worse."

45. On Monday 31st May (a bank holiday) I was told that Dr [I/S] (psychiatrist) would come to see Colin to carry out a Mental Health Assessment that day. I waited with Colin all day, but she failed to show.

46. It was also now clear to me that Colin was continuing to have a lot of trouble urinating and reported this to the staff, but as far as I know, no action was taken. The following is noted in the Niche report (page 45 para 3.120 2nd bullet point):

"Colin reporting that he was having difficulty passing urine on 1 June. A bladder scan showed 103mls of residual urine and it was noted that the difficulties were potentially related to constipation but that he had also not been taking his tamsulosin, which had been prescribed previously for urine retention due to an enlarged prostate. Staff were advised to monitor his bladder at night, but fluid intake and output charts were not commenced and there was no care plan to ensure that staff understood the monitoring required."

47. By now I was in a complete state of chronic exhaustion and panic, I could see how much Colin was suffering. Despite all my very considerable efforts I was getting nowhere with getting anyone to listen to me. All I wanted was for Colin to get the care and treatment he needed and for those responsible for his care to work together and with me to put a proper plan in place to ensure optimum mental and physical health going forwards. I have a handwritten note of me

pouring out my feelings and frustration – the note was written on Tuesday 1st June and is a contemporaneous record of what I was going through. The contents of the note are copied below: - (my original handwritten note is referenced in the appendix).

"Tues

I broke this morning on phone to Colin's daughter *said I don't think I can cope Was trying so hard to get Colin to a care home if they insisted, he should stay in place of safety. Keep asking if you had made a will and that care home would be expensive.*

Said she and his son *could have Colin at their house, I suggested I move out as no care package here. Not happy when suggested* Colin's son *came to stay and I did not agree.*

Then told that Colin owned half of house. I didn't need that not helpful - they worried about how much money it could cost for care home! What the fuck my darling Colin has worked hard for all his money - if it was needed to give him the best care - it would be used for that! I'm so sad. I am scared. I am so frightened and love Colin so very much.

'Darling please stay strong - I love you so much! If you need care, I will pay it if your family don't agree to me spending your own money on you. So sad.

Later at hospital I met **Colin's children** *and was asked if you had Colin had made a will again and power of attorney.*

I told the truth this time and 'yes and there is no way Colin is going to the Crystal Center. If they want to move him, he will go to a care home until they have his meds sorted.'

Colin's daughter *was very upset and angry that she hadn't known. I told her that I was respecting Colins decision he had made it a number of years ago - it was not for me to tell her. It was Colins decision - I hope he is not angry with me that I told*

her, but what a good decision he made – this upset all about money + wills! What about my beautiful Colin and doing the best for him?

My poor Colin has been to hell and back and for what - he had a slow heartbeat, and this week will have scared us all for life.

So, I went in and spent the day with him until 8.30 - I'm so sad Colin was crying – why are they so cruel - I just hate what they are doing - I'm home now with Jed - we miss Colin so much.

Dear God, please please bring him back home to us. Please keep him safe - my love for him is so sincere lord - please give me the strength to cope. I can't take this either Lord. Why are we being so tested? Why lord? Haven't we been through enough? Please lord bring him home - I want to cuddle him, love him, and keep him safe. I can't at the moment.

Why is this happening!

Why?

My love is poorly please please lord, look after him. Send angels lord - the most powerful you have. Send them to help him lord - please xxxx,

It 11pm - Colin must be sleeping. I can't eat I can't stop worrying - I'm so very sad.

the psychiatrist should have come today. They failed to turn up or even say they not coming. Its shit. but what can I do - I tried to discharge today they told me I couldn't - even with power of attorney I have don't have the power over their order of the state."

48. On Thursday 3rd June, I saw new and extensive bruising on Colin's abdomen in the area where he had a pre-existing hernia. I spoke to staff about it and was told it was due to the blood thinning injections that Colin was getting. I did not understand why they would choose to give these injections into the area of the hernia. At my request, Colin was then seen by a doctor and the injections

stopped – which made no sense to me. If he needed blood thinning medication, then surely, he should have it, but in appropriate area.

49. The findings in the Niche report (page 42 para 3.108) echo my concerns: -

"On 3rd June, it was noted by ML that Colin had bruising on his right lower abdominal quadrant (near his preexisting hernia), medical staff believed this to be a result of the enoxaparin injections that he had been receiving. This was reviewed by a doctor, who examined Colin and directed staff to observe for changes in the size of the bruising and to call the doctor again if there were further concerns. We can see no evidence of this being referenced again; the enoxaparin medication was discontinued the following day, but no rationale included in the medical record. The bruising was not included on a body map despite one being readily available on the daily rounding charts that were completed for Colin."

50. On Friday 4th June the MHLT carried out a mental capacity assessment, with the ward consultant present. Again, I was not allowed to be present for this assessment despite holding an LPA. The assessment concluded that Colin did not have the capacity to make decisions about discharge from hospital. I spoke to Dr **[I/S]** after the assessment and told her that Colin needed people he could talk to - the room he was in, had no radio and a broken TV. Colin was not a reader and so books the only thing that he could have been provided with, were not a viable option. He would have happily chatted to the security guards (still stationed outside his room) but they were mostly foreign and spoke little if any English and spent most of their shift looking at their mobile phones. I was acutely aware that all of these factors taken together with a background of confusion and unfamiliar surroundings would inevitably increase Colin's agitation and frustration

which would then equally inevitably result in aggression and lashing out behaviour. As far as I am aware my concerns did not result in any meaningful change.

51. On Saturday 5th June Dr [I/S] called me to tell me that Colin had Alzheimer's disease and that she had put Colin on regular lorazepam. I explained what I had witnessed previously when Colin had been given lorazepam. I told Dr [I/S] that lorazepam seemed to exacerbate Colin's confusion and made him extremely agitated. It also made him sweaty and itchy, and he would then have trouble sleeping. It was clear to me that the drugs that they were giving Colin were turning a mild and gentle man into a monster but nothing I said made any difference. The staff were determined to treat Colin like an out-of-control animal that could only be managed by pumping him full of drugs.

52. In the Niche report (page 44 para 3.116) the use of these drugs is commented on as follows: -

"*While it is recognised that there are occasions when pharmacological interventions are required, benzodiazepines such as lorazepam can increase paradoxical agitation (some older adults can become disinhibited or more restless when given these drugs, confusion can increase and there is potential for cognitive decline to be accelerated…….. Understanding the causes of adverse behaviours and addressing them before offering regular treatment can prevent things from getting worse and prevent any harm. Behavioural charts were requested for Colin, but we can see no evidence of any planned distraction techniques being employed, which may have helped to orientate Colin or prevent or manage his episodes of agitation and aggression before the use of regular medication.*"

53. On the same themes, the Niche report continues (page 45 para 3.120, 3rd bullet point): -

"Colin continuing to have security staff present at all times but without a plan of care to help them (or nursing staff) to understand what interested him, which activities might help to distract him from wanting to go home, the approaches that might help him to prevent him becoming agitated, violent and aggressive, or the types of restrictive practices that could be employed. ML said that Colin was accommodated in a side room with a broken television and no radio. He did not read, the lighting was very bright during the day, and the windows frosted, with workmen hammering and drilling continuously (Colin confirmed this to EPUT Consultant Psychiatrist during assessment on 2nd June). It would therefore have been all the more important for staff to know how to keep Colin from becoming bored and agitated by being confined to his room and the corridor of his ward. The MHLT queried Alzheimer's disease as being the cause for Colin's confusion on 2nd June, and the Trust's Care or Patients with Dementia Policy 2020 describes some key principles for patients with dementia. These include requiring staff to liaise with family and carers to establish normal routines, to use 'This is me' to personalise care and to try to identify what triggers a patient's particular mood or behaviour and what interventions might help resolve them. We can see no evidence of normal routines being discussed with family or the 'This is me booklet' being completed at this time."

54. It was around this time that discussions began to take place around the best place for Colin to go following discharge. I recall a ward manager, [I/S], [I/S] saying to me that she did not know why Colin was on the ward at all; that she had not been given any particular instructions in relation to his care, and

that as far as she was aware, he was only there to wait for a mental health assessment.

55. On Sunday 6th June, Colin was assessed for transfer to a care home. I note from the contemporaneous diary that I had been keeping (which forms part of my statement prepared for the Inquest), that I had remained on the ward that day until around 8.45pm when I was asked to leave, Colin became very upset and did not want me to go as he had no one to talk to. He had been kept in what effectively amounted to solitary confinement for some eleven days by this time.

56. I understand that there was an incident that night and when I spoke to the ward manager the following afternoon, I asked whether Colin had had his medication the day before. The ward manager [I/S] checked Colin's notes and told me that lorazepam had been given at 6pm. This cannot have been true – I had been sitting with Colin from 2pm to 8.45pm. I had learned to know when Colin had been given lorazepam, as within 15 minutes of administration he would start to sweat profusely, he would have to lie down and would become extremely confused and muddled in his conversation.

57. I recall that a female nurse had come by when I was there, I witnessed her breaking a pill in half and putting half into a white pot and the other half in a yellow bucket on her trolley. I think she may also have put some other pills into the white pot. This pot was placed on Colin's bedside table/locker and the member of staff then left. She did not return during the period that I was there. When I left Colin, the medication was still where she had left it.

58. Colin's physical and mental health continued to visibly deteriorate but no one seemed to care. On Tuesday 8th June, in a lucid moment, Colin told me that if he

was kept confined in this way for much longer, he was going to kill himself. I was extremely worried by this as I was aware that Colin had both a razor and a belt in his possession. I met with Dr [I/S] and told her that Colin had been talking about killing himself, I also told her about the belt and the razor. Dr [I/S] said she would have these items removed. When I visited the next day, these items were still there and so I removed them myself. My concerns were ignored. The Niche report (page 45 para 3.121 comments: -

"…. it was clear that ML was indicating significant risk for Colin. His mental state should have been reassessed to determine his mental capacity and suicide risk; however, we can see no evidence or MHLT or medical or nursing teams having a discussion with Colin to ask him about his suicidal intent and to determine whether there was an urgent need for the MHA assessment to be undertaken that day. A risk assessment should also have been undertaken in response to the concerns raised and his room searched to ensure that potentially harmful items had been removed (including an assessment of ligature points). Colin's level of observation should then have been reviewed with consideration about whether a side room was the best environment for him. We can see no evidence of these actions being undertaken, this left Colin at risk of self- harm."

59. On Wednesday 9th June 2021, I arrived on the ward at around 9.30am. I was devastated to find Colin incoherent and unable to walk – to my mind this very sudden and acute deterioration in both his mental and physical state could only be as a result of excessive medication.

60. I was told that Colin had been given 4mg of lorazepam. I was also told that he had tried to leave the ward and been restrained. I thought that Colin looked very dehydrated and wondered if he was getting enough to drink/how he was

managing with urinating. [I/S] (one of the security guards) told me that they (he and the other security guard) had been up and down all-night helping Colin to the toilet as he could not walk on his own. He also told me that Colin was struggling to urinate at all. I was so stunned by the state that Colin was in, that I took a video. This video and others are listed in the Appendix to my statement.

61. I should explain here, that this is not something I would normally have done but I had learned the very hard way, based on my experience of the care and treatment provided to my late son Matthew (whose story will be shared with this Inquiry in a separate statement) – that if you could not show evidence, then it hadn't happened.

62. At around 10am that same day, a psychiatric assessment was carried out. I could not believe that this was even considered to be appropriate at that time, given the state Colin was in. I asked to be present for the assessment and was refused yet again. I kept reminding staff that I held Power of Attorney for Colin's health and welfare, but no one was the least bit interested – they held all the power in this situation and in my view repeatedly abused it.

63. As a consequence of the assessment, I was told that Colin was going to be to be detained under Section 2 of the MHA and transferred to Goodmayes Hospital. The approved mental health professional (AMPH) told me that she would write to Goodmayes and ask them to let me have extended visiting hours so that I could spend more time with Colin.

64. I now know she did no such thing. I have seen the email she wrote - what she did say to staff at Goodmayes was that I was not acting in Colin's best interests. Fortunately, the staff at Goodmayes assessed the situation for themselves and

concluded that I was acting in Colin's best interests. The email correspondence evidencing this is referenced in the Appendix.

65. I was very unhappy with the decision to place Colin under section and the transfer to Goodmayes; I had gone through a great deal of agonising in respect of what would be the best option for Colin once he was discharged from hospital. Whilst I very much wanted him home, I did not think I would be able to manage to look after him until he was a bit more stable. I had therefore looked for and found a suitable care home to enable this to happen and give me some time to get our home sorted to accommodate Colin's needs better. However, the fact that Colin had been sectioned, meant that this was no longer possible.

66. I had to watch helplessly as Colin was taken by four security guards, in a highly medicated state, unable to walk unaided, to an ambulance. I was not allowed to go with him and was told that I could not visit him at Goodmayes because of Covid restrictions.

67. Colin was admitted to Stage ward. I called to ensure that he had arrived safely and was told that he had, but that they had not received any documentation from Broomfield Hospital regarding what medication Colin had been prescribed or what he had already be given that day, so they had simply given him some more lorazepam.

68. I understand that Colin's son **[I/S]** tried to visit the following day (Thursday 10th June) but had been refused any access to Colin – even to meeting him outside the hospital.

69. In desperation, I wrote to Paul Scott (CEO of EPUT), and Claire Panniker (CEO of Mid and South Essex NHS Trust) and the CEO of NELFT. A copy of my email sent on 11th June 2021 is referenced in the Appendix. I decided to express my concerns by way of a formal complaint as no one was listening to me, and I thought a formal complaint might have some effect. I set out my concerns ending with a plea for help: -

"All I want is for Colin to get the care and treatment that he needs in a supportive and caring environment am willing to pay for the same. Can you please look into what has gone on/ is going on and tell me why despite being cared for by professionals, Colin's mental and physical health is deteriorating and why I am not being allowed to be involved in his care plan. Given the circumstances, I would appreciate your looking into this matter as a matter of some urgency."

70. All I got by way of a response from EPUT was: -

    I. Initially an acknowledgement and signposting to the Patients Liaison service (PALS) and then when I chased: *"Thank you for your email. I can assure you that this is being looked into and a response should be with you shortly."*

71. And from NELFT, an acknowledgement and a request for a copy of the LPA. A substantive response never came.

72. During his stay on Stage Ward, I understand Colin was consistently very confused and disoriented, which sometimes led to violent outbursts and then Colin being sedated. I wrote to the ward asking for Colin to be discharged, as I did not believe the ward was the best place to help him.

73. On Sunday 13th June Colin called me; he told me that he was very scared and that the staff were threatening him. He told me that he thought was he was being threatened because he was being associated with my campaign for a statutory inquiry into Matthew's death. He told me to tell staff that he had nothing to do with it and to be careful myself as I could be in danger. I tried to speak to a doctor but was told there were not doctors available over the weekend.

74. On Monday 14th June, Colin called me at around 1am. He was very distressed; he told me that staff had been pushing and shoving him and that he was frightened for his life. He told me that he thought one of his fingers had been broken. I tried to reassure Colin and said I would speak to staff and find out what was going on. Before I could do anything, Colin called again and told me that he had been beaten up and asked me to call the Police.

75. I called the ward and was then called back by the Deputy ward manager [I/S]. She told me that Colin had been assisted back to his room without physical contact. She also told me that Colin had reported being pushed in his hernia area and that he had urinated in the corridor. Colin had never done anything like this in his life. I felt powerless and scared for him and began to fear that he would not come out of this alive. I called back later that day and spoke to a ward manager [I/S]. She told me that Colin had been physically restrained by the emergency team. This completely contradicted what Deputy Ward Manager had told me.

76. At 1pm on Tuesday 15th June I attended a virtual meeting with Dr [I/S] Dr [I/S] told me that they had picked up a heart problem known as atrial fibrillation (AF) but when she had called Broomfield Hospital to discuss this, she was told that they had not picked up any heart issues. She also informed me that she did

not receive Colin's discharge summary from Broomfield Hospital until 14th June. As a result, Colin had been receiving two different types of prostate medications.

77. On Thursday 17th June 2021 a Mental Health Tribunal was held which concluded that Colin could be discharged home to my care.

78. Colin was discharged home the same day, arriving home around 7pm. By this time Colin was a shell of his former self as can be seen in the selection of photographs listed in the Appendix.

79. Colin came home in a what was obviously a highly medicated state, but without the medication he would need thereafter. Three of my friends had kindly agreed to come and stay with me for a few days to help me settle Colin back at home. We spent a lot of time running around trying to get all that he needed. We struggled but managed to get all the medication he needed to cover him for that evening and night, by around 9.30pm.

80. When I gave Colin the prescribed medication it had the effect of knocking him out completely. He was on the sofa at the time, and it soon became clear that he needed to pee, but he could not get up and so he rolled onto his side and pee'd where he was. It took all four of us (my friends and I) to transfer him from the sofa and onto the bed. It was when I undressed him that I saw that he was covered in bruises (a photograph is in the appendix).

81. Because of his prostrate problems, Colin kept getting the urge to pee but could not get up to go to the toilet and I couldn't get him up, so I ended up getting a bin and helping him try to pee into that. We both got little (if any) sleep that night.

82. The following morning, I called the ward to chase for the missing medication, and to question the bruising. After much to-ing and fro-ing Colin's medication arrived by courier later that afternoon.

83. I asked [I/S] (Deputy Ward manager of Stage ward) about the bruises, but she was unable and unwilling to give me any answers.

84. For the few days that Colin was at home, he was placed under the care of the EPUT Dementia Intensive Support service (DISS). I believe he was seen some four times during the period 18th – 21st June.

85. During these visits, whoever came would chat with Colin for a short time, which was all well and good, but all the visiting took place during working hours i.e. 9 - 5 hours. I was told if we had a crisis out of hours, we would need to go to A&E or call the police/ambulance.

86. On Saturday 19th June, Colin walked into the kitchen and collapsed. He was still on the floor when the Dementia Team arrived. They phoned Colin's GP practice to make an appointment for me to take Colin to see his GP to review his medication. They then left. Looking back, I am astonished that they thought it was acceptable to leave me to cope with dealing with all that. At the time I was too exhausted and overwhelmed to question this and just followed their advice as best I could. With the help of my friends, and considerable difficulty, we managed to get Colin into the car.

87. Colin's GP (Dr [I/S]) was reluctant to change his medication. I asked Dr [I/S] to body map Colin's bruises, he explained that that was not something he could

undertake and suggested that I keep a note of the bruising, so I took photographs of them myself. These photographs are referenced in the Appendix.

88. Throughout Colin's stay at home, I was helped considerably by my friends. Despite this, Colin remained agitated and disorientated and on Sunday 20th June he managed to leave the house in the evening. My friends and I went out looking for him but failed to find him. We then informed the Police who also went out looking for him. Colin must have somehow worked out that he was lost as he flagged down a car which coincidentally turned out to be the police who were looking for him. The police brought him back.

89. From memory, there were three or four officers with him. These officers (from Essex police) were really kind and helpful. They sat with me for a while, had a cup of tea with me, and chatted. They had seen the bruises on Colin's body and advised me to make a complaint. They told me that they had come across many cases of abuse from Goodmayes Hospital before.

90. I duly reported the bruising to the Met Police via an online form **(Merlin Incident [I/S]** I got call back from an officer **[I/S]** who asked for more information, so I sent him photographs and videos. A series of telephone calls and communications via email followed with no results. During one of these conversations Officer **[I/S]** told me that the staff at the hospital had not allowed him entry and so that was that, maybe I would have better luck. I found this response bewildering but was at a loss as to how to get the police to take things seriously.

91. The complete recording itself is referenced in the Appendix. Relevant extracts of the transcript (with superfluous sections of exchange removed here in the interest of avoiding the unnecessary lengthening this statement) are set out below:

92. **First extract**

i. **"PC [I/S]**: *How're you doing? You alright?*

ii. **Melanie**: *I'm not too bad, thank you.*

iii. **PC [I/S]**: *No worries. Sorry for the delay [muffled]. I've been trying to investigate this case; it's a bit lengthy.*

iv. **Melanie**: *Mm*

v. **PC [I/S]**: *Er, I've been speaking to a few nurses at Goodmayes.*

vi. **Melanie**: *Yeah*

vii. **PC [I/S]**: *In the hopes to try and get some sort of like a care log, uh you know...10 am: Colin woke up...11 am, that kind of thing. Um, I've been able to have a look at the care log. I've been read the care log out to me. Um, admittedly, there is no concerns on the care log. Um, which…*

viii. **Melanie**: *[dry laugh] that's a surprise.*

ix. **PC [I/S]**: *was surprising to me. Which is funny that, isn't it? Like..*

x. **Melanie**: *Yeah*

xi. **PC [I/S]**: *you wouldn't suspect they're doing…which is unfortunate done that. But obviously, they're going to have to cover themselves, aren't they?*

xii. **Melanie**: *Yes.*

xiii. **PC [I/S]**: *Um, unfortunately as well, there is no CCTV, you know, where the bedrooms he was staying so we can't get him on that one.*

xiv. **Melanie**: *Yeah*

xv. **PC [I/S]**: *Uh, it's gonna be difficult to progress this matter obviously because we would've had multiple suspects but there's not gonna be one*

nurse doing what she was doing. It's gonna be all of them, its gonna be like a group.

xvi. **Melanie**: *Well, she said on the phone call that she has the team so who were the team? ……. ……. Yeah, she said on the phone call that the team… the team from the other ward were called so you need to know who the other team were.*

xvii. **PC [I/S]**: *Yeah, exactly that. And, you know, she also said that, when I was speaking to her on the phone, that, I'm sure you're aware of this, that Colin had some tendencies, you know, like to lash out a little bit and be a bit short-tempered.*

xviii. **Melanie**: *He's…He's he has dementia.*

xix. **PC [I/S]**: *Yeah, exactly.*

xx. **Melanie**: *Yeah, and that gives them no right to do a physical restraint like they've done there. Absolutely none.*

xxi. **PC [I/S]**: *Absolutely.*

xxii. **Melanie**: *So, what're you trying to tell me?*

xxiii. **PC [I/S]**: *Well, no, at this stage, what we're gonna do is we're gonna raise our concerns with the hospital because Goodmayes in general, isn't just your case, Goodmayes in general are pretty awful with dealing stuff like this like other dealings with Goodmayes, they just don't sort it out for you.*

xxiv. **Melanie**: *Yeah, well, this is an assault so I wanna know who was on that ward, who the people were for that team, the nurse that called me has clearly lied um in her phone call to me telling me that she called that team and that it was just to persuade him into his room. So, she's clearly lied.*

xxv. **PC [I/S]**: *Yep.*

xxvi. **Melanie**: *Right, um yeah, I need this to go further.*

xxvii. **PC [I/S]**: *Yeah no, I understand. At this stage, that's what I'm trying to find out, but at this stage, what I'm doing is I'm putting out a MERLIN Report for Colin. Um, it's basically a report we get um which basically raises awareness for his condition and what he's been through and obviously, if need be, it can be raised to multi-agencies. Um, so if you, you know, bring this back up two months down the line and say, you know, Colin's condition is getting worse um then you'll reference the MERLIN number and say 'look the MERLIN number has been put on um there's already concerns about Colin and I'll need this to go further'.*

xxviii. **Melanie**: *Right, well, Colin's condition is getting worse. And I do need it to go further,*

xxix. *did he deserve bruises like he's got? You're telling me that that's acceptable?*

xxx. **PC [I/S]** *No, I don't think so at all. Goodmayes is an organisation, though and absolutely terrible…….*

xxxi. **Melanie**: *Then someone needs to make a stand. I don't know if you're aware but, you probably aren't, but put my name in Google, have a look. I fight for the mental health system; my son was murdered within the mental health system at 20 years of age within seven days of entering the system. I refuse to sit back and allow them to do the same to my 81-year-old partner. He's totally traumatised by his experience.*

xxxii. **PC [I/S]** *100%, I couldn't agree more. I personally-*

xxxiii. **Melanie**: *And these people, unless they are brought out, and actually made to answer for their actions, it will continue.*

xxxiv. **PC [I/S]** *100%.*

xxxv. **Melanie**: *You know… so, go back to whoever is above you. I'd like to talk to whoever is above you, your supervisor himself….."*

93. **Second extract.**

i. **"Sergeant [I/S]**: *This is Sergeant* **[I/S]** *from the Metropolitan Police, how are you?*

ii. **Melanie***: I'm not too happy at the moment…….*

iii. **[I/S]** *Okay. So, you're a sergeant, yeah so you're aware of the situation, no doubt?*

iv. **Sergeant [I/S]**: *Yeah, yeah, fairly aware of the situation.*

v. **Melanie:** *Okay. ….. Well, yeah, I mean uh…I uh…was encouraged to speak to, to put this complaint through, by an Essex police officer that used to work on your team um dealing a lot with Goodmayes and she said it's absolutely disgusting there um and unless somebody makes a stand, and creates some accountability, it will continue so…*

vi. **Sergeant [I/S]**: *Yeah, so, obviously I don't know what the conversation was that you had with my officer. Uh, have you currently raised issue with the Care Quality Commission?*

vii. **Melanie:** *Not yet, that will be my next move.*

viii. **Sergeant [I/S]**: *That should be the first point of call that is made in relation to… is he your husband, sorry?*

ix. **Melanie:** *He's my partner.*

x. **Sergeant [I/S]**: *Your partner.*

xi. **Melanie***: But no, it's not the first point of call. I've been through this process um, for the last 12 years…well, 10 years sorry, um corporate manslaughter, the whole lot within the mental health system and the Care Quality Commission, I'm not wasting my time with them just yet. This is a, this is clearly an assault um.*

xii. **Sergeant [I/S]**: *So, I'll explain to you where the, this station's got yet [muffled]*

xiii. **Melanie***: Alright love, thank you.*

xiv. **Sergent [I/S]**: *So, so there's no CCTV available of it, so what must've done is ask for the care logs for your partner.*

xv. **Melanie**: *Mhm*

xvi. **Sergeant [I/S]**: *To be made available. So, the care logs, at the moment, are obviously the only line of inquiry we've got in relation to what's happened while he's there, for the time he's been in care at Goodmayes.*

xvii. **Melanie:** *Okay so, let me stop you there. You might have the care logs, he actually was on one-to-one observation so that means one member of staff was observing him for 24 hours, so they would have done maybe one-hour, two-hour shift and then it changes to the next person.*

xviii. **Sergeant [I/S]**: *Yeah, yeah. I spoke to the ward manager already.*

xix. **Melanie**: *Right, well, she's a liar. Yeah, we proved that by her phone call to me. So, one person would have been observing Colin at that hour where the situation occurred between uh whatever it was, 12 and one…? I'll have to look…*

xx. **Sergeant [I/S]**: *Yeah, yeah.*

xxi. **Melanie**: *So, that person is suspect number one. Now, in the phone call, she says how she called the emergency team from the other ward, so we need to know who was on that emergency team because they have jumped all over my partner.*

xxii. **Sergeant [I/S]**: *Right, so, the investigation at the moment will be for the care logs to be ascertained. Now, the officer's been to Goodmayes-*

xxiii. **Melanie**: *Yeah*

xxiv. **Sergeant [I/S]** *And unfortunately, to get the care logs, we have to do, to book the appointment to view the care log. What they wanted to do initially was to read them over the phone, but unfortunately, evidentially, that's not good enough. So, we need a copy of the care logs to be able to review them.*

xxv. **Melanie**: *Yeah*

xxvi. **Sergeant** [I/S] *So, in the care log, it should say, obviously, staff member A, staff member B, this is what's happened, timescales. Now, because there's no CCTV, we can only go over there and shuffle through care logs. And that's what we need to do.*

xxvii. **Melanie**: *Right.*

xxviii. **Sergeant** [I/S] *Now, as you're aware, as you've already said, you know Goodmayes is not in a good state. Unfortunately, that takes time.*

xxix. **Melanie**: *Of course, yeah.*

xxx. **Sergeant** [I/S] *Nothing is a quick process ……*

xxxi. *Unfortunately, what we'd love to be able to do and what we can actually do are separate things. Um, so we have to be able to have the evidence. I mean, you've seen on the news yourself, multiple times, where you see horrific things and you think 'ah, that's gonna be really easy' and then, they go to court and the court goes 'ah no, there's not enough evidence.'*

xxxii. **Melanie**: *Well, I know. I've been through a four-and-a-half-year corporate manslaughter case.*

xxxiii. **Sergeant** [I/S] *Yeah, it's just ridiculous. We spend months and months on investigations ad of course, they go to court, and the court goes 'na, not enough.'*

xxxiv. ……...

xxxv. *I was just gonna say [laughs] It's not just old people. We have uh multiple cases but to be honest with you, the normal protocol is for uh the case files we put together and it gets put forward to the Care Quality Commission um because that's one of the protocols that we have to follow.*

xxxvi. **Melanie**: *Yeah, I know. I've been through the whole lot of these people…yeah, we just won a case uh it's no accountability to health and safety executive just sued the trust for one point five million after 11 deaths it's taken me…seven years to prove it.*

xxxvii. **Sergeant [I/S]**: *Yeah, yeah well that certainly will be outside the remit of my investigation …. - to be honest with you [laughs] we're not really dealing with a seven-year investigation that's for sure*

xxxviii. ……..

xxxix. *well, to be fair, I've seen [muffled] on this investigation team for just over two years, and it is very rare that you are successful against any NHS trust. I'm not talking about Goodmayes, because it is very difficult to deal with and you are dealing with such a large-scale violation and the majority of the time, we do our investigations, we don't have enough evidence to meet the review criteria for [muffled], but then obviously it puts the people in a better position for going towards the Quality Commission and the trust. Um, because once you get, once you actually get accepted by the trust as a quality of care, then obviously they have to deal with it because then it's sanctioned.*

xl. **Melanie**: *Hmm*

xli. ……..

xlii. **Sergeant [I/S]** *Um, I understand your concerns. The care log will be reviewed. Now, it is to [muffled] on these crime reports [muffled] but I will make sure. [distant] Can you put on that one as* **[I/S]** *to contact Goodma… [to Melanie] sorry, I'm just talking to my officer. [distant] and contact them now, [muffled] the ward manager and request this Thursday for the care log to made available and if they're not made available, then we'll just go down there. Yeah? Cool.*

xliii. **Melanie**: *Good man."*

xliv. ……..

xlv. **Sergeant [I/S]** *Um, so let my officer get on with what he needs to do, and we'll be back in contact with you. Alright?*

xlvi. **Melanie**: *Yeah, I appreciate your time. Thank you"*

94. To the best of my knowledge, the Met Police did nothing further. Colin died. On the 16th of September Officer [I/S] sent his condolences and that seemed to be the end of the investigation if one could even call it an investigation.

95. In any event, going back to the events of 20th June, it was then clear to me that I would not be able to look after Colin and keep him safe at home, until his condition was more stable. I therefore researched into suitable care homes that Colin could go to in order to be stabilised on his medication. My thinking was that he could go for a couple of weeks and then come home on a good regime of medication that worked for him.

96. On Monday 21st of June Colin was admitted to Woodland View Care Home. This was after considerable struggle on my part to find a suitable care home, there was no support from Social Services. At the same time, I understand that responsibility for Colin's mental health care was transferred from EPUT Dementia Intensive Support service (DISS) to the EPUT Dementia Intensive Support Team (DIST).

97. On Thursday 24th June, I reported some concerns to both the Woodland View Care staff and the Dementia Care nurse [I/S], these included yellowing in Colin's eyes and the fact that Colin's medication did not seem to be working for Colin very effectively. It wasn't helping to stabilise him, just knocking him out. As far as I am aware none of my concerns were acted upon.

98. In respect of medication, the Niche report (page 65 para 3.269) comments: -

"*Medicines reconciliation and medicines management was poor at the care home. The medicines administration charts and nursing notes indicated that*

Colin's blood pressure and continence medications (ramipril and tamsulosin) were unavailable for a period of 4 days between 30 June and 3rd July while arrangements were made for these to be restocked, and on 6th July the drug chart indicated that no medications were given but not why".

99. I also had a telephone conversation with Doctor [I/S] who had assessed Colin later that day. We discussed Colin and my concerns. Dr [I/S] told me that he could not see any evidence of mental deterioration and was of the view that Colin may have been suffering from delirium. He told me that he had noticed Colin scratching his left ear during his assessment and found green discharge emanating from it. Dr [I/S] followed up by confirming his findings in a letter to me dated 25/06/21 (referenced in the Appendix).

100. The relevant extracts are copied below: -

"After the assessment, I was able to feedback to you on the assessment. I did not see any acute evidence of deterioration and aggression at the assessment, although Mr Flatt had clearly experienced these difficulties previously.

I explained the possibility of an episode of delirium due to urinary retention at that time. Mr Flatt did not have any sign of confusion …

I would just like to add that, at the assessment, there was evidence of a green discharge and itchiness in the left ear, and I will be arranging for a review in primary care."

101. As far as I am aware, no such review took place.

102. [I/S] the Care Home manager telephoned me on Tuesday 29th June and told me that Colin had been aggressive on the previous Saturday (26th) and that

he had been discussed by the Dementia Team. She told me that they had decided that Colin was "too well" and that this care home was inappropriate for his needs. She told me our contract would expire on 5th of July and that I needed to find him somewhere else.

103. On 30th June, I had a conversation with a nurse from the Dementia Team. I asked her about this discussion, and she said that no such discussion had taken place.

104. I cannot prove this to be the case, but I feel very sure that my recent appearance on national television in connection with the Health and Safety Executive (HSE) prosecution of the Trust (in connection with 11 inpatient deaths, one of which was my son Matthew) played at least some part in the Care Home's sudden change in attitude towards me and Colin. A link to the coverage is referenced in the Appendix.

105. I was then in a position where I had to desperately try and find somewhere else and fast. I was panicking and desperate to try and get some help, but I wasn't given any. The only help I was given by Colin's social worker [I/S] [I/S] was the names of a few places that might have availability, and if there was none, I was told he would have to go back to hospital which was untenable. I contacted them all and was told that none of them could cater for Colin's needs.

106. After much searching by myself, I finally found somewhere that would take him. Colin was transferred to Anisha Grange Care Home on Wednesday 7th July 2021. My understanding was that an urgent DoLs authorisation was made by the nursing home on acceptance to their residence. On arrival at the Care Home, we

were told that there had been an outbreak of COVID-19 in the care home and visits were not permitted.

107. I believe that initially Colin had settled in reasonably well. Thereafter, however things changed. On 14th July 2021 I understand Colin became agitated, wanting to go home. He managed to abscond through a locked door, even though he was supposed to be receiving one-to-one care and be under close supervision. Colin was given large doses of Clonazepam, to sedate him.

108. In the meantime, I was becoming increasingly concerned about the delay in Colin seeing a cardiologist. I wrote to a number of agencies to try and get Colin a cardiology referral: -

"I appreciate the effort that is going in to try to keep Colin safe and get him to some calmer place throughout the 24-hr day.

Colin has and is struggling with anxiety and it appears medication change is being delayed due to cardiac specialist being required.

The clonazepam only does so much, as we all know.

I have been requesting a cardiac specialist review the heart medication since the weekend of 19th June 2021, when the psychiatrist **[I/S]** *from the Essex crisis team requested an URGENT referral.*

It's now the 20th July 2021. That's 31 days and still no review of cardiac medication has happened.

I am aware an ecg was done as a matter of urgency day two after arrival at Anisha Grange…. why is my Colin still waiting and in so much distress and on the verge of an inpatient stay? (Which I am trying to avoid with every breath of my being

Had this issue been addressed sooner surely some control of his mood may have been obtained.

What happened with the ecg? Has it been sitting in a box gathering dust? In one breath I'm told the doctor sees no concerns with the ecg and then Dr **[I/S]** *herself tells me she is concerned and doesn't like the look of it!*

I have spoken with the crisis team **[I/S]** *Doctor* **[I/S]** *and* **[I/S]** *today…I am aware a zoom meeting is to be convened.*

This needs to be done tomorrow as a matter of urgency and my suggestion that Colin is taken to Basildon hospital (cardiac specialists of Essex) as an urgent cardiac case remains… .. I'm no expert but even I can see that his distress grows by the day.

Colins anxiety is beyond waiting another few weeks for a referral, his cardiac review needs to be done now and fast.

I look forward to hearing a meeting is to be convened tomorrow (Wednesday 21st July) and not delayed until Friday (as per whisperings I have heard.) Also to hear a cardiac review has been confirmed for this week. So that medication if Colin is suitable can be changed before the weekend and not after.

I'm also very concerned that the lowering of the mamentin may have exasperated Colins anxiety? When is it due to increase?."

109. On 21st July 2021, despite being on 1:1, Colin absconded again through an unlocked garden gate. Police returned Colin to the home and stayed until paramedics arrived to review him. Colin was then taken to Basildon Hospital due to abnormal findings on his ECG.

110. I had in fact been asking for some time for Colin to be referred to a cardiologist to assess the health of his heart both generally (he was known to

have heart disease and abnormal rhythms as set out in paras 19 and 77) and in the context of all the antipsychotic medication he was receiving.

111. So, although it had taken this incident to escalate being seen, I was glad that finally his heart was going to be checked.

112. Due again to Covid, I was not allowed to go with Colin either in the ambulance or be with him when he arrived at the hospital. I understand from his medical records that he arrived there at 3.44pm. A capacity assessment was carried out at 7.15pm in order to enable them to carry out a CT scan under sedation.

113. I understand that he was then transferred to the acute medical unit (AMU) / Osler ward in the early hours of the following morning.

114. The comments made by Niche (page 77 para 3.355) speak to the details of that admission and the shortcomings in care: -

"When Colin arrived in the department, a CT head scan had been requested by the medics, and a mental capacity assessment was completed to allow the CT head scan to be undertaken. This was in line with the requirements of the Trust's Consent to Examination or Treatment Policy and also the Mental Capacity Act (MCA). The concerns which triggered the assessment were that Colin may have intracranial bleeding following his fall., but the capacity assessment did not include a description of how the assessment was carried out, how the decision was made or about any interaction with Colin (or his family) in relation to this. The section about the potential requirement for an independent medical capacity advocate (IMCA) was left blank as was the section about the best interest

decision and involvement of family or lasting power of attorney (LPA)……...

Colin became violent and aggressive at 7.40pm. He had been in the emergency department for four hours. It is recorded in the progress notes that he was given IV diazepam and an incident form completed (2361) by the nursing staff in line with the Trust's Policy for the Management of Incidents and Serious Incidents (2019): this was categorised as 'safeguarding adults – chemical restraint'. The form states that 'security had to be called and assisted; however, it does not include whether any physical restraint was also required. An incident form was not submitted by the security team to clarify event. Absence of this information will have limited the ability of senior managers to understand whether proportionate restrictions were placed on Colin when reviewing the chemical restraint Datix incident form, and we can see no evidence of this information being requested during that review."

115. The Niche report goes on to state (page 78 para 3.361): -

"Colin arrived in the emergency department at 3.44pm and was transferred to the AMU at 4.50 am. The reasons for this extended stay were not specified in the clinical records, and we can see no reference to his nutrition and hydration needs being met, but the length of time spent in this busy emergency department and the transfer in the early hours of the morning would have been detrimental and unsettling for him"

116. During this admission Colin's condition seemed to deteriorate further. On the 24th of July Colin was transferred to Florence Nightingale Ward. Again, this was inexplicably in the early hours of the morning around 1am. Worryingly, at the time the ward was also being used to treat Covid patients.

117. I spoke to a nurse [I/S] later that day. I told her that I understood that Colin had been given Haloperidol the night before, against my very clearly expressed request that Colin (on the basis of the authority that I held by virtue of Power of attorney) was not to be given Haloperidol. She told me that a mental capacity assessment had been carried out and that it "trumped" the Power of Attorney. I was told that a Dr [I/S] had prescribed it. Somehow, I found Dr [I/S] on what was then known as Twitter and asked him about it. Dr [I/S] told me that he had not been on duty and that junior doctors must have been using his name and that they did this (use his name to sign off medication being prescribed) at weekends. He also told me this was being investigated. I have screen shots of this conversation via text – the screen shots are listed in the Appendix. I heard nothing further.

118. The nurse also told me that Clonazepam had been prescribed for Colin but that they did not have any on the ward yet to give him. I also understood from what she said that Colin wasn't getting his usual medications either.

119. With regards to this transfer at 1am, the Niche report (page 87 para 3.426) comments: -

"*Colin was transferred from the AMU to Nightingale ward at 1 am. This was despite the Care of Patients with Dementia Policy (2020) stating that patients with dementia must not be moved within the ward or between wards unless clinically indicated between 8pm and 8 am. The decision to transfer Colin had been made at the 5pm review meeting on 23rd July yet he was not moved until 8 hours later. As mentioned before this would have been very unsettling for Colin, and shortly after transfer, Colin started to become very agitated. Security were called and they helped to deescalate the aggression although they did not submit an incident*

form and details of the de-escalation techniques employees used were not included in the form (2612) that was submitted by the nursing staff, which was reported under the subcategory 'security attendance for restrictive intervention' . The local Restrictive Intervention Review section of the Datix was left blank and the form closed without further questions being asked."

120. On the 25th of July, I met Colin's doctor in the corridor and asked why Colin was not being given his usual medications. The doctor told me that they do not do clonazepam on this ward and did not have Colin's medication to hand. I told the doctor that I was worried about the fact that the ward door was not kept locked as this meant that Colin could get out and onto the main road – which in his current very confused state would be very dangerous both for him and road users.

121. I also spoke to [I/S] the Ward manager about these concerns. She told me that she had not known that Colin was at risk of absconding and that she had minimal staff to look after 28 patients. I think the point she was trying to make was that the staff could not watch everyone all of the time.

122. She then told me earlier that Colin had become very agitated and walked straight out of the ward. He had returned on his own accord and then left again.

123. The second time he had gone outside he had not returned and so the Police had been called. In the event [I/S] (Colin's daughter) when visiting later had found him in the grounds at around 2pm. He was in a terrible state, scared, confused, and covered in cuts and grazes (photograph referenced in the appendix). She emailed me about this and told me that the police had been on the ward and advised staff to keep the ward doors locked. The staff had duly locked them only to then re-open them when the police had left.

124. Following this incident (and the behaviour that Colin had been exhibiting earlier), another mental health capacity assessment was undertaken, which was clearly an inadequate if not a pointless exercise. It is described in the Niche Report (page 88 para 3.432): -

"A Foundation Year 1 (FY1) doctor completed a mental capacity assessment after these incidents had occurred, but it is not clear what these were for. In the section marked 'what is the specific decision relevant to this MCA,' they wrote 'aggressive patient. Absconding. Aggressive to staff.' In the section describing why this decision could not be delayed, they again wrote 'Aggressive absconding.' As with many other mental capacity assessments for Colin, the independent medical capacity advocate (IMCA) and 'best interest decision' section of the capacity assessment was left blank, and the lack of understanding of the MCA and best interests decision processes would have meant that the capacity assessment was not valid for any decision – making purposes."

125. The findings of the Niche report in relation to the way in which the hospital staff dealt with Colin's mental health/capacity issues make it very clear that the staff had minimal understanding if any of the MHA, the concept of Best Interest decisions or the significance of an LPA (page 89 para 3.433): -

"On return to the ward, the ward doctor prescribed IM lorazepam in consultation with the on-call registrar and 1mg was given IM, but ML contacted the ward to say that she did not want him to have this medication. The doctor was informed and replied that Colin had MCA/DoLs in place and that this isn't the partner's decision; this is a medical decision.' This was incorrect. The mental capacity assessment did not include the purpose, and we can see no evidence of an

assessment of Colin's capacity to make decisions about his care and treatment (other than for the CT scan when in the emergency department). Also, ML was Colin's attorney and held a valid LPA and could make decisions regarding medication (if it had been determined that Colin did not have capacity in relation to this). As stated previously, if ML's requests were against the perceived medical opinion the MCA makes provision for this through the use of best interests' meetings /mediation and ultimately Court of Protection applications or referrals to the Office of the Public Guardian."

126. On 26th July I spoke to Colin on the phone. His speech was very slurred. He was clearly confused and distressed and kept talking about suicide. I called the ward around 8am to report my concerns and find out what is going on. I was told that the doctors would do their ward rounds at 9am and that once Colin had been given the 'all clear' he would be assessed by the Mental Health Team. I kept calling repeatedly throughout the course of the day to find out the outcome, but no information was forthcoming.

127. I spoke to Colin's daughter at some point that day who told me that she had spoken to a number of people (staff). She had been told that Colin had been declared medically fit and was now waiting for the Mental Health Team to do an assessment and for the Complex Care Team to find him accommodation. She also told me that apparently a note had been put on the file to remind them to speak to me re Colin's background. I did not hear anything back from staff directly.

128. Given my telephone conversation with Colin earlier, it was obvious to me that he was not at all well and I did not understand how the staff looking after him could not see that.

129. On 27th July 2021, I received another very worrying call from Colin – he sounded desperate. He told me that he had had enough and was going to kill himself. In a panic I phoned the ward and told a member of staff (that I now know to be [I/S]) that Colin had phoned me and said he would kill himself. He was very rude. I told him that I wanted to speak to the ward manager. He refused, he said that I was not a nurse, and that they knew what they were doing. He ended the call by putting the phone down on me. I then spoke to another person who identified herself to me as the discharge facilitator, and who then did exactly the same i.e. put the phone down on me.

130. Finally, some hours later, I managed to speak to [I/S] the ward manager. I played her the recording I had made of Colin over the phone saying he wanted to kill himself. She agreed with me in that the ward was not a safe enough environment for Colin.

131. I was becoming increasingly worried, so I drove down to Basildon Hospital. I had a meeting with [I/S] the ward manager and a junior doctor whose name I cannot recall. I explained Colin's history and how I believed the medication to be affecting him.

132. I then went to see Colin on the ward. Colin was waiting for me with packed bags and seemed to think he was coming home with me. Initially he was very anxious but then became quite aggressive towards me. I did not feel safe and so I left at around 3pm. Before I left, I asked the ward manager to call security as I was also worried about Colin's safety. The ward manager told me she would.

133. Approximately 10 minutes after I left, I got a call and was told that Colin had fallen from the fire escape. I later found out that this was not the case; that in fact Colin had stabbed himself with some scissors and then run out of the ward and fallen over the main atrium stairwell. I went straight back to the hospital. I was shown to a room and left there. After a few minutes I went outside to the atrium area and was just walking around when someone who looked like a patient told me that that someone had fallen there.

134. A nurse then came to find me and took me to Colin. Colin was in the resuscitation area of A&E. I understand that he had arrived there at 4.01pm. One of the doctors told me that Colin had stabbed himself but that the wound was superficial. It didn't look superficial to me. I could see blood seeping through. I lifted Colin's top up and showed the doctor what was happening – Colin's abdomen was getting bigger and bigger.

135. The Niche Team have done their best to establish exactly what happened but were unable to establish a definitive account – this is deeply troubling. What they do say in the report is (Page 91 para 3.447 onwards): -

"*The incident is described in different ways in the clinical records (in incident reports 2977 and 2984) and in staff statements. In relation to the fall there is reference to Colin having both fallen and jumped, with additional comments about self-harm and a suicide attempt. There is no closed -circuit television coverage to corroborate the version of events. It is clear that Colin was on a mission to escape and that his mental capacity was impaired. Several staff have said that they witnessed him leaning over the rail and falling headfirst.*

We have not been able to definitively establish if his fall was intentional (i.e. he understood the consequences of a fall from a height) unintentional (i.e. he had

not appreciated the drop having determined to go over the obstacle) or accidental (i.e. that he could not stop the momentum of the fall after leaning over the rail). Beyond the incident reports, an initial Management Review was undertaken by a matron on 10 August 2021. This was 20 days after the incident despite the Policy for the Management of Incidents and Serious incidents (2019) requiring this to be undertaken within 3 days of a serious incident being declared. This review was incomplete.

In particular we note: The absence of an initial analysis to determine whether any immediate actions to maintain patient safety and reduce the risk of recurrence were required or undertaken; this section of the report was left blank. There is no evidence for example of the stairs being immediately assessed to ensure no potential risk to other patients. There was no description of the scissors. We have been unable to gain a full description of the scissors that Colin stabbed himself with but have been told that they were craft scissors. A photograph or full description of the scissors should have been included within reporting to ensure they were appropriate for use on the ward.

The sections on the legal status of the patient and describing how staff were involved were being supported was left blank despite this being a traumatic event and these details being a requirement of the form.

There is reference to a safeguarding alert being raised but with no details of the outcome despite this being a requirement of the form.

The duty of candour section did not include whether an initial verbal apology and explanation had been given to Colin (and his family), and we can see no evidence of this statutory requirement having been discharged within the medical records.

The level of harm was not recorded (although recognised as a serious incident). This was reviewed by the Executive Review Group who stated that this would be determined during an investigation. Colin had fallen from a height, had

embolization of an epigastric bleed and was in ITU at that time; in our view severe harm was evident at that time."

136. Worryingly, the evidence in relation to this is extremely inconsistent. In addition to the concerns raised by Niche, I have seen a post-incident statement prepared by nurse **[I/S]**, referring to a 'knife.'

137. After the fall I contacted the police to ask for CCTV footage as I wanted to understand how this had happened. Whoever it was that I spoke told me that, the police could not simply ask for CCTV footage unless it was a criminal matter.

138. When I spoke to Colin (who was fully conscious) in the A&E (resus) department, he told me that he was feeling scared, he thought he was being chased and so he had run to get away. He said he had run down the stairs and didn't see the glass at the end. The impression he gave me, was that he was frightened and running to get away and out of what felt like captivity to him.

139. The Niche team visited the site as part of their investigation and noted: -

"We visited the site and walked the route that Colin took before he fell. The optics of the staircase are such that when approaching the barrier, the top (transparent line) of the balcony exactly matches the window opposite and there is an illusion that the atrium is not far below. At some angles, the view can be interpreted (especially likely if someone is confused or visually impaired) as leading directly outside at the same level."

140. In the A&E department Colin was found to be in urinary retention and to have a *"massive abdominal wall haematoma."* The need for urgent surgery was raised but not followed through on.

141. There then seemed to be endless delays with the doctors seemingly trying to work out the best course of action. In the event it was decided at around 5am the following day that Colin should now have the urgent surgery that they had been discussing. However, it then transpired that the hospital did not have the necessary staff available and so the surgery was delayed further.

142. When Colin was finally taken to theatre a man who identified himself at the Head of A&E came to speak to me and Colin's son [I/S]. He laughingly apologised, saying "*sorry about the delay, lessons learned and all that….*" We were both shocked by his blasé attitude.

143. I remained with Colin up until he underwent surgery. Colin's level of distress and discomfort had steadily increased throughout. Finally at around 12.30pm (28 July) Colin underwent embolization of his right inferior epigastric artery.

144. The delay in making a decision caused Colin a significant degree of avoidable suffering and was agonizing for me to watch. In the event, I started experiencing chest pain, which was subsequently diagnosed as angina, and I ended up being admitted to hospital and put in a bed beside Colin with my heart being monitored.

145. In the Niche report it states: - (page 98 paras 3.513 – 3.514 & 3.518): -

"There was a lack of collective and assertive decision- making and ownership of Colin by the IR [Interventional radiologist], ITU, anaesthetic and surgical teams despite him having come to significant harm while in the care of the Trust.

The embolization should have been instigated much earlier, but as an absolute minimum, Colin should have been transferred to a high dependency unit (HDU) or close monitoring bay to allow further assessment and stabilisation to occur …… …… Notably, these unacceptable delays and 'handoffs' were similarly recognised by the emergency department staff, who documented their concerns in an incident report"

146. Relevant extracts of the Incident Report: -

"Under surgical care for abdominal wound/bleeding. Surgical team not happy to take over care as previously under medics. After multiple consultations they agreed to take him under their care after repeated CT abdomen. Patient became hypotensive and escalated to surgical team. Decision made to give Beriplex and blood transfusion to optimise surgery. Patient became aggressive and agitated. Surgical team decided not to perform surgery but to refer to IR due to multiple previous surgeries. IR not happy to take care of patient as unsafe to do so being too agitated. Called surgical team again to due to IR saying he needed surgery. Surgical team then escalated to ITU as unsafe to keep patient on ward due to agitation – midazolam given with no effect.

ITU refused to admit patient and stated patient needed urgent IR. Surgical team contacted again. Nursing team organised ITU, IR and surgical meeting to make a collaborative decision. The output was for patient to go to IR under general anaesthetic. IR stated that unable to do procedure until 8 am. Patient has been in the Emergency Department for 15 hours, not clerked by surgical team for 15 hours, delays in making decision from surgical team, delays in reply to escalation

from surgical team, lack of leadership and management in the whole process resulting in patient being uncomfortable and agitated."

147. The Niche Report continues: -

"The emergency department incident form concluded the outcome was 'no harm' and a 'near miss.' It is our understanding this is an initial grading and the delays , increased agitation, pain and distress that were noted for Colin will be taken into account one the Niche investigation has been completed, and it is linked to the incident form that was submitted for the fall. The full grading of the incident is yet to be determined but Colin developed a haematoma which increased in size after his fall, his abdomen became infected and by 5 August a fistula had formed; in our view this was serious harm".

148. I was told that following the surgery and after the requisite time in recovery, Colin would be taken to the Intensive Care Unit (ITU). I was also told that Colin needed to keep his legs straight for a minimum of 5 days to allow healing.

149. At around 7pm I telephoned the hospital and was told that Colin had had the surgery and had been taken to Colne ward. I spoke to [I/S] the ward manager on Colne who told me that the plan had been for Colin to go to ITU but that there had been no beds. He said that he had initially been told the operation had been cancelled but that it had in fact then gone ahead in the hope that a bed would become available; it hadn't. He was unable to tell me where Colin was, he was effectively 'missing.'

150. Frantically I phoned around, but no one could tell me where he was. Finally, around 9pm, I found out that Colin was on Bulphan ward.

151. On Bulphan ward, Colin was placed in a room with five other males which given his mental health was far from ideal. Although he was being given regular pain relief, he was clearly still experiencing a lot of pain. There was talk of discharging Colin as soon as he was medically stable.

152. I understand that Colin was reviewed on the 30th of July by the specialist registrar (SpR) and a plan documented to the effect that Colin was now medically safe for discharge but subject to review by the EPUT Mental Health Liaison Team (MHLT).

153. In the event it transpired that the mental health review could not take place as Colin's blood results were "*deranged*." Colin was becoming increasingly agitated and aggressive and that notwithstanding the blood results the SpR contacted the on-call psychiatrist to come and assess Colin for transfer as he was apparently surgically fit to go. When the MHLT arrived, I prevented their access to Colin. Thankfully they agreed and confirmed that Colin could not go to a mental health ward as his bloods were deranged and he was not medically fit for transfer.

154. This lack of any joined-up thinking is made clear in the Niche report (page 103 para 3.563: -

"*During these 2 days, there were multiple comments about Colin having no acute surgical problem and that his elevated CRP was due to tissue damage, 'however, he is also on antibiotics'. Colin had fallen from a height, had a haematoma with extensive abdominal bruising, and had undergone an embolization of his epigastric artery, complications of which are known to be bleeding or infection. He had a significantly elevated and rising CRP and WCC. The absence of clinical*

stability was evident including to the MHLT, who were asked again to assess Colin for an MHA assessment. It would appear that the focus was on Colin's behaviours and confusion rather than his underlying and deteriorating physical condition. He became increasingly agitated, and his physiological parameters varied significantly with episodes of hypotension, tachycardia, and pyrexia; however, delirium was not documented as being considered by the surgical team despite his presentation and the behaviours displayed."

155. During his stay on Bulphan ward, I would invariably find Colin in an absolutely appalling condition. He would be naked, sweating, distressed and often laying on urine-soaked sheets. There never seemed to be enough staff on duty to look after him properly. I found myself having to take over a lot of his care needs as there simply weren't the staff around. This was noted in the Niche report which states (page 113 para 3.167): -

"While we recognise the benefits of family being able to support patients while in hospital, using them to achieve safe staffing levels was unacceptable, particularly given the violence and aggression being displayed by Colin. Safety concerns should have been incident reported, and a meeting held with senior medical and nursing staff to discuss the options available to the ward."

156. It was not only very difficult as in exhausting for me, but also heartbreaking for me to see the man I loved reduced to the state he was in. He was not aware of himself, or his surroundings - constantly naked – all sense of dignity gone.

157. I was getting increasingly concerned that Colin had a wound infection and was worried that his would be exacerbating his confusion and agitation. I kept raising these concerns to staff, but no one was listening. On the morning of 31st

July, I told staff that Colin was sweating, in pain and getting very upset, I was struggling to manage him and needed some help. The response was: - "*We are not mental health trained. We are only general nurses and surgery*," and I was left on my own with Colin. When I asked how I was expected to manage a nurse [I/S] said, "*I don't know, but we are just as frustrated as you, that we haven't got the help we need either"* and "*we don't normally deal with this either."*

158. That entire weekend (Saturday 31st July/Sunday 1st August) I must have stopped at least 19 or 20 attempts at restraints being used. Each time that the staff considered using them, it was wholly inappropriate – the staff simply didn't understand (or try to) the cause of Colin's agitation and try to remedy that first. For example, Colin would be sleeping and wet himself and then wake up all agitated. I was able to calm him down by telling him it was okay, that we simply needed to sort him out. I would then get him cleaned up and into new clothes and change the bedsheets. He would then relax and go back to sleep.

159. I was very unhappy with the lack of care being afforded to Colin and asked that staff escalate the situation. I was told that it had already been escalated to the medical team and senior managers and that they were struggling to find the right care/staff for Colin.

160. The Niche report states (page 113 para 3.618) notes: -

"*On 31 July, the on-call manager was asked to see ML who remained concerned about the care Colin was receiving. Her concerns were about staffing, an ECG being performed inappropriately, observations not being taken, sepsis /infection, plans for mental health, sedation, physiological monitoring after 'rapid sedation' and wound review. ML was advised that staff could not update her on a*

permanent basis and that video and recording of Colin and conversations with staff were not permitted. ML was told that bloods were being regularly reviewed and that Colin was on a broad-spectrum antibiotic. She was also told that sepsis pathway triggers were in place, and the abdominal wound had been reviewed by the team, with no signs of infection. An agreement was made to have touch points for updates, although the frequency of these were not specified and we can see no evidence of proactive meetings being held with ML after this time. These responses were not accurate: serious concerns had been raised by ML, many of which had foundation, yet a safeguarding concern was not raised. Colin continued to deteriorate, and further harm was caused to him and other staff."

161. I understand that Colin was reviewed again by the MLHT later that day (31st July), who confirmed that Colin was not fit for discharge. The appalling conditions and lack of care continued.

162. That same afternoon I noted that Colin seemed to be hallucinating, reaching out for things that are not visible. I was horrified to learn later that Colin had been given penicillin. Colin was allergic to penicillin and had in fact been wearing a band on his wrist stating this. I had previously seen [I/S] (Director of Nursing) cut it off and remove it from Colin's wrist the day before, prior to the surgery and I assumed it was in preparation for a 2nd surgical procedure that I had been told would be taking place. This seemed to be confirmed by a doctor that came to see Colin at around 3pm. I think this doctor was called Dr [I/S] Director of Nursing was also present. Dr [I/S] said that Colin needed an ITU bed. Director of Nursing asked when, to which Dr [I/S] said post procedure. Despite this, later when Colin was in ITU (transferred on 4th August – see para 167) and I asked doctors about this procedure, they almost laughed when they told me that there had been no plan for any further procedures, and that he had

simply been placed on ITU to contain him. I now know from Colin's medical records that a 2nd procedure was considered and decided against. I found this lack of clear and respectful communication deeply distressing.

163. On Monday 2nd August Colin was reviewed on the ward round. His abdomen was swollen on the right side, and he was in pain and agitated. The next day, Colin was reviewed by the medical specialist registrar, who noted that his inflammatory markers and haematoma were increasing.

164. In desperation I wrote to Colin's social worker [I/S] to whom I have been expressing my concerns and seeking help from for some time. The content of my email dated 2nd August timed at 09.50am is reproduced below and referenced in the Appendix.

"*I continually ask for ur help*

I understand the ward nurse has today asked for your help.

I have not left hospital since Friday and this lack of social worker input is disgraceful.

A call to ward to request discharge meeting is not enough.

I spent 2 ½ hours trying to get hold of social services without any joy.

I have emailed multiple staff and nothing.

A safeguarding meeting must be raised immediately.

Colin is being failed here at Basildon Hospital

Escalate without delay

I will have no problem publishing this chain of ignored emails if I see no action to assist today.

You must get over here to see what is going on"

165. The social worker responded later that morning at 11.06am. I have not reproduced the entirety of her email as the main point she makes is that social care will not get involved until Colin is "deemed fit for discharge." However, she does go on to say: -

"Please be advised that a safeguard has been raised by Anisha Grange and I have requested a safeguard is raised by Florence Nightingale ward also. These safeguards will come to social care to investigate. If you feel a third safeguard should be raised, please provide any addition information and I will look into this….."

166. My response sent that evening was short but heartfelt, I was beside myself with anxiety and fear for Colin's life: -

"A third safeguard.. most definitely
The care has been no better than torture
It's too much to write down here
You will need to come down and do an interview and record me.
He will die because of this appalling care."

167. On Wednesday 4th August, Colin became extremely agitated. He was desperate for a drink of water having been kept nil by mouth for some time now. He saw a sink in the corridor and went for it to try and get a drink. The simple act of trying to geta desperately needed drink of water, resulted in him being restrained by three security staff and held on the floor in the neighbouring room for over an hour and a half, whilst senior directors and doctors attended the ward to discuss what to do with him. Whilst he was being restrained Director of Nursing who was present at the scene, arranged for maintenance services

to come and take the sink in his room away. Colin was confused, agitated and trying desperately to get away from the security staff. It was utter chaos on the ward. Colin had been medicated yet further and was in his room fighting to get out of the window. I watched as the Director of Nursing locked him in his room. Colin went into a ball into the corner of his room and fell asleep. They had to get a hoist to get him back into the bed and continued to restrain him forcibly. As a result of the restraint, Colin's haematoma burst, and he was transferred to ITU. Things were going from being dire to unbelievably worse (a photograph is listed in the appendix).

168. I wrote again to Clare Panniker, the content of my email sent on 5th August at 07.57am (reproduced below and referenced in the Appendix) is self-explanatory: -

"Yesterday evening after repeated requests from both myself and staff on Bulphan ward, Mr Colin Flatt 30/01/1940 was transferred over to Basildon ICU.I called this morning at 6 am ..only to find that he is not being given all life sustaining care he can be, as a dnr has been placed on his by the doctor. The doctor did not explain that care would be withheld from Colin. I do not agree – as his power of attorney. He is not being given medication for his blood pressure, and I do not know what else. I insist this dnr is revoked immediately I did not sign any dnr.

Your trust is trying to kill my partner and has been doing so since his arrival to Basildon Hospital.

Please confirm receipt of this email and that the consultant has removed the dnr and Colin gets all the care he is entitled to and deserves."

169. My email was acknowledged by [I/S] (Senior Executive secretary) and after many further exchanges over a period of several days, I believe that the DNR was removed, at least for the time being. In terms of care, it remained as appalling as before.

170. I turned again to the police for help. I telephoned and spoke to Police Constable [I/S] and followed this up with an email. The content of my email sent on 7th August to Essex Police (which was also copied to Colin's children; [I/S]) is reproduced below and referenced in the Appendix: -

"Further to our conversation with regards you seizing cctv of the fall at Basildon Hospital and asking some questions.

On Sunday night I went to the ward at 11.30 pm.

Colin was being held in his bed at a 45-degree angle by two security guards, with absolutely no nursing care. Urine-soaked sheets. And completely naked.

He was being repeatedly restrained over the week. He was in immense pain.

On Monday morning, despite repeated requests for laxatives since Friday, staff had to do and emergency enema.

After this Colin's tummy started to grow.

I took this picture on Tuesday lunchtime [a picture showing how horribly distended Colin's abdomen was, was copied into the email]

He was in agony and very confused.

By Wednesday when I went to the ward .. copious amounts of blood were coming out of his stomach.. straight out … It had burst.

Yesterday in a call with social services .. I am told Colin was restrained by security and they burst it during this restraint.

This is and has been inhumane treatment by unqualified staff.

I am told that it is suspected that Colin has had an infection since the start of this horrendous journey and it was not picked up and merely treated as a mental illness.

He currently now resides in ICU in a life-threatening position."

171. I received a response from PC **[I/S]** the following day: -

"Melanie,

I have received your email, and I will be forwarding it to our safeguarding team who are currently dealing with the investigation regarding the potential neglectful care of Colin."

172. Even I who was witnessing much of what was going on and being appalled by it, did not know how bad things were. Some of the findings in the Niche report filled me with (and continue to haunt me) horror at what my poor Colin suffered at the hands of those looking after him. The Niche report is 218 pages long and it would not make sense to repeat every appalling finding here when it is referenced in the Appendix and needs to be read in its entirety by the Inquiry team and Chair. However, I have set out below a brief extract which gives an

indication of the chaotic management of a very sick man (page 118 paragraphs 3.663, 3.664 & 3.665): -

"*On 7 August, a doctor was asked to review Colin (untimed) as faecal matter was 'pouring out of the abdominal wall' (abdominal diagrams indicate this was on the right quadrant of Colin's abdomen). A stoma bag was placed over this wound entry, which was separate to the fistula that had already formed. At 3.30pm, results were received from microbiology for blood culture samples that had been sent on 5th August. These indicated that Colin had klebsiella infection and he was to continue receiving tazocin.*

From this point there are some confused entries about the two wounds on Colin's abdomen with ward round sheets depicting different positions and descriptions. There was no commentary about the source of the second wound site, and we have been unable to ascertain whether this was the original stab site. On 4 August, nurses referred to two dressings, one midline which was blood soiled and one upper right quadrant that was mildly soiled. On 9 August, nursing staff documentation included 'two puncture wounds collecting into stoma bags draining a lot', but when reviewed by the SpR, the notes indicate that the right quadrant wound had drained 250mls and the midline fistula 'negligible'. By 12 August, the right quadrant was draining a small amount of pus, while the midline fistula was draining bowel content. ***The MHLT reviewed Colin that day and documented that no one was able to clarify what both bags were for.***

On 13 August, both stoma bags were draining faeces. Daily ward round notes from 13 to 16 August did not include wound markings, but on 17 August only one (midline) wound was depicted, and it is unclear what happened to the second right quadrant opening….".

173. I have put emphasis (bold type) on the last few lines of that extract as even now I find it hard to accept that, that such poor practice is taking place in an 'intensive care' setting. My poor Colin, who was a fighter, didn't stand a chance.

174. On a separate note, I must make clear that I did not find out that Colin had klebsiella until after his death. Klebsiella is bacterial infection that is spread by person to person contact and can lead to serious illness and complications. Fortunately, neither my friends or I got infected, but I should have been told and advised re the necessary precautions to take to avoid spread of the infections. My friends and I were put at risk, which must surely be unacceptable clinical practice.

175. Throughout the remainder of August things continued in the same vein. My contemporaneous notes of daily events (set out in my statement prepared for the Inquest – and referenced in the Appendix) sets out the detail. The key headlines being, I continued to try and get Colin the care he needed… every day felt like a fight to get even the most basic care for Colin: to get the staff to work with me, rather than against me.

176. On 12th August I contacted PALS asking for them to contact Dr [I/S], who I believed to be Colin's consultant as I wanted a second opinion on Colin's care. This never happened.

177. As the staff are not listening to me, I reach out in desperation to organisations that might help. Both that I approached listened to me and shared my concerns to the extent that they are willing to write to the Trust directly to express their

concerns. The letters in their entirety are referenced in the index. The relevant extracts are copied below: -

178. Letter from Mrs [I/S] of Families Bereaved by Medication- Induced Suicide dated 12 August 2021 – addressed to Claire Panniker: -

"*We agree with Melanie's observations that Colin has suffered and will possibly continue to suffer adverse reactions should this course of prescribing continue….*"

179. Letter from [I/S] of Citizens Commission on Human Rights (UK) dated 17 August 2021 – addressed to all doctors involved in Colin's care: -

"*Ms Leahy has witnessed a rapid decline in Mr Flatt's condition following the administration of multiple psychiatric and anti-epileptic drugs …….*

Of considerable alarm are the restlessness, agitation and suicidal ideation that has manifested…. the behaviour that Ms Leahy has described is reflective of a condition called akathisia, a recognised side effect of antipsychotic medication…"

180. To the best of my knowledge neither letter was acknowledged or paid any attention to.

181. On 23rd August, I wrote to Claire Panniker, [I/S] and Paul Scott: -

"My partner Colin Flatt currently is on life support at Basildon Critical Care Unit, where he has been for the last three weeks.

Since the start of his stay in Basildon Hospital he has been under the Basildon Mental Health Liaison Team.

I was advised that doctors in CCU needed two mental health staff, each shift for Colins safety and staff safety.

This did not happen…. initially I was told due to funding. Then told funding had been agreed.

Yet to date there has not been one shift where has there been two mental health nurses and at times, zero, other times, student MH nurses.

On Friday 20th August the plan was to remove the breathing tube for Colin and remove him from ventilator. This was stopped as no mental health nurses available.

Saturday and Sunday, this weekend Colin remained sedated…

This morning, I was called into the hospital to sit beside Colin- whilst plan was to remove sedation and try to remove Colin from ventilator.

I turned up, only to find this was cancelled due to lack of mental health staff and Colin remains sedated, yet again.

I have just left a meeting with Colins consultant, who tells me this situation cannot continue. The delay puts Colin at risk. That the situation with staffing has been escalated to senior staff mental health, yet I cannot find out which senior staff the situation has been escalated to

Hence my email now to you both.

The doctor plans on removing Colin from the ventilator tomorrow with or without mental health staff present. He says Colin is not safe to leave on ventilator any longer than necessary and I have to agree. So, this situation must be addressed urgently.

The doctors have been calling for two mental health nurses, as a minimum - each shift.

If Colin is brought round tomorrow and is agitated (which is very likely - due to common icu delirium) and there are no MH staff to assist, then ccu will be back to square one and have to sedate Colin again.

I request a safeguarding is raised and this situation is given your immediate attention."

182. On the 25th of August, I reported three nurse's sleeping on duty in ITU, one of them was Colin's nurse. The response – I am told my visiting is to be reduced to hour an hour a day only. I am punished for reporting staff asleep on duty.

183. On the 28th of August Colin is off sedation and one of the doctors tells me that Colin is getting "*brighter and brighter".* This was good to hear but in conflict with the rest of the messaging I was getting.

184. On the 29th of August I began to think and hope that Colin was improving. I recall that Colin had his eyes closed and would not open them upon the doctor's request or mine, but I then told him there was a naked nurse at the end of his bed and he smiled!

185. On 1st September, I understand that an MDT took place during which the ITU staff apparently agreed that it was not in Colin's best interest to escalate treatment and that the resuscitation status would need to be reviewed. This was relayed to me the following day. The following extract from the Niche reports depicts the reality of the situation (page 126 paragraph 3.714): -

"On 2nd September, the ITU team (names not specified) met with ML and Colin's two children. They explained that it was not now in Colin's best interest to remain in ITU, as their support was no longer required. Instead, Colin would benefit from transfer to a side room on a ward where there would be less noise and stimulation. ML objected to this saying that he needed to stay on ITU 'where he is

safe' and that a hospice or home would be preferable. Colin's daughter additionally advised that they would like to ensure that things happened in the most dignified way in her father's final days. The ITU consultant concluded that it would be in Colin's best interests to move him from ITU, but that hospice services may be a possibility and would need to be explored. While it was good practice to have a family meeting to inform them of plans for Colin, presenting the family with decisions that had already been made was not in line with the MCA."

186. I have a recording of the meeting described above (referenced in the Appendix).

187. I understand that after the meeting with us, Colin was referred to the palliative care team. I note how this (palliative care) is meant to work, set out in the Niche report (page 121paragraph 3.681): -

"… palliative care is specialised medical care for people living with serious illness and is focussed on providing relief from the symptoms and stress of illness. The goal is to improve quality of life for both the patient and the family and is based on the needs of the patient, not on the patient's prognosis."

188. The 'care' that Colin received departed a long way from what is set out above. The ongoing pattern of chaotic medical/nursing management and at best poor and worst complete lack of meaningful communication with me/Colin's family continued. The Niche report notes (page 121 para 3.682): -

"*When the palliative care nurse reviewed him. Colin was unresponsive; the palliative care specialist nurse noted that Colin looked comfortable with no signs of distress. It was not felt to be in Colin's best interest to continue IV fluids /TPN due to excess secretions. They advised prescribing anticipatory drugs in order to minimise any symptoms and to maintain Colin's comfort. However, the palliative care specialist nurse did not speak directly with ML, and on review 2 days later, the medication regime has not been prescribed as Colin was for ward–based care and not 'end of life'. This reflects a lack of understanding by the medical staff because although anticipatory medicines are often given towards the end of life, these are medicines which can also be used for symptom management and can be given at any point in someone's illness if they need them.*"

189. On Friday 3rd of September, a decision was made to transfer Colin to Bulphan ward. I understand that this transfer was scheduled to take place at around 11am. Coincidentally I telephoned at around 11am to ask about plans for discharge – based on my understanding that Colin would either be transferred to a hospice or then discharged home, as had been discussed previously. I was petrified and very upset to be told that Colin was being transferred to Bulphan ward.

190. Despite my considerable dismay the unilateral decision made by the ITU staff prevailed and later that day, Colin was transferred back to Bulphan ward.

191. Later that day a doctor from the MH team came to discharge Colin from MH Care. This Dr told me that she had not seen any behavioural disturbances in Colin during the last three weeks, and so her role had ended. I asked they leave MH staff on duty as there did not seem to be any other staff available to assist me with Colin's care.

192. At 5.20pm, that day I attended a meeting with Dr [I/S] Matron [M] and one other who was taking notes. Referring to the the notes I made at the time: - Doctor [I/S] explained: -

I. At least a year to repair the bowel and potentially an operation that Colin would not survive.

II. That where bowel connects to abdominal wall, that food / nutrition would come out at top. Colin would lack nutrition and salts. He explained that there was not enough bowel to absorb nutrition. Explained that salts/ potassium etc. would go out of balance.

III. That he did not think Colin would survive all of this.

IV. That Macmillan care had seen him but did not think him poorly enough for palliative (non) care pathway.

V. That Colin had lot of inflammation where body is fighting to repair itself.

VI. He wanted to keep Colin as comfortable as possible. To remove Total Parenteral Nutrition ('TPN'). I was told TPN would need to be removed before he could go home and that he would be given meds to keep him comfortable. Then he would be placed on the palliative (non) care pathway.

193. I said: -

I. NO to palliative non care pathway.

II. NO to syringe driver.

III. NO to Midazolam.

IV. NO to Morphine.

V. I said I wanted him to die naturally.

194. I had investigated the (non) care pathway and I had the right to make medical decisions for my partner. I had made an informed decision to refuse these drugs, but the doctors seemed intent on completely ignoring my opinions. Matron M told me Colin would be made "*end of life*." The fact that I held a power of attorney was of no consequence and that it was entirely within their remit to make what they were calling *"a best interest decision."*

195. After considerable discussions however we reached an agreement. Dr [I/S] and Matron M said that they would hold off until the following day so that I had some time to think everything through and return in the morning with my decision as to whether the central line should be removed and Colin started on palliative (non) care, so I could take him home to die. I left around 6pm.

196. However, I could not rest at home, and so I went back to hospital and got there around 9pm. I was horrified to find all fluids and feed had already been removed. I spoke to WS the Ward sister, who checked Dr [I/S] notes and told me the decision to stop fluids had been made during the meeting. I was stunned and extremely upset. The removal of feed and fluids had happened without my consent. I told WS about what had been agreed with Dr [I/S] and Matron M. WS very grudgingly agreed and attached Colin to a bag of clear fluid at the slowest possible infusion rate.

197. I could not understand what was happening. How could it be that we have a discussion, agree a plan of action and then the staff completely renege from the plan.

198. The following morning (Saturday 4th September) I wrote to Claire Panniker in desperation. The relevant extracts from the two emails I sent in quick succession are copied below (the emails in their entirety are referenced in the Appendix).

199. **First email** (sent 7.47 am)

"I *met with the surgeon Dr* [I/S] *and senior nurse* M *and one other…*

We discussed Colin at length and the options available at this time.

It was a very distressing discussion for me, and it was explained to me that for me to take Colin home that he would need to be removed from the feeding tube then palliative care would kick in.

I was distressed and upset and unable to make the decision to put him on palliative care.

M *and Dr* [I/S] *and one other agreed that I should go home and come back in the morning with my decision.*

I left the ward (Bulphan and returned about nine pm in the evening.

I noticed the glucose feed had ended … and that Colin was in pain.

Went to ward sister WS *and asked who was Colin's nurse and could she come out as soon as possible.*

Only to be informed and witness notes in the file that staff for this shift had been advised to stop all feed tonight.

What the … is going on in this hospital? "

200. **Second email** (sent 7.48 am)

"… It is now 7.35 am. Colin still has no fluids, as it appears duty doctor was confused as notes say: -

- *Withhold fluids.*
- *Continue fluids.*

Despite the uncertainty … duty doctor has not prescribed fluids, so Colin suffers yet again.

Last night Colin was the most active he has been, and 2 mental health nurses were kept busy throughout the night, and myself.

The shift has just changed and now Colin is at risk once more… the MH team have reduced staff for Colin to one. The departing staff were frightened not only for the new staff member but for Colin too.

This is unsafe practice.

Why am I having to challenge this lack of understanding/assessment at every stage.

Bulphan ward do not have the staff to help the MH nurse with Colin….."

201. Later that morning, I had a meeting with Matron M who told me not to keep going to the nursing station. If I had a question or needed help, I should ring the buzzer. I did this multiple times over the weekend and was usually left waiting well over an hour before anyone came.

202. It was however agreed with Matron M that Colin would not be put on palliative (non) care over the weekend and we would meet again Monday morning to discuss further. I asked Matron M if I could have a chat with a Macmillan nurse to help me understand what was involved better, she told me that Macmillan nurses only get involved when patients are *"end of life"* and that Colin was not. I felt I was being pushed to make a decision to remove Colin's TPN and fluids.

203. Colin had been without any sedating medications for the first time in days and opened his eyes. He actually woke up and acknowledged me. I was so happy to see that. I took a short video of Colin talking to me (referenced in the Appendix).

The student MH nurse who was with me at the time was as excited as I was. He rushed off to tell the more senior staff on duty, but it seems their response was somewhat derisory as when he returned, he was upset and told me that the response he met with was only to be questioned as to his qualification status. The only interpretation that I could put on that was the staff were not happy about the fact that Colin was awake. I told the student MH nurse that I had been told by doctors that Colin hadn't woken for days. He said that was not right, that he had seen Colin awake in ICU when he had been on shift.

204. Colin was begging for a drink of water. I was unable to sit Colin up to give him a proper drink as the bed would not operate. I asked multiple times to have his bed changed and each time was ignored. I was told that Colin was not have any water. I was only permitted to give him sips of water to suck off a pink lolly sponge. At the time, emotionally and physically exhausted I simply listened to what the 'professionals' told me I could and could not do. I now question why this was, why was Colin not allowed water, why was his suffering increased unnecessarily? To the best of my knowledge Colin had not been diagnosed having any problems with swallowing or to be at risk of aspiration. I have a video of Colin repeatedly asking for water and his swallowing when sucking water from the pink sponges. (The video is referenced in the Appendix).

205. Later that day I was told that there might not be any one-to-one staff to assist me that night with Colin's care. I asked the nurse [I/S] if they had any mittens available. She told me they had some, but they could not be used without a mental capacity assessment in place. This made no sense to me, but that is what I was told. Nurse said there must be an MCA for them in place, as they had been used previously in ICU, and then went off duty.

206. The following morning, Matron M told me at some point that mittens were available as she had seen them in a cupboard. In any event no mittens were provided, and I could not understand why they had not been used.

207. On the 5th of September, the excessive medication regime resumed. I note now, from Colin's medical records that he was given 5mg of midazolam at 8.30am – I have no idea why, Colin was not showing any signs of restlessness or agitation. Colin was peacefully sleeping when I left the ward to get a drink. When I returned I could not believe the state I found Colin in. His eyes were rolling in the back of his head, he seemed to be struggling to breathe and was sweating profusely.

208. **At 4.40pm Colin was reviewed on the ward round where it was noted that he was unrousable and that his pupils were constricted and non-reactive. I understand that this is consistent with the effect of a morphine overdose (a video is referenced in the appendix).**

209. Despite this, as the list of medication (page 96 of this statement) shows, Colin was given a further 5mg of morphine at 6pm and another 5mg at 6.25pm. I am not sure how much more evidence could possibly be needed to show that Colin was excessively and inappropriately medicated, and this hastened his death. This was not non-voluntary euthanasia as the concept of euthanasia pertains to the ending a life to end suffering. In Colins case, those looking after Colin made him suffer and then took wilful steps to end his life prematurely. In my view this must amount to unlawful killing.

210. The day wore on and by that evening, I was beyond exhausted and so laid down on a mattress on the floor beside Colin with my head at the end of his bed, so I could keep an eye on him. MHN the Mental Health nurse from EPUT who was meant to be looking after Colin on a 1:1 basis was on the other side of Colin's bed and from what I could see mostly busy on her phone. At around 2am one of Colin's legs fell out of bed in front of my face. I pushed it back up, but it fell again so I got up and lifted Colin's leg to put it back on the bed. I was shocked to see four people standing on the other side of the bed, standing in silence in the semi darkness. One was MHN and one, WS the ward sister. The other two were nurses that I had seen before but did not know their names. They did not say anything, and I was too stunned to ask them what they were doing.

211. What I saw was that MHN had the central venous pressure (CVP) line that had been in Colin's neck, in her hand. There was no sign of any blood, and I could see that the stitches that had been used to hold the line in place together with the tape and dressing were missing.

212. As I stood there watching much like a 'rabbit in headlights,' I saw WS lean over the bedrail and place a piece of gauze over the puncture site (where the line had been inserted) and then secure it with a piece of tape. WS then left with the two other nurses. MHN then turned to me and told me that Colin had pulled out the line himself.

213. I know now, as I knew then that there was no way that Colin who was fast asleep (and as I now know heavily sedated – by the 5mg morphine he had been given 10 minutes prior) could not have done anything of the sort. Quite apart from

the fact that he was in no state to do anything, if he had, there would have been evidence of a torn dressing, ripped stitches and some blood.

214. I understand that an incident report form was submitted by presumably other members of nursing staff, the headline point being that they were of the view that as Colin was supposedly being looked after on a one-to-one basis, he should not have been able to pull out his CVP line in any event.

215. The reporting of this incident is muddled and confusing in the extreme – the Niche investigators were not able to get to the bottom of it.

216. Colin was dehydrating in front of my eyes. From 2am Colin had no fluid or feed, and I was desperate to get it re-attached. The Nurse told the on-call duty doctor who refused to do anything. It was only after considerable begging and pleading that a bag of clear fluid was re-attached at 2pm the next day.

217. At 8pm on the 6th of September I took Colin home by private ambulance.

Finally at Home…

218. I will never forget those months, those final days and then those final hours leading up to Colin's death. They are etched into my brain like a scar that I will carry forever, a wound that time will never heal.

219. All Colin wanted was to come home. For months, he had said it again and again: I just want to go home. He had become frail, his body weakening, his mind weary of the constant indignities of hospital life, yet his wish remained clear and consistent. And still, I was told repeatedly that he could not leave the hospital. The message was blunt: he would die there. I remember thinking, with absolute conviction, that if that was the case, then I would die there with him. I had, in fact already worked out how I would be killing myself in that hospital room if it came to that. The thought of him trapped on that ward — starved of love, stripped of dignity, and surrounded by strangers instead of family — was unbearable. He had fought for three long months, enduring neglect and mistreatment, and his only wish was to spend his final hours in his own home.

220. It felt impossible. Every avenue seemed blocked, every request dismissed, and then, out of nowhere, one Macmillan nurse [I/S] broke through the wall of indifference. She listened to me when others had turned away. She saw me as more than an inconvenience, and Colin as more than a bed number. She showed compassion where the system had shown none. I will never forget that one moment of kindness. It was she who started the ball rolling for a rapid discharge, and suddenly there was a glimmer of hope.

221. But it came at a very heavy cost. The effort it took to bring Colin home almost broke me. I was so tired, so utterly exhausted by it all. The weight of responsibility was crushing. I had to make call after call, holding everything together myself while he lay dying. I phoned the electricity board to make sure our power would not be cut — Colin would need oxygen, and the thought of the supply failing haunted me. I phoned friends to ask for help because no carers had been provided. I called my family, and they came to clear the lounge, to make space

for an airbed, so he could at least have a place to lie in comfort. Everything had to be ordered and delivered: the bed, the oxygen, the ambulance. Each item was another hurdle, another weight on shoulders already bent with grief.

222. The discharge was organised that same afternoon. Two ambulance drivers arrived on the ward, but even then, the process was slow and draining. Paperwork had to be completed before we could leave. It seemed to take forever, every tick of the clock like a cruel reminder that Colin's time was running out. I was warned repeatedly that he might not survive the journey, that he could die en route because he was now so weak and so ill.

223. Finally, everything was sorted, and we were able to leave the hospital. The ambulance journey took about an hour and a half, but to me it felt like six. I sat beside Colin the entire way, holding his wrist, feeling for his pulse, willing him to keep breathing. His breathing was slow, shallow, punctuated by gasps that made my heart stop each time. I whispered to him, telling him he was nearly home, that he was loved, that we were almost there. Every second felt like a battle. By some miracle, he held on until we reached our front door.

224. We reached home at around 9.30pm, after a frantic day of pleading, planning, and rushing to coordinate everything, Colin finally came home. Waiting there for us were my three friends. They had been brilliant — they had everything ready for his arrival. The bed was in place, the oxygen set up, the room prepared. They had taken on the role the system had abandoned, and because of them Colin was able to come home with at least a little dignity and care.

225. The first thing we did was to clean him. His stoma bag had been left full on the ward, another sign of how badly he had been neglected. Together, we emptied it, washed him, and tried to make him comfortable. It was a small act of love, restoring some dignity to him in the face of everything he had been denied.

226. And yet, even in that moment of peace, the failures continued. No carers arrived. There was no professional support. Just me, and those same three friends, left to carry the weight of it all. We tried to give Colin comfort, to give him dignity, to make up for everything that had been denied to him. But in truth, we were powerless.

227. The toll of neglect was already written across his body. He had been dehydrated, starved, and over-medicated until he was paralysed, trapped in a body that no longer responded. His lips were cracked, his skin grey and frail, his once-bright eyes dulled. He was silenced, unable to ask for what he needed, unable to fight back. The drugs had taken his strength and his voice. I begged for gentleness, for compassion, for even the smallest acts of humanity. None came.

228. When two community nurses finally arrived, I clung to a shred of hope. But hope quickly turned to despair. They placed a syringe driver at his side, filled with morphine and midazolam. I knew what it meant, and I knew I had no power to stop it. My heart sank as the reality set in this was the end. Not a natural, peaceful end, but one hurried along.

229. The medication paralysed him. The morphine slowed his breathing; the midazolam silenced him, taking away his ability to respond. His lips were

distorted, pierced into a permanent small circle as he gasped desperately for air. Each breath came like a struggle, a drowning man fighting to surface. Watching him, I thought of how he had been such a fantastic sailor, strong and confident at sea — and yet his biggest fear all his life had been drowning. And here, in his final hours, that is exactly what happened: the drugs forced him into a slow, suffocating death that mirrored the terror he had always dreaded.

230. I did not feel he was being murdered — I knew he was. I sat powerless, forced to watch the man I loved being killed in front of me, unable to stop it.

231. Through the night, I held him in my arms. We played calming music, trying to soothe him, trying to bring him peace. His gasps grew weaker, his body frailer. I whispered words of love and reassurance. I told him he mattered, that he was not alone, that I was there. On the outside, I was calm, steady, trying to give him comfort. Inside, I was raging — watching the man I loved, drugged, paralysed, starved, dehydrated, and now effectively drowned by the very medications meant to 'ease' his passing.

232. At 7.17am, Colin took his final breath. The silence that followed was crushing. He died in my arms — not peacefully, but after ten hours of avoidable, manufactured suffering.

233. And still, it was not over. After he died, I had to cope. I rang Essex Police again, and again to inform them of his death, but I could not get through. By 2pm, exhausted and desperate, I went online and reported: "**I have a dead body in my house"**. Only then did the phone ring instantly. Soon after, the undertakers

arrived. They asked us to leave the room while they placed Colin into a black body bag.

234. I will never forget what happened next. As they wheeled him out to the hearse, the door opened, and I saw two other full body bags already inside. As they lifted Colin in beside whoever else was in that van, they dropped him. The image is burned into me: the man I loved, treated like cargo, his dignity stripped even in death.

235. But even then, there was no peace. I was not able to lay Colin to rest for ten and a half months, while a police investigation and post-mortem dragged on. Ten and a half months before he could be given the dignity of a funeral. And all for nothing — because the investigation was poor, shallow, inadequate. It was, in truth, a disgrace. To wait so long, only to see such a half-hearted process, compounded the cruelty and deepened the trauma.

236. Even now, years later, I wait for Colin's inquest. He died on 7th September 2021, and still there has been no closure, no justice, no accountability. The waiting is its own form of torment. Time passes, but the pain remains raw, and the silence from those responsible speaks louder than any words.

237. Those final months, weeks, days, and hours changed me forever. To see someone, you love to die in such a way — starved, dehydrated, paralysed by drugs, medicated to death — and then to see them handled so carelessly. All Colin had wanted was to come home, and for that I had to fight against the very

system meant to care for him. He deserved peace, love, and dignity. Instead, he was neglected, and disrespected — in life and in death.

238. There seems to be no end to the trauma. Having to endure poor investigative processes and being forced to repeat the details of Colin's final hours over and over, just compounds it. Each retelling reopens the wound, yet to date there has been no accountability, no justice, no meaningful change.

239. My now final and enduring hope is that the Lampard Inquiry will finally bring justice for Colin, and in doing so, begin to restore some dignity to his memory. But this is bigger than Colin alone. What happened to him exposes an uncomfortable truth: so much of what is called "end-of-life care" is not care at all — it kills people. It silences them, it drugs them, it starves and dehydrates them, and it strips them of their final chance to live and die with dignity.

240. That is what was done to Colin. That is what I witnessed. And that is why I will never stop speaking out until the truth is recognised, accountability is delivered, and change is forced through.

After Colin's death

241. I had been left exhausted and traumatised having lived through, and by witnessing what Colin was subjected to, for what proved to be the last few months of his life. I still struggle to understand how the cruelty and neglect that Colin experienced could actually happen inside hospitals in England.

242. Colin was a wonderful man dignified and proud, kind, gentle and courteous, he did not deserve the appalling treatment he was given. I cannot forget what he and I as his partner experienced during those awful few months.

Investigations & Legal Proceedings

Inquest

243. An Inquest has been opened.

244. The Inquest scheduled for 2026 has been determined to be an Article 2 Inquest.

Niche Report

My fight for an Independent Investigation.

245. After Colin's death, I expected that there would be a thorough and impartial investigation into what had happened. However, when [I/S] in her capacity as deputy director of Nursing, contacted me to say that ***she*** would be carrying out the investigation herself, my heart sank. If the very people involved in and responsible for Colin's care were now going to be the ones to investigate his death, there was no way that the investigation was going to be independent. I knew I had to fight this, and so and I refused to cooperate with any process run by the Trust.

246. I was then told that the Clinical Commissioning Group (CCG) would take the investigation forward. Again, I challenged it providing detailed legal arguments

setting out why such an "in-house" investigation was wholly inappropriate, and incapable of delivering truth or accountability.

247. Eventually, the case moved to NHS England, and at last there was acknowledgement that independence was required. NHS England agreed to source an external organisation to carry out an investigation.

248. Niche Healthcare Consulting was appointed, following which we had some considerable discussion and exchanges in respect of the terms of reference. Inevitably they were not as extensive as I wanted but did go some way towards what I was looking for. Niche then went on to provide a very comprehensive, independent report. This is the report referenced throughout my statement as 'the Niche Report.'

249. As has been evidenced throughout my statement and upon the reading of the report in its entirety, the investigation carried out by was robust, wide-ranging, and detailed. It has laid bare many of the serious failures in Colin's care.

250. However, whilst the Niche report could and has exposed a lot of the truth, it does not tell the full story. Its scope was limited by the terms of reference and the areas pre-agreed for investigation, so not everything I wanted looked into was examined. Significant areas of concern were left out — not because of a lack of evidence, but because of the limited terms of reference.

251. It also lacks teeth as it cannot call for any degree of accountability nor punish those responsible via appropriate forums civil or criminal.

252. I am therefore now left holding a report that only tells part of the story, does not hold anyone accountable, and so ultimately does not deliver justice.

253. It should never have been this way. At a time when I was grieving and traumatised, I had to fight at every single stage just to secure the basic principle of independence — only to learn that even an "independent" report could still be restricted and powerless. That fight alone added months of stress, exhaustion, and pain on top of the loss I was already carrying.

254. My hope now is that the Lampard Inquiry will not repeat these mistakes — that with its statutory powers and wider scope, it will go beyond the limits imposed on Niche, uncover the whole truth, and finally deliver the accountability that has been denied for so long.

The lasting impact.

255. The events I witnessed during the final months of my partner Colin's life have had a profound and life-changing impact on me. For months, I lived in a constant state of stress, fear, and helplessness. I was forced to watch the man I loved being neglected, restrained, over-medicated, and stripped of his dignity. I saw him bruised, confused, in horrific pain and frightened. I felt utterly powerless to protect him, despite doing everything within my ability to advocate for his care and safety. The images and memories of what he endured are indelible and continue to haunt me.

256. Colin was my partner for more than nineteen years. He was my closest companion, my support, and the person with whom I shared my daily life. To witness him treated in such a way and to lose him under those circumstances has

left me devastated. His absence has taken away the stability, comfort, and shared history that we built together over two decades.

257. I consider myself a strong person. I had already survived what any mother would describe as the worst life event imaginable—the premature death of my only child, Matthew. But I could never have imagined that I would be forced to endure something as horrendous again, this time with my partner. The combination of grief and the trauma of what I witnessed has been life-altering.

258. Colin was my strength and my anchor throughout the years I have spent fighting for answers and justice for my son Matthew's death. He was my confidant, my encourager, and my emotional backbone during some of the most difficult years of my life. He supported me through the campaigning, the endless meetings, and the traumatisation of repeatedly reliving Matthew's story. Losing Colin meant losing not just my partner but also the person who gave me the courage to keep going. His absence has left me feeling exposed, isolated, and without the one person who held me up when the weight of grief and the fight for accountability felt unbearable. The strain of this period has also torn our wider family apart. Colin's daughter and son struggled to cope with the shocking reality of their father's decline, and tensions and misunderstandings escalated to the point where our relationships completely broke down. Those relationships remain broken to this day.

259. Even Colin's beloved dog, Jed, was affected. His world changed in an instant. Used to daily walks and bike rides, suddenly he was bundled into a car daily and delivered to whichever of my friends/family were free to care for him whilst I attended Colin in hospital. When home he would walk from room to room, sniffing

the places that Colin used to sit, and then go and wait by the door for the footsteps that never came.

260. Jed recently passed away. Jed had become my shadow having lost Colin, who had been cried on and hugged through such a traumatic time. We settled into life alone. We shared walks, quiet lonely days and evenings, and he was such a comfort. But I have had to say goodbye to him too.

261. Now his ashes sit besides my fireplace, carefully place inside a small model of a spaniel, watching over the room like he used to. I am grateful for every moment we had but losing him feels like losing the last living link to a chapter of life that I will never get back.

262. The impact has been profound. I did not just lose Colin; I lived through the suffering that preceded his death. Life is permanently marked by those experiences. Ordinary moments—birthdays, holidays, even the simplest routines—are shadowed by the absence of both Matthew and Colin. Colin's final months remain especially raw because of all that I saw, lived through, and could not prevent.

263. Despite this devastation, I remain determined that Colins suffering, and the failures that allowed it, will not be forgotten. His dignity in life and his right to proper care in his final days were denied to him.

264. His death, and the failures I witnessed, have left scars that will never fade. I cannot rest while such harm continues unchecked.

265. For Colin, for Matthew and for all those who cannot speak for themselves, I will continue to press for truth and accountability — because silence would be another betrayal.

Overall - Views and Concerns

266. Looking back at the months before Colin died, I know with absolute certainty that he was let down by the health and care system at every level. The way he was treated caused avoidable suffering, stripped him of his dignity, and directly contributed to his death.

267. I am certain that at least some of the poor treatment that Colin received including delays in assessments being carried out were due to disagreements between EPUT and Mid Essex as to who should be responsible for assessment. The doctors and nurses were aware of my campaigning in connection with Matthew's death and made it very clear in all their interactions with me that they really did not want to engage with me any more than they absolutely had to.

268. More specifically I am very concerned by the circumstances surround the removal of an essential CVP line on 5th September. See paragraphs 202-207. The truth of what took place that night has not been ascertained. The reported facts such as they are do not add up. This is a very serious matter on any analysis and must be investigated.

269. I am also deeply concerned by the inappropriate and excessive use of midazolam and morphine which I believe accelerated Colin' s death – this cannot be seen as anything other than enforced euthanasia.

270. I have set out below the contents of the prescription charts from the 21st July to 6th September (Colin's last admission to Basildon Hospital) in as far as the medications comprise of sedating or antipsychotic drugs. These charts can all be found in the bundle of medical records referenced in the Appendix. Even as I was aware at the time of the fact that Colin was being overmedicated, seeing the information set out in black and white is horrifying, and the administration of excessive and often very unwarranted medication is very clear.

271. The page numbers refer to the numbering in the medical records (Colin's medical records are referenced in the Appendix)

21/07/21

a) Clonazepam

500mcg 09:07 – page 889

b) Diazepam

5mg 19:30 – page 893

c) Promethazine (Start Date listed as 21/07/21 but no recorded administration) – page 907

23/07/21

a) Lorazepam

1mg 16:38 – page 896

b) Clonazepam

500mg 15:50 – page 907

24/07/21

a) Haloperidol (Start Date listed as 24/07/21 but no recorded administration) – page 907

25/07/21

a) Clonazepam

500mg 20:45 – page 907

b) Lorazepam

1mg 15:50 – page 908

26/07/21

a) Clonazepam

500mg 08:55 – page 907

b) Lorazepam

1mg 01:30 – page 908

0.5mg 08:45 – page 908

27/07/21

a) Clonazepam

500mg 08:10 – page 907

28/07/21

a) Haloperidol

5mg 06:45 – page 921

b) Midazolam

2-3mg Start Date listed as 28/07/21 but no recorded administration – page 921

29/07/21

a) Lorazepam

0.5mg administered lunch time – page 904

0.5mg administered evening time – page 904

1mg 10:20 – page 908

1mg 21:05 – page 908

1mg 23:20 – page 908

b) Haloperidol

5mg 18:00 – page 908

30/07/21

a) Lorazepam

0.5mg administered breakfast time – page 904

0.5mg administered lunch time – page 904

1mg administered evening time – page 905

1mg administered night time – page 905

1mg 12:55 – page 908

b) Risperidone

0.5mg administered night time – page 904

c) Midazolam

2mg 13:25 – page 908

2mg 18:50 – page 908

d) Haloperidol

5mg 11:52 – page 908

e) Oramorph

10mg, 5ml 09:40 – page 908

31/07/21

a) Lorazepam

1mg administered breakfast time – page 905

1mg administered lunch time – page 905

1mg administered evening time – page 905

1mg administered night time – page 905

b) Risperidone

0.5mg administered evening time – page 905

c) Haloperidol

5mg 04:59 – page 908

d) Oramorph

10mg 08:10 – page 908

10mg 11:20 – page 908

10mg 18:00 – page 908

01/08/21

a) Lorazepam

1mg administered breakfast time – page 905

1mg administered lunch time – page 905

1mg administered evening time – page 905

1mg administered night time – page 905

b) Risperidone

0.5mg administered breakfast time – page 905

0.5mg administered evening time – page 905

c) Midazolam

3mg 14:05 – page 908

3mg 21:10 – page 908

d) Haloperidol

5mg 14:20 – page 908

e) Oramorph

10mg 17:33 – page 908

02/08/21

a) Haloperidol

5mg 12:15 – page 908

5mg 13:55 – page 908

2.5mg 18:00 – page 897

2.5mg 23:30 – page 934

b) Promethazine

50mg 18:00 – page 897

c) Lorazepam

1mg 11:20 – page 908

0.5mg 18:00 – page 897

0.5mg 23:30 – page 934

d) Risperidone

0.5mg administered breakfast time – page 905

1mg administered breakfast time – page 906

e) Midazolam

3mg 11:15 – page 908

f) Oramorph

10mg 08:16 – page 908

10mg 14:23 – page 908

03/08/21

a) Lorazepam

0.5mg 06:20 – page 934

1mg 15:15 – page 935

b) Haloperidol

1.25mg administered breakfast time – page 931

1.25mg administered lunch time – page 931

1.25mg administered evening time – page 931

1.25mg administered night time – page 931

2.5mg 02:45 – page 934

2.5mg 06:20 – page 934

5mg 12:30 – page 935

NOTE → Numerical next to administration times listed on page 931,

unsure what they pertain to

c) Oxycodone

5mg 15:20 – page 934

04/08/21

a) Risperidone

1mg administered evening time – page 906

b) Oxycodone

5mg 00:15 – page 934

5mg 02:10 – page 934

5mg 09:10 – page 934

5mg 13:12 – page 934

NOTE → Naloxone listed below this entry, no recorded administration.

c) Lorazepam

1mg 00:21 – page 935

1mg 11:45 – page 935

d) Haloperidol

5mg 05:43 – page 935

5mg 13:10 – page 935

e) Propofol 1%

1g/100ml 19:00 – page 940

1g/100ml 23:00 – page 940

05/08/21

a) Risperidone

1mg listed for 05/08/21 but no recorded administration – page 930

b) Haloperidol

2.5mg administered breakfast time – page 931

2.5mg administered evening time – page 931

c) Midazolam

50mg/50ml 16:00 – page 940

d) Propofol 1%

1g/100ml 03:08 – page 940

1g/100ml 15:00 – page 940

1g/100ml 19:20 – page 940

06/08/21

a) Haloperidol

2.5mg administered breakfast time – page 931

2.5mg administered evening time – page 931

b) Midazolam

50mg/50ml 07:00 – page 940

50mg/50ml 23:00 – page 940

c) Propofol 1%

1g/100ml 02:30 – page 940

1g/100ml 09:00 – page 940

07/08/21

a) Haloperidol

2.5mg administered breakfast time – page 931

2.5mg administered evening time – page 931

b) Midazolam

10mg/50 16:00 – page 940

c) Propofol 1%

1g/100ml 06:00 – page 940

1g/100ml 12:00 – page 940

1g/100ml 20:06 – page 940

08/08/21

a) Lorazepam

1mg 14:40 – page 896

b) Haloperidol

2.5mg administered breakfast time – page 931

2.5mg administered evening time – page 931

c) Midazolam

50mg/50 02:00 – page 940

d) Propofol 1%

1g/100ml 06:00 – page 940

1g/100ml 15:00 – page 940

1g/100ml 20:30 – page 940

09/08/21

a) Risperidone

1mg listed for 09/08/21 but no recorded administration – page 930

b) Haloperidol

2.5mg administered breakfast time – page 931

2.5mg administered lunch time – page 932

2.5mg administered evening time – page 932

c) Chlorpromazine

50mg administered lunch time – page 932

50mg administered evening time – page 932

d) Midazolam

50mg/50 07:00 – page 940

e) Propofol 1%

1g/100ml 02:50 – page 940

1g/100ml 11:50 – page 940

10/08/21

a) Chlorpromazine

50mg administered breakfast time – page 932

50mg administered lunch time – page 932

50mg administered evening time – page 932

b) Haloperidol

2.5mg administered breakfast time – page 932

2.5mg administered lunch time – page 932

2.5mg administered evening time – page 932

c) Midazolam

50mg/50 06:00 – page 940

d) Propofol 1%

1g/100ml 10:00 – page 940

11/08/21

a) Chlorpromazine

50mg administered breakfast time – page 932

50mg administered lunch time – page 932

50mg administered evening time – page 932

b) Haloperidol

2.5mg administered breakfast time – page 932

2.5mg administered lunch time – page 932

2.5mg administered evening time – page 932

c) Propofol 1%

1g/100ml 03:30 – page 940

1g/100ml 14:30 – page 940

12/08/21

a) Chlorpromazine

50mg administered breakfast time – page 932

50mg administered lunch time – page 932

50mg administered evening time – page 932

b) Haloperidol

2.5mg administered breakfast time – page 932

2.5mg administered lunch time – page 932

2.5mg administered evening time – page 932

c) Propofol 1%

1g/100ml 03:30 – page 940

1g/100ml 17:50 – page 940

13/08/21

a) Risperidone

1mg listed for 13/08/21 but no recorded administration – page 930

b) Chlorpromazine

50mg administered breakfast time – page 932

50mg administered lunch time – page 932

50mg administered evening time – page 932

c) Haloperidol

2.5mg administered breakfast time – page 932

2.5mg administered lunch time – page 932

2.5mg administered evening time – page 932

2.5mg administered night time – page 932

d) Lorazepam

1mg 16:40 – page 935

e) Fentanyl

1000mcg/50ml 16:30 – page 940

f) Propofol 1%

1g/100ml 07:00 – page 952

1g/100ml 20:30 – page 952

14/08/21

a) Chlorpromazine

50mg administered breakfast time – page 932

50mg administered lunch time – page 932

50mg administered evening time – page 932

b) Haloperidol

2.5mg administered breakfast time – page 932

2.5mg administered lunch time – page 932

2.5mg administered evening time – page 932

2.5mg administered night time – page 932

c) Fentanyl

1000mcg/50ml 05:30 – page 952

d) Propofol 1%

1g/100ml 07:00 – page 952

15/08/21

a) Chlorpromazine

50mg administered breakfast time – page 932

50mg administered lunch time – page 932

50mg administered evening time – page 932

b) Haloperidol

2.5mg administered breakfast time – page 932

2.5mg administered lunch time – page 932

2.5mg administered evening time – page 932

2.5mg administered night time – page 932

c) Lorazepam

1mg 12:00 – page 935

1mg 18:00 – page 935

d) Fentanyl

1000mcg/50ml 04:22 – page 952

e) Propofol 1%

1g/100ml 02:30 – page 952

1g/100ml 08:00 – page 952

1g/100ml 14:00 – page 952

16/08/21

a) Diazepam

2.5mg 10:35 – page 923

5mg 13:00 – page 924

2.5mg administered evening time – page 933

2.5mg administered night time – page 933

2.5mg 21:00 – page 967

NOTE → overlapping diazepam records between page 933 and 924

b) Chlorpromazine

50mg administered breakfast time – page 932

c) Haloperidol

2.5mg administered breakfast time – page 932

2.5mg administered lunch time – page 932

2.5mg administered evening time – page 932

d) Lorazepam

1mg 05:00 – page 935

e) Propofol 1%

1g/100ml 04:00 – page 952

17/08/21

a) Diazepam

2.5mg 15:10 – page 924

2.5mg 19:00 – page 924

2.5mg 01:30 – page 924

2.5mg administered breakfast time – page 933

2.5mg administered evening time – page 933

2.5mg administered night time – page 933

2.5mg 04:00 – page 967

2.5mg 11:00 – page 967

NOTE → overlapping diazepam records between page 933 and 924

b) Haloperidol

2.5mg 00:15 – page 924

2.5mg administered breakfast time – page 932

18/08/21

a) Diazepam

2.5mg 06:20 – page 924

2.5mg administered breakfast time – page 933

2.5mg administered lunch time – page 933

2.5mg 18:00 – page 967 (NOTE → date not fully eligible here)

b) Fentanyl

1000mcg/50ml 14:30 – page 952

1000mcg/50ml 22:00 – page 952

c) Propofol 1%

1g/100ml 14:30 – page 952

d) Risperidone

0.5mg administered night time – page 963

19/08/21

a) Propofol 1%

1g/100ml 06:00 – page 952

1g/100ml 10:30 – page 952

1g/100ml 21:30 – page 952

20/08/21

a) Propofol 1%

1g/100ml 04:45 – page 952

1g/100ml 21:20 – page 952

21/08/21

a) Propofol 1%

1g/100ml 03:30 – page 952

1g/100ml 11:40 – page 952

1g/100ml 21:30 – page 952

22/08/21

a) Propofol 1%

1g/100ml 03:40 – page 952

1g/100ml 08:00 – page 952

1g/100ml 15:45 – page 952

1g/100ml 00:00 – page 952

23/08/21

a) Propofol 1%

1g/100ml 06:30 – page 954

1g/100ml 12:20 – page 954

1g/100ml 18:45 – page 954

24/08/21

a) Propofol 1%

1g/100ml 21:30 – page 954

1g/100ml 05:00 – page 954

26/08/21

a) Propofol 1%

1g/100ml 14:50 – page 954

04/09/21

a) Morphine Sulphate

2.5mg 17:40 – page 967

b) Levomepromazine

6.25mg – 12.5mg Start Date listed as 04/09/21 but no recorded administration

05/09/21

a) Morphine Sulphate

5mg 00:32 – page 967

5mg 01:50 – page 967

5mg 18:00 – page 967

5mg 18:25 – page 967

b) Midazolam

5mg 08:30 – page 968

06/09/21

a) Morphine Sulphate

5mg 07:20 – page 967

5mg 14:33 – page 967

b) Midazolam

5mg 05:30 – page 968

5mg 15:43 – page 968

272. The excessive, and often inappropriate use of sedating/tranquilising medications is abundantly clear, however as will be seen in the copied entries from prescription charts there are some gaps in the dates – this is because not all the pages of some prescription charts have been disclosed. Nor have copies of the relevant pages of the Controlled Drugs book been provided despite repeated requests. The current position of the Trust is that they have provided all that they have. That is unacceptable – the Trust must be asked to provide this missing documentation or then explain why it is unable to do so.

273. The Inquiry team will no doubt be aware of the currently suspended (widely reported) Inquest touching on the death of Derek Dimmock. Mr Dimmock's family is one of an increasing number of families raising concerns about their elderly loved ones being overmedicated and more specifically being inappropriately prescribed midazolam and then being given excessive doses.

274. I understand that Professor [redacted] a retired neurologist who raised the Liverpool Care Pathway alarm said: -

"Midazolam depresses respiration, and it hastens death. It changes end of life care into euthanasia."

275. Below is a link to the most recent coverage that I have been able to find. The Inquest has been suspended until December 2025. I urge the Inquiry Team to follow the progress – the issues arising in Mr Dimmock's Inquest are pertinent to this Inquiry: -

https://www.conservativewoman.co.uk/unanswered-questions-over-the-death-of-del-dimmock

276. Please see below a second link which relates to similar experiences of other families. I fully appreciate that this Inquiry is looking at Essex only, but it must be the case that it should be aware of similar issues arising elsewhere:

https://www.phototimetunnel.com/our-troubles-with-midazolam-a-story-of-death-dying-and-a-powerful-drug

277. More generally I would like to add: -

278. **Failures in Clinical Care**

I. Lack of a proper and comprehensive assessment of Colin's condition that took into account both his mental and physical health needs both when first admitted and throughout.

II. Repeated failures to investigate underlying causes for Colin's behaviour.

III. Throughout Colin's care, no single clinician or team took overall responsibility for his wellbeing.

IV. Different services – hospital, mental health, care homes, social workers & safeguarding teams – worked in silos, each assuming someone else would lead.

V. There was no effective multidisciplinary planning to coordinate his complex physical and mental health needs, leaving him unsafe and unsupported.

VI. Simple health issues – such as an ear infection, constipation, and urinary retention – were ignored until they worsened, which increased his confusion and physical decline.

VII. I noted Colin being given out of date medication. I called staff up on this, but nothing was done.

279. **Nursing care**

I. Inadequate training and inadequate staffing resulting in: -

i. Colin's basic needs not being met. He was often left thirsty, hungry, or in wet and soiled clothes.

ii. Bruises and injuries being sustained by Colin that were not properly accounted for or properly recorded/monitored thereafter.

iii. Safeguarding processes were neglected.

iv. Colin's dignity was frequently disregarded; I often found him exposed, distressed, or left alone.

v. Nursing staff relied on restraint and heavy sedation instead of providing calm, compassionate, and attentive care.

I. Inadequate Observation Levels

i. I saw EPUT mental health nurses carrying out observations, but there is no record of these. No observation charts have been provided.

ii. Colin was becoming increasingly confused, agitated and suicidal but was often left entirely alone or under minimal supervision, with extensive reliance on security staff with no mental health or restraint training to keep him safe.

280. **Mental Health Failings: -**

II. Mental health assessments were delayed or carried out while he was heavily sedated, making them meaningless.

III. Colin's confusion and agitation were treated as misbehaviour, rather than as signs of illness or distress. Possible (if not highly probable) underlying causes – including pain, constipation, dehydration, and side effects of medication were not considered or investigated.

IV. Colin was overmedicated; repeatedly given lorazepam, diazepam, clonazepam, and haloperidol instead any kind of therapeutic care or treatment.

V. Despite holding Power of Attorney for health and welfare, I was excluded from assessments and care planning.

VI. Staff failed to carry out any proper risk assessment or put protective measures in place despite knowing that Colin had begun to express suicidal thoughts.

VII. On one occasion a DNR had been in place for three days before at my insistence it was removed

281. **Medication: -**

I. Medication was used primarily to control Colin, not to treat his physical or mental health needs.

II. Colin was given excessive sedatives, sometimes exceeding safe limits, without consultation or proper review.

III. Side effects – including severe sweating, itching, and worsening confusion – were ignored.

IV. Errors occurred, including giving penicillin despite his known allergy.

V. Some medications/laxatives were prescribed but never given or not available on the ward.

VI. This excessive and sometimes inappropriate use of medication accelerated his decline, leading to immobility, incontinence, falls and ultimately his death.

VII. In relation to medication, the Niche Report (page 110 paras 3.601 and 3.602) states: -

"This prescribing and administration of medications did not appear to be joined up across the teams and was not in line with good practice guidelines and other causes of agitation such as pain and infection were not addressed sufficiently.

There were also occasions when this prescribing exceeded the limits of various Trust policies, including in the initial Pharmacological Management of Agitated Behaviour Symptoms arising from an Underlying Delirium in Adults guidance (2021), which says that no more than 2mg lorazepam should be given in a 24-hour period for adults over 65 and not

more than 3-5 mg haloperidol. Also, the Emergency control of the Acutely Behavioural Disturbed /excited Delirium Patient: Rapid Tranquilisation Policy (2021) which states that a maximum of 4mg lorazepam can be given daily or 12mg haloperidol.

A recording has been shared with us, and thi includes a doctor telling a nurse to 'give sedation and painkillers freely as this is the only way to keep him calm."

282. **Resuscitation and Value of Life: -**

I. Do Not Resuscitate (DNAR) decisions were repeatedly made without consulting me, despite my legal authority under his LPA.

283. **Mental Health Act, Capacity, and Best Interests: -**

I. Colin was kept in hospital unlawfully at times – without valid Deprivation of Liberty (DoLS) authorisations – and later sectioned without full exploration of less restrictive options.

II. Capacity assessments were poorly completed, with missing reasoning and blank best-interest sections.

III. I was excluded from key decisions, despite my legal role under the Mental Capacity Act.

IV. No best interests meeting was held, and the attitude I encountered suggested ageist assumptions – that Colin's life was no longer worth saving.

V. It felt as though the focus was on containment and risk management, not on preserving his life or dignity.

VI. These failings left Colin unsafe and unprotected, with decisions made in breach of the law.

284. **Culture and Attitude: -**

I. The culture I encountered was defensive and indifferent.

II. My warnings and concerns were ignored, and staff sometimes misled me or withheld information.

III. Complaints and safeguarding reports were not acted upon, creating a system where poor care continued unchecked.

285. **Ageism and Wilful Neglect: -**

I. There is no doubt in my mind whatsoever that Colin was treated as though his life had less value because of his age.

II. Care decisions were arbitrary with a clear disregard for the sanctity of life.

III. This went beyond human error – the repeated failures, omissions, and indifference amounted to wilful neglect, and in my view, to unlawful killing.

My recommendations:

286. The Inquiry asks for recommendations, but at this stage, I do not feel in a position to provide a properly considered and comprehensive response. As the Inquiry is aware, Colin's inquest is scheduled for August 2026, and I believe the evidence that will come out during those proceedings must inform what I place before this Inquiry.

287. I intend to provide joint recommendations in the names of both my son, Matthew Leahy, and my partner, Colin Flatt. Their cases are deeply connected — both reveal systemic failings across physical health, mental health, safeguarding, and accountability. Only when both processes have concluded will I be in a position to present considered recommendations that honour them (Matthew and Colin) properly.

288. In addition, for the reasons set out above, I will be providing a further statement for Colin (as part of the Rule 9 Request) after the inquest.

289. I therefore ask that the Inquiry accepts this statement as my evidence for now and understands that a further statement and my joint recommendations will follow after Colin's inquest.

List of Documents which I have:

Please see Appendix A

Statement of Truth

I believe the content of this statement to be true.

SIGNED ..... [I/S] .....

MRS MELANIE LEAHY

DATED .01/09/2025.....

WITNESS STATEMENT OF MELANIE LEAHY PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

APPENDIX A – LIST OF DOCUMENTS WHICH I HAVE

I. Inquest bundle

i. Witness Statements

1. Melanie Leahy, family (undated)
2. Melanie Leahy, family (06/06/25)

ii. Medical Records

1. Anisha Grange
2. Basildon Hospital
3. Essex County Council
4. Tiptree Medical Centre

iii. Reports and Other Documents

1. Autopsy Report, Professor [I/S] (20/09/21)
2. NICHE report, (April 2025)
3. Postmortem Report, Dr [I/S], (17/03/22)
4. Supplementary Postmortem Report, Dr [I/S] (29/03/22)

iv. Essex Partnership University NHS Foundation Trust (EPUT) Policies and Procedures

1. Community Dementia Nursing Service Standard Operational Procedures, (01/11/17)
2. Discharge and Transfer Clinical Guidelines, (September 2019)
3. Mental Capacity Act and Deprivation of Liberty Safeguards Policy, (01/07/17)
4. Mental Capacity Act and Deprivation of Liberty Safeguards Procedure, (01/06/17)
5. Mental Health 24/7 Crisis Response & Home First Service, (30/03/20)
6. Mental Health Liaison Operational Guidance, (August 2021)
7. Older Adults Community Mental Health Clinical Guideline, (July 2017)
8. Policy for the Administration of The Mental Health Act 1983, (April 2017)
9. Procedural Guideline for the Administration of The Mental Health Act 1983, (April 2017)
10. Safeguarding Adults Policy, (April 2017)

11. Safeguarding Adults Procedure, (01/04/17)
12. SET Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Guidance, (March 2022)
13. SET Safeguarding Adults Guidelines, (Sept 2022)

II. Inquiry bundle

i. Statements

1. Commemorative Statement by Melanie Leahy, (undated)

III. Documents held by our client

i. Emails

1. Correspondence between Melanie Leahy and Basildon Hospital
2. Correspondence between Melanie Leahy and Broomfield Hospital
3. Correspondence between Melanie Leahy and Claire Panniker (MSE CEO)
4. Correspondence between Melanie Leahy and Essex Police
5. Correspondence between Melanie Leahy and Paul Scott (EPUT CEO)
6. Correspondence between Melanie Leahy and Tiptree Medical Centre
7. Correspondence between Melanie Leahy and [redacted] (Social Worker)
8. Correspondence between Melanie Leahy and Woodland View Care Home

ii. Photographs

1. Colin looking well, (14/04/21)
2. Colin looking well, (16/04/21)
3. Colin in hospital, (27/05/21)
4. Bruises & skin tears on Colin's arms and wrists, (27/05/21)
5. Bruises & skin tears on Colin's arms and wrists, (27/05/21)
6. Colin's hernia, (04/06/21)
7. Bruises to Colin's arm, (04/06/21)
8. Bruises and skin tears to Colin's arm, (04/06/21)
9. Colin's hernia, (05/06/21)
10. Bruises to Colin's leg, (09/06/21)
11. Bruises and skin tears to Colin's arm, (09/06/21)
12. Bruises to Colin's arm, (09/06/21)
13. Colin in hospital bed, incoherent, unable to walk or open eyes, (09/06/21)
14. Significant bruising to Colin's arm, (09/06/21)
15. Colin at home, Bruises to Colin's body, (17/06/21)
16. Bruises to Colin's body, (17/06/21)
17. Bruises to Colin's body, (17/06/21)
18. Bruise to Colin's upper leg, (18/06/21)
19. Colin after fall, (18/06/21)

20. Photo of stairs Colin fell down, (27/07/21)
21. Photo of stairs Colin fell down, (27/07/21)
22. Colin's head injury after fall, (27/07/21)
23. Bruises and skin tears to Colin's arm, (27/07/21)
24. Expansion of Colin's stomach in resus, (27/07/21)
25. Bandage put on Colin's stomach, (27/07/21)
26. Bandage on Colin's stomach, (28/07/21)
27. Bandage on Colin's stomach & bruising, (28/07/21)
28. Bandage on Colin's stomach & bruising, (28/07/21)
29. Colin in hospital bed, stomach bruising, (28/07/21)
30. Colin bruising and bandage, (30/07/21)
31. Colin in hospital bed, (30/07/21)
32. Colin's bandage and bruising, (30/07/21)
33. Colin's bandage and bruising, in pain in bed, (30/07/21)
34. Colin's bandage and bruising, (31/07/21)
35. Colin's bandage and bruising, (31/07/21)
36. Colin's baseline observations, (31/07/21)
37. Colin's purple stomach and leg, (31/07/21)
38. Colin's stomach, leg and bandage, (31/07/21)
39. Bruising to Colin's stomach and body, (02/08/21)
40. Colin's stomach growing, (02/08/21)
41. Colin's bruised back, (02/08/21)
42. Colin's stomach growing, (02/08/21)
43. Colin struggling to breathe, (03/08/21)
44. Colin's stomach getting bigger, (03/08/21)
45. Colin's bruise (03/08/21)
46. Colin's drip (medication out of date), (17/08/21)
47. Colin extubated, (18/08/21)
48. Colin awake and eyes open, (04/09/21)
49. Colin trying to breathe, (05/09/21)
50. Colin sleeping, (05/09/21)

iii. <u>Recordings</u>

1. Compilation of Videos and photos of Colin both prior and after MHA leading to transfer to Goodmayes Hospital, (09/06/21)
    - 09.59am: Photo of Colin in bed.
    - 10.14am: Photo of Colin in bed, taken just before MHA. 10.18am: Team of doctors around Colin's bed before MHA.
    - 10.55am: Video of Colin after MHA.
    - 11.20am: Video of Colin after MHA.
    - 14.44pm: Video of Colin just before transfer to Goodmayes Hospital.
2. Compilation of videos, (31/07/21)
    - 06.11am: Video of Colin after he had been deemed medically fit and was due to have a Mental Health Assessment.
    - 06.27am: Video of Colin's wound and request of water by him.
    - 06.30am: Further video of Colin in hospital bed.
3. Video of stairwell and balcony Colin fell down, (04/08/21)
4. Video of Colin awake asking for water, (04/09/21)
5. Compilation of videos, (05/09/21)

- 09.02am 5 September 2021: Video of Colin in hospital eyes shut and not responding. Breathing laboured.
- 14.00pm 5 September 2021: Colin starting to come round.
- 14.34pm 5 September 2021: Video of Colin understanding.
- 21.20pm 5 September 2021: Video of Colin in evening after morphine.
- 16.38pm 6 September 2021: Video of Colin after Midazolam prescribed

6. Video of Colin responding to Melanie, (05/09/21)
7. Audio recording, Colin phoning Melanie saying he is suicidal
8. Audio recording, Phone call between Melanie Leahy and Officer [I/S]
9. Audio recording, meeting with ITU team, (02/09/21)

iv. Diary Notes

1. Contemporaneous Diary Notes by Melanie Leahy, (25/05/21 – 06/09/21)

v. Medical Records

1. Alzheimer's Society
2. East of England Ambulance Service
3. Essex Partnership University Trust
4. Mid and South Essex Foundation Trust (Broomfield Hospital and Basildon Hospital)
5. North-East London Foundation Trust (Goodmayes Hospital)

vi. Other documents

1. HSE Prosecution of North Essex Partnership Trust, 2021
2. Letter from Ms [I/S] to Claire Panniker, (12/08/21)
3. Letter from Mr [I/S] to 'doctors involved in Colin's care', (17/08/21)