Name of witness: Paul Rucklidge-Smith
Statement No: 1
Exhibits: Appendix 1
Date: 1 September 2025

LAMPARD INQUIRY

RULE 9 WITNESS STATEMENT OF MR PAUL RUCKLIDGE-SMITH

I, **MR PAUL RUCKLIDGE-SMITH**, date of birth **[I/S]**, of **[I/S]**, **[I/S]** **WILL SAY AS FOLLOWS**: -

Contents

Section 1: Preamble

1. I make this statement further to a Rule 9 request from the Lampard Inquiry in relation to treatment provided to my late mother, Doris Joyce Smith, while under the care of Essex Partnership University NHS Foundation Trust ('EPUT'). I make this statement from my own memory of events, knowledge and belief. I have also had the assistance, input and support of my partner, Anna Rucklidge-Smith (date of birth [I/S], of [I/S]. This statement is written and submitted on behalf of both of us and we will be jointly providing evidence at the live hearings.

2. Please note that we have had sight of various documents and reports in our possession which have assisted us in preparing this statement. We have identified additional key documents for the Inquiry to obtain. Further to receipt of the same, we would like to submit a further rule 9 statement.

Section 2: Diagnosis and Admissions

Early Admissions

3. My mum was born on 6 December 1945; she died on 14 October 2020 at age 74 years old. I believe she has had some form of mental health issues throughout most of her adult life; however, my own personal knowledge and experience of her mental health decline began in 2012.

4. In March 2012, she suffered a mental breakdown and was referred to EPUT psychiatric services for the first time by her GP. At that time, Anna and I organised for her admission to Peter Bruff / Landermere Mental Health Unit, in Clacton. It was a struggle to get her to go in the first time we took her, we had to beg her to go in on her own accord as the facility suggested they would need to call the police to forcibly remove her from our car if she did not consent. When we told her this, and tried to explain that we wanted to ensure we were in control of the process so as to avoid them choosing to section her involuntarily, she agreed. She ultimately stayed in that facility for around six weeks.

5. In 2016, she had another mental breakdown and was taken to Colchester General Hospital ('CGH'). She was at that time very psychotic. She stayed there only three days because on the third day, she came out of her psychosis and appeared totally normal again. When she was back in a fit state, she told us she thinks she was experiencing a hallucination. The doctors diagnosed her with a

Urinary Tract Infection after doing only minimal testing. There was no formal assessment of her mental health and no follow up.

6. By early 2020, her mental health had significantly deteriorated. We had noticed it happening because in the past when she was having an episode, it would always start with her feeling off balance, unsteady on her feet and/or having slurred speech. When we started noticing these signs in 2020, we would attempt to discuss them with her but she would always she say she was fine.

7. In the evening of 22 April 2020, she had a bad fall inside her home which caused her to fracture her right wrist in two places. Although it was not her first fall, it was the first time she fell that caused a serious injury. She took herself to CGH A&E department where she was diagnosed with a shoulder ligament injury and sent to the walk-in centre, Colchester to be given a cast.

8. When she got home, she called Anna and I to tell us what happened and we arranged to visit her the next day to see how we could help. She was becoming increasingly confused by this time; she called us again at 5am that night asking why we were outside of her house (we were not) and had cut off her cast overnight. We visited her on 23 April 2020 and helped her wash and dress. We also took her to the hospital to have the cast put back on and arranged for social services to provide some home support. Over the course of the next week, her condition worsened, she was calling me multiple times a day, talking quite a lot about the past.

9. She had a few more similar incidents in the following few months which resulted in multiple admissions and readmissions to hospital:
    a. 5 May 2020 – 7 May 2020
        i. On 5 May 2020, my mum was taken by ambulance to A&E CGH with a complaint of dizziness and feeling *"unsteady on the feet"* as is recorded in the A&E record. However, it was actually much worse than that, her speech was very slurred and she was struggling to stand. She was ultimately admitted to CGH on a medical ward. The next day, she called me on the phone and was extremely aggressive which was not like her at all. She was referred to the mental health liaison team. We spoke to the hospital to explain our concerns about her worsening mental health but not much was done for her; she was later referred to the

Older Adult Home Treatment team ('HTT') and discharged home on 7 May 2020.

b. Evening of 7 May 2020 – 16 May 2020

   i. Within a short time of her being home on 7 May 2020, she was found wandering the street in an agitated state, she was banging on neighbours' doors and had called me screaming down the phone, so I called 999. She was taken by ambulance to CGH A&E again, this time with reports of feeling *"suicidal"* according to her notes. The notes also record that I told them she has had similar episodes, has been admitted to the mental health unit for assessment and is not safe to be left alone. At around 10:45PM that day she suffered a seizure whilst in A&E, it was determined to be a *"pseud-seizure caused by high anxiety*". She was diagnosed with delirium and deemed to *"not have capacity to stay at home."* [1/64]. She remained in hospital until 16 May 2020.

   ii. Prior to her discharge, we spent a lot of time talking to the HTT, the Ace team and the discharge team explaining how worried we were about her going home, she was at that stage incredibly delusional and was displaying odd behaviours. We were assured she would be well supported, but, in reality, we did not feel like we were being listened to.

c. 16 May 2020 – 21 May 2020

   i. After her discharge on 16 May 2020, my mum continued to call us, being verbally abusive on the phone. I spoke to the HTT on 18 May 2020, which was the next Monday, wanting someone to assess her as she was clearly deteriorating and the repeated admissions, discharges and readmissions were doing her no good. The HTT were very unhelpful, noting that she had capacity and so they would not be able to visit her without her consent. We disagreed that she had capacity and explained that her behaviour was not normal for her. Our pleas were going on deaf ears.

d. 21 May 2020

   i. On 21 May 2020, we had called the HTT again literally begging them to visit my mum and do an assessment as her behaviour became more worrying. They finally agreed to attend her home the next day, I think they only agreed because we had asked that they give her a call to speak to her so they could assess the situation

for themselves. Once they spoke to her, we received a call back and it appeared they finally understood our concerns. However, before they could visit the next day, my mum had deteriorated further and two ambulances attended her home between 5PM and midnight. Unfortunately, both times the paramedics had to leave her in the house after the crisis team refused to get involved, so my mum remained in the house, calling us throughout the night, again in a severely delusional state. We updated the HTT who assured us they would still visit the next day to do an assessment as planned.

e. On 22 May 2020 – she was taken to A&E CGH by ambulance following a visit from **[I/S]** in the HTT. The complaint is recorded in the A&E notes as *"mental health deterioration"*. The records state *"patient now being delirium, speaks frequently, saying [that] she is having fits"* and it *"appears now [that the] medication [is] causing current symptoms"*. She was again referred to the mental health team who note in their records that at 9:40PM they were unable to conduct a mental health assessment as *"capacity not evident – incoherent, giggling, unable to answer questions – did not know why she was here or where she is. Mental Health Act assessment required"*. She stayed overnight and was discharged at 1:55PM on 23 May 2020 under the care of the psychiatric team.

f. On 23 May 2020 – the issues continued. Her hospital records note that she was found to be *"chaotic"* in the community, including having gone to the bank in her pyjamas that evening. She was also *"not sleeping, was neglecting her personal care"* and *"continued to call her family repeatedly"*. She was at that point taken to A&E CGH and assessed by **[I/S]** Advanced Mental Health Practitioner (AMHP), who was the first person who we felt actually listened to us and who we felt was interested in helping my mum. **The AMHP** notes that my mum was *"muddled and fixated in thoughts, unable to engage or focus"*. She organised for her assessment by two psychiatrists, Dr **[I/S]** and Dr **[I/S]** both of whom had specialist training under Section 12 Mental Health Act 1983 ('MHA'). The conclusion of the assessment according to the AMHP's report was that mum's presentation *"was of significant anxiety, confusion and vulnerability and her known history of wandering, poor dietary intake and spending money excessively warranted admission to*

hospital for further assessment under Section 2 MHA 1983". She was ultimately transferred to the Henneage ward, detained and maintained until 15 June 2020.

Henneage ward

10. On Henneage ward, the care and treatment my mum received was completely substandard. My mum had undergone a scan at one stage that showed she had small vessel ischemia. Instead of giving us an opportunity to discuss her history and our concerns, we were told the ischemia was nothing, just a normal part of aging, and that they were giving her a diagnosis of *'delirium'* which supposedly stemmed from her right wrist injury.

11. Anna being a nurse, has medical training and together, we were concerned that this may have been a misdiagnosis, or at the very least, a missed opportunity to consider whether something more progressive was taking place, particularly when her decline had been apparent for years before her wrist injury occurred. Even if we were wrong, we simply just wanted to help and be heard.

12. In our view, it felt like mum was suffering bi-polar symptoms on account of her frequent manic episodes, thoughts of grandeur and her excessive spending. Since 22 April 2020 alone, she had been hospitalised for a mental health crisis four separate times. She was also doing alarming things like going to the bank in her pyjamas, shouting at neighbours in the street and calling us throughout the night. We wanted desperately for a proper assessment for her.

13. We note from the records that the delirium was also only a *"working diagnosis".* We take issue with the fact that Henneage ward were adamant about discharging my mum despite only having a *"working diagnosis"*; one that also requires aggressive treatment to improve outcomes and yet there was no aggressive treatment offered post-discharge in my mum's case.

14. My mum was discharged on 15 June 2020 after only 3 weeks of her admission. This is critical to flag because I strongly believe that had the facility been willing to engage with us, my mum would have been diagnosed correctly, and we could have ensured she was getting the home support that was appropriate for her needs. This may have meant she was not left to deteriorate in the manner and at the pace that she ultimately did.

Care in the community

15. In the community, my mum was under the care of the HTT. Her care coordinator was **[I/S]** who worked as part of the Specialist Mental Health Team. Unfortunately, on the day of her discharge, my mum had called me, shouting that she did not want anything to do with me so we did not hear from her for several weeks but did get updates from family and her neighbours. To our understanding, she coped reasonably well for the next few weeks.

16. That being said, we have considered the report **the care coordinator** prepared for the inquest that took place following my mum's death. We note the following key entries regarding my mum's presentation in those weeks:
    a. 09.07.2020 – During her home visit with **the CC** my mum describes her mobility as *"wobbly"* and that this had been affecting her getting in and out of the bath;
    b. 22.07.2020 – My mum told **the CC** she recently had another fall and again reported feeling wobbly. Specifically, the entry states "…*she reported during this meeting having felt fed up on the Monday but did not feel this was low mood but instead precipitated by her feeling wobbly…Doris also reported having had her hair cut and falling over due to her foot getting stuck and so had plans to buy a shopping trolly"*. The note goes on to say *"in terms of input at the meeting we discussed Doris current presenting problems these were mainly in relation to her mobility however she reported she still felt able to manage activities of daily living and was completing housework, cooking, ironing and shopping. From memory I remember discussing a possible social care referral for support at this point, however Doris declined this…she denied any problems with depressed mood, anxiety, suicidal thoughts however reported an going worry about it deteriorating again the future."*

    I know from personal experience, that these should have been signs that my mum was edging closer to having a mental health episode.

17. On 3 August 2020, **the CC** reports receiving a call from Anna with concerns about my mum. The record states:
    "Anna stated that Doris' neighbours had reported her balance had worsened which is usually a sign of her mental health deteriorating and that she had fallen against a neighbour's car and damaged it."

18. On this occasion, we had noticed that my mum had been on Facebook in the early hours of the morning (around 3AM). My mum's neighbours had also begun to raise concerns; her balance had deteriorated, she was spending all night awake, there was banging throughout the night and on one night she went out at 7:30PM and did not return until 1AM. The house had also started to become unclean, which was usually another telling sign of a problem.

19. One thing about my mum is that her house was always clean, it may have even been to the level of obsessive compulsion, Anna used to say that she had never seen a house so clean. So, mum's house being unkempt was a tell-tell sign that something was wrong with her. **The CC** says the same in her reporting.

20. **The CC** notes that she went to the house on a 'cold call' that day after speaking to us, she says *"I observed on entering the house that it was unkempt which was unlike Doris and that she had items on the sofa…Doris was documented to have remained euthymic in mood, however some irritability was observed when questioned about her home."* In her view though the irritability was *"usual for Doris when she is questioned"*.

21. She also reports my mum was denying *"any problems with her mood".* She notes that she advised us she would visit again on 5 August 2020 to monitor and review her mental health and to assess whether support needs to be increased.

22. On 5 August 2020, **the CC** reports that my mum's presentation was *"well kempt"*, she presented as euthymic both objectively and subjectively, there was no evidence of any elation, confusion, delusional ideas and her cognition appeared intact. She notes she did **not** see the upstairs of the home but that the downstairs was relatively clean. On the topic of spending she says, *"she did report some thoughts of more extravagant purchases",* and when they discussed this together, my mum is said to have become frustrated. They discussed a physical health check and MRI.

23. **The CC** reports having a call with Anna subsequent to the visit:
"Anna reported that following my visit Doris had gone out and the neighbours had worried a tap may be left on so they let themselves into her home….She reported during this time the neighbours facetimed her showing her upstairs in disarray, they reported ongoing concerns for her mental health and her balance as week

as risk of her going out late at night and risk for her finances…I reassured Anna that her concerns were being taken seriously and advised her of my plan for monitoring Doris' mental health and physical health.".

24. She goes on to say, *"I advised Anna that from my assessment that day she would not be detainable under the Mental Health Act due to no reason being given to doubt her capacity or imply an imminent risk to herself or others despite the concerns."*

25. We felt extremely let down by the service. **The CC** admits that my mum confessed to wanting to make big purchases on 5 August, which was usually a sign of her cognition declining, and that my mum became frustrated when **the CC** attempted to discuss money with her. **The CC** admits to not looking at the upstairs of my mum's home to confirm what state it was in but was seemingly satisfied enough because the downstairs portion was *"relatively clean".* She admits to knowing there were discrepancies in the observations the neighbours were making, who saw my mum every day, compared to what presentation *she* had seen of my mum herself, and despite all of this, not once in her notes does she mention the possibility that my mum was masking the true extent of her issues.

26. Her report notes that when she raised the discrepancies *"between [her observations] and those of family/neighbours"* with the HTT "*they advised also that from observations she would not appear to require their support at present but to continue monitoring."*

27. It is notable that, within two weeks of this date, my mum would go on to be hospitalised, again, and this time until her death a few months later. In our view, neither **the CC** nor the HTT appreciated the gravity of my mum's condition, or her masking or the speed at which she was deteriorating.

28. Then on 8 August 2020, three days after **the CC's** last visit, we were called by a security officer at Morrisons who informed us my mum had been caught shoplifting and that it was the second incident that week. The security officer had taken my mum home and had seen the state of chaos the place was in; there were piles of belongings as well as blood stains in the home (my mum had reportedly cut her finger). The security officer called the police and an ambulance and my mum was taken to CGH A&E hospital that same day.

29. We were so afraid for my mum that we called A&E to explain all the things we had been noticing about her mental health decline, they assured us that she would be assessed and not discharged home without a review. She was definitely not safe to be home alone. Despite our efforts and to our complete shock and upset, my mum was discharged back to her house that same evening.

30. Out of concern we travelled up to Claton to visit her the next day. She was in a state of mania; she was sitting in dirty clothes and appeared delusional again. She had not eaten and her home was in disarray. We were shocked because **the CC** had told us only a few days prior that the home was clean and kept. However, the condition she and the house were in on 8 and 9 August 2020 suggested that her deterioration had been ongoing for at least a few weeks.

31 **The CC** reports contacting my mum again on 10 August 2020, which was the following Monday after the shoplifting incident. It is frustrating that my mum was left over the weekend, after what would have undoubtedly been a traumatic event for her, without professional support from the HTT.

32. **The CC** records her note from that day as follows:
"On my contact with Doris on 10/08/2020…Doris reported she had recognised that there has been something going on with her mental health ***over the past week****,* ***however she said she felt clearer now*** *and slept well so is planning on slowly cleaning her home but was aware she should not do too much because of the heat".*

33. She goes on to say "*we discussed her recent* ***spending*** *and she maintained she had enough to make these purchases and did not want anyone involved in this. I offered an appointment for that day but she declined and was aware of [our] planned appointment the next day".*

34. Again, we are troubled by these notes, whilst we understand that my mum had moments where she could present as calm and coping, surely it was clear by now that she was, in actuality, masking the extent of her deterioration? Surely it was clear that there were obvious inconsistencies between what my mum was saying and her actual behaviour being reported by third parties, and that her case was far more urgent than she was presenting it to be?

35. To minimise the events that occurred on 8 August 2020 as simply my mum's *"spending"* is also gravely misleading, when it was actually multiple shoplifting incidents. **The CC** also failed to gather information about the blood stains in the house or the condition it was in when the security officer saw it, when that ought to have raised alarm bells given her account of what the house looked like three days prior was that it was *"relatively clean"*. She did no due diligence, instead she accepted my mum's explanation on face value and accepted her rejection of an in-person meeting that day.

36. When we spoke to **the CC** we explained what happened and that the paramedics had advised that my mum needed a two-to-three-month hospital admission. Again, there was not much of a response from her. **The CC** even says in her note that *"I gave [Anna] reassurance again that the team were taking their concerns seriously"*. We did not feel this was the case.

37. **The CC** attended my mum's home on 11 August 2020; she was greeted by a neighbour who reportedly told her my mum's home *"was in a state of neglect and maggots had been found in the kitchen"*. In her notes, **the CC** says the house was *"**slightly disorganised**"* and that upon examination of my mum *"**there was not any real evidence of elation**"*, the only real issue was that *"Doris was persistently talking about the past without recognition that I was attempting to discuss current concerns and events"*. However, she goes on to qualify this by saying *"**I noted in the past meetings she had also done this though**"*.

38. She concludes by saying:
"There was no reason in this meeting to doubt her ability to make decisions, weigh up pros and cons of these or to doubt capacity" but qualifies it by saying *"although she acknowledged periods over the weekend which she was unclear about and described these as "having an episode*".

39. Ultimately, **the CC** notes that a plan was made with my mum to refer her to the HTT team, contact social care regarding a Care Act Assessment and chase her MRI results. On 13 August 2020, **the CC** notes that my mum was referred for crisis support.

40. On 21 August 2020, six days later, we received a phone call from mum's neighbour asking for help because my mum was running around the mews banging on doors, shouting that she needs medication and being verbally

abusive. I called my mum and she was hysterical, so I called an ambulance and she was again taken to hospital.

41. **The CC's** notes of that day state that the social care team believe she may have taken an overdose of **[I/S]** Again, no real concern about what was going on with her and no push for a formal mental health assessment.

42. My mum was assessed at A&E and due to concerns about her confusion and their feeling she was unable to weigh up the benefits of going into hospital, a Mental Health Act assessment was requested and she was detained under Section 2 and admitted to Ruby Ward on 22 August 2020.

43. She had been assessed by the same assessing team of **[I/S]** AMHP, Dr **[I/S]** and Dr **[I/S]** According to them, it was clear my mum *"was not coping at home"*, she had no insight and lacked the mental capacity to agree to informal admission. It was concluded that she was at risk of further deterioration and that a section 2 admission was in her best interest.

44. She was diagnosed formally with *"high anxiety, depression with psychotic features"*. Her risk factors were: *"Self-neglect, vulnerability, poor mobility, risk of falls. History of #wrist 27/05/20. Mrs S had pseudo-seizures causing increase risk of falls and she was mobilising with a walking stick."*

45. When we had spoken to **the AMHP** on 22 August 2020, she was shocked that no real diagnosis had been made since she last saw my mum on 23 May 2020 and explicitly told us how disappointed she was that the Essex mental health service had failed my mum. Within a few hours of her team's assessment, she called us back and advised that my mum had been sectioned and taken to CGH.

46. It was demoralising to have to go through the same painful process over and over again with my mum in and out of hospital admissions and not be taken seriously when we were desperately seeking help for her. My mum's support in the community between April and August 2020 was totally insufficient; the supposed help she was getting did nothing but leave her in a worse condition than she had ever been by the time of her sectioning. Both Anna and I place significant blame on the support she was given in the community, especially by **the CC** and the Specialist Mental Health Team, because had the support been effective, had we been listened to about the gravity of mum's symptoms, she would never have

gotten as bad as she did, which may have meant her admission to ruby ward and thus the events that led to her death, would not have occurred.

Section 2: Ruby ward experience

Early assessments

47. My mum was admitted onto Ruby Ward on 22 August 2020. Ruby Ward is a seventeen bedded older adult inpatient functional assessment unit. It is a secure unit staffed day and night by nurses and HCAs with access to an on-call doctor. My mum was reportedly placed on level two observations, which consist of four random checks within a one hour period. The records note that whilst my mum was admitted under a section 2, this was rescinded four days later, on 26 August, after she was deemed to have capacity to consent to care and treatment. She was thereafter managed under the mental capacity act.

48. Her medications on admission to Ruby ward were:
    a. Levetiracetam 250mg bd (for epilepsy)
    b. Betahistine 16mg tds (for dizziness)
    c. Vitamin B
    d. Chloramphenicol eye drops; and
    e. Amoxicillin (infection).

49. According to the EPUT case notes and 4-hour risk assessment notes, my mum was identified as **high risk of falls**. Ruby Ward is supposed to follow the EPUT Trust Falls Risk Management Policy (CG58) in such instances, which says, *"all patients are expected to have a falls risk assessment* ***within 24 hours of admission"****.*

50. This assessment was not done in my mum's case, which is something the Serious Incident Investigation ('SII') report found to be a failing by Ruby Ward. In fact, my mum did not have her first falls risk assessment until 2 September 2020 despite being categorised as high risk. No rationale has been provided as to why the assessment did not occur on time.

51. As she was high risk of falls, my mum was also placed in a room with Assistive Technology ('AT'). As far as we understand it from our own research at the time, and according to the root cause analysis report, AT is an infrared system of mattress sensors and floor sensors that alert caregivers or monitoring services when a fall or potential fall is detected.

52. We were specifically told that the AT would be on in her room at all times which we were of course pleased to hear. However, we later found out that the AT system was only activated in her room when she was asleep, not during the day, and that at times it was not on at all. The SII investigation also found that there was no Trust process on the use of AT or any training programme which complied with the requisite guidance (CLPG17). This all makes sense now because despite being in an AT room, my mum went on to have multiple unwitnessed falls in her room, the last of which led to her death.

53. On 23 August 2020, my mum was referred to the physiotherapist and a mobility walking aid assessment was requested. My mum had not arrived at Ruby Ward with a walking stick but was provided one. On 24 August 2020, she was assessed by **[I/S]** (ward physiotherapist), she was reportedly *"mobilising well with her walking stick, **but was anxious about falling** and her mobility was variable due to her mental state"*. The physiotherapy recommendation was to *"continue to use A/T in the room as a safety measure*". It is unclear to me whether the physiotherapist knew the AT was not fully functioning in the room at the time or whether she knew the falls risk assessment had not been done on time.

54. We believed that my mum was being well looked after on Ruby Ward, and based on the records, she was in fact doing well initially, attending group exercise sessions, being pleasant and walking independently. Her observations were being monitored regularly and were even reduced from level two to level one on 28 August 2020 and again on 1 September 2020 after a determination that she was walking independently using her walking stick, was in a settled mood and was sleeping well.

55. The communication we had with Ruby ward at first was also good. However, on 29 August 2020, I was told that they were not going to be able to give us any more information about my mum as she had rescinded her consent to us being involved. I questioned whether she was capable of making that decision given her mental health situation, and I was told she had capacity and it was her right to do what she wanted. So, we did not hear anything for about a week.

56. As above, the first falls assessment was completed late, i.e. on 2 September 2020. Her care plan was also completed then. We later found out from the root

cause analysis report that the falls risk assessment was not only late but was filled with inaccuracies, did not document all of the interventions that the nursing team were implementing to reduce the risk of falls and was completed by an unregistered person instead of a registered nurse as per EPUT Trust CLPG28 Clinical risk assessment and safety procedure."

My mum's deterioration

57. By early September 2020, my mum's health started to deteriorate and the staff realised they needed to involve us again. Around this time, I started receiving calls from the ward and my mum when I was at work. When I spoke to my mum, she was very confused and upset saying she was being kept against her will and that we needed to call the police.

58. I spoke to Dr **[I/S]** who explained that my mum had deteriorated, that they believed she had a form of dementia and were doing another scan to confirm, we were advised to look up the Alzheimer's society for information and let them know if we had any questions. We were invited to attend the next review on 16 September 2020 via video link.

59. We visited my mum on 12 September 2020 and saw that she had massively deteriorated. She had also lost a significant amount of weight, around a kilo, which was very noticeably concerning. She was absolutely tiny.

60. On 14 September 2020, we had asked for a new care coordinator as we felt **the care coordinator** had let my mum down.

61. On 16 September 2020 we attended the review at 10am. Those involved were Dr **[I/S]** Dr **[I/S]**, Dr **[I/S]** **[I/S]** (discharge coordinator) and **[I/S]** (social care team). They asked us for a brief history, gave us an update on the current state of my mum's health, i.e. that she was very confused, her mobility was fine however her paranoia and sleep were disturbed and that she had started to refuse food and drink.

62. It was at that meeting that we were told they had done a CT scan and they believed she has vascular dementia. Given it was the first time we were hearing of this diagnosis after eight years being involved with the mental health system, we asked why this was not picked up before. They advised that they could not comment on a previous hospital's diagnosis. They advised that they would start

her on risperidone and promethazine and that once the CT scan results came back and the diagnosis was confirmed, she would be referred to Meadow view in Thurrock, which is a specialist dementia unit for older individuals.

63. We note from her records that Meadowview ultimately refused to accept my mum because she was from Clacton. This is according to the ward review carried out on 5 October 2020. A new plan was then made to transfer her to Tower Ward (dementia assessment unit) in Clacton in the interim.

64. My mum's health became progressively worse, on 21 September 2020, **the physio** reports that she was "*presenting with challenging behaviour using [her] walking stick as a weapon towards the nursing staff,* ***also nursing staff reported that Doris food and fluid intake was reduced****".* She goes on to say *"due to the risk posed by Doris using the walking stick as a weapon, nursing staff withdrew the walking stick from Doris who was nursed on level 3 observations due to falls risk".* We are concerned about this, my mum's mobility was such that it would have rendered her bedbound to have her walking stick removed from her, and given she was already deteriorating and struggling to eat and drink anything, this decision is likely to have made her mood even worse. It would have also put her at serious risk of injury on account of her being at high risk of falls. We were not informed about the removal of her stick.

65. On the same day, **the physio** is said to have reviewed my mum but from a distance because she was presenting with challenging behaviour due to her mental condition. **The physio** concludes that *"following my observation Doris remains at falls risk due to recent deterioration in mental health. Therefore, I agreed with nursing staff to continue with level 3 observations due to falls risk despite Doris been observed to be steady on feet".*

66. On 22 September 2020, we were told she was unsettled, very hostile, throwing things and spitting at staff. We were told her olanzapine was helping a little, but that it usually takes a while to take effect. She was presenting more unsteady on her feet and they believed it was due to her minimal food and fluid intake.

67. On 24 September 2020, we were told that the CT scan results came back and the diagnosis of vascular dementia was confirmed.

Repeated falls

68. EPUT has a post-fall protocol that must be followed after each patient fall, it is titled the *"Slips, Trips & Falls"* guidance and it was in place at the time of my mum's stay.

69. The guidance stipulates that after an unwitnessed fall; neurological observations must be implemented for a 24-hour period and all observations must be done by a qualified member of staff. The guidance also recommends that observation levels are re-considered (and increased if deemed appropriate) and that the patient is sent to A&E for a CT scan if an injury has been sustained.

70. On 1 October 2020, my mum had an unwitnessed fall. To put this into context, she had arrived to Ruby ward with a history of frequent falls (including as recently as April, July and August 2020), she had been categorised since her admission as a high-risk-of-falls patient, she was elderly, frail and had been losing weight due to lack of food and fluid intake. She had also recently been diagnosed with vascular dementia. She was on level two observations and was increasingly and more frequently exhibiting signs of confusion, aggression and agitation.

71. My mum had reported to staff that another patient pushed her over which caused the fall, and she had hit her head in the process. The on-call doctor responded and noted that the left side of her skull had a *"palpable mass [which] was growing in size"*, she also had one instance of vomiting. She was transferred to A&E for a head CT scan in line with the guidance. On examination, she did not have focal neurology and her observations were stable, she was managed conservatively in the general hospital and then returned to the ward the next day. She was maintained on level two observations and her falls risk assessment was updated.

72. The root cause analysis report notes *"whilst awaiting for transfer to the acute trust, Mrs S should have received 4 sets of neurological observations by a qualified member of staff.* ***Only one set of neuro-observations was taken by an unqualified member of staff. Post-fall protocol not followed…"***.

73. It goes further; ***"levels of observations should have been increased to level 3 or zonal observations by charge nurse following a fall which resulted in a head injury requiring transfer to acute trust. Non-compliance with good practice."***

74. We were informed about the fall but not the failure to follow procedure in this case. In particular, we feel the failure to review the level of observations may have been a detrimental error by the ward.

75. On 2 October 2020, The physiotherapist assessed my mum's condition. She was said to be mobilising safely with the aid of a walking stick *"but observed to be unsteady at times, however managed to walk safely with close supervision of one when offered palm to palm assistance"*. As a result, the physiotherapist recommended that when mobile, **my mum must be closely supervised by one member of staff.** Again, no mention of a reconsideration of the level of observations, the root analysis report records that she should have been increased to level 3 after the fall.

76. My mum's last ward review was on 6 October 2020, at that time she was still behaving aggressively. The notes state that Meadow view had decided not to accept her as a patient and that on 6 October *"a discussion with Tower ward in Clacton for transfer in the interim [was] instead [discussed]",* however the root analysis investigation found "*no documented correspondence regarding a possible transfer to Tower ward"* exists.

77. On 8 October 2020, at around 8:25PM, my mum had another unwitnessed fall when she walked into her bathroom, this time hitting her head and hurting her back. This was the second unwitnessed fall she suffered in the space of eight days. The notes confirm she did not lose consciousness and there were no visual problems. The on-call doctor, Dr **[I/S]** was called and he found a 2cm lump in the occipital region of her head. The root-cause analysis report notes *"the doctor suggested she needed a walking frame".*

78. On this occasion, my mum was **not** taken to A&E for a CT scan despite the lump found and neurological observations were **not** completed for the full 24 hours – the second time after an unwitnessed fall that the guidance was not followed. However, what we found even more distressing, was the fact that that root cause analysis report notes that in all the level two observations carried out that day no staff member had documented whether the AT in my mum's room was put on or not;

    "throughout the night time observations no staff member has documented whether the A/T was turned on".

79. In my view, these facts are gravely concerning, particularly given my mum went on to die from yet another unwitnessed fall that happened less than 24 hours later. Specifically, we wish to note:
    a. It is EPUT's own policy that after any unwitnessed fall a patient has to be assessed for injury, and if there is an injury found, they must be taken to A&E for a scan;
    b. I find it striking that my mum was not referred to A&E on this second occasion when she had also fallen less than 24 hours prior to this one and had a lump on her head that time as well as a lump on this occasion too;
    c. Dr [I/S] asked for neurological observations to be conducted for 24 hours and yet they weren't – again – with no explanation as to why;
    d. The level of observations were also supposed to be reviewed, again, and were not, by either Dr [I/S] or the staff medical team;
    e. It is concerning tha the physiotherapist gave clear instructions that my mum was to be monitored closely by one member of staff when she was mobile indoors and this was not done, clearly, which is why my mum had repeated falls on this ward;
    f. There is also no record on whether the AT was fully functioning or turned on in my mum's room. The AT is there for a reason, to prevent the very thing that led to my mum's death and now on two occasions we are left questioning whether it was in use or was working or not.

80. We were informed about the fall on 8 October the next morning but not the multitude of failures that were involved. We had spoken with **the ward manager** who said my mum hit her head the day before but that there had not been any need for her to go to the general hospital. She also advised us that my mum was in an AT room that they **would turn on** so that if she were to get up staff would be alerted to hopefully stop another fall. I am appalled now that the key detail of it being off prior to her second fall was left out of her update to us.

81. On 9 October 2020, the notes stipulate that the physiotherapist attended around midday to complete a ward review. The following was determined about my mum's now significantly fragile condition:
    a. She had swelling and discoloration in her lower limbs;
    b. She was unsteady on her feet using the walking stick; and
    c. She was observed to be irritable and confused but did follow verbal instructions.

82. Given my mum's worsening physical and mental health conditions, the physiotherapist then decided to conduct a mobility assessment with aid of a wheeled zimmer frame. She notes my mum *"was able to transfer safely from **sitting to standing** with aid of a wheeled zimmer frame with verbal instructions **with close supervision of one staff."*** She was also able to *"mobilise from **bedroom to shower** safely and slowly with aid of wheeled zimmer frame **with close supervision of one staff** (HCA staff)."*

83. After considering the risk factors, the physiotherapist made new physiotherapy recommendations for my mum and the nursing staff, which are documented as follows:
    a. ***"To continue to use assisted Technology in Doris' room (AT room – staff to ensure AT is activated as and when required), high low profile bed as a safety measure.***
    b. ***To encourage Doris to elevate both lower limbs on a footstool and nursing staff to elevate foot end of the bed when Doris is in lying position***
    c. ***To request for Doctor's review to examine Doris lower limbs***
    d. ***To refer to orthotics for a helmet to minimise the head injury dur to falls risk-Doctor and Physiotherapist to liaise and complete the referral***
    e. ***For all transfers and indoor mobility – Nursing staff to encourage Doris to transfer and mobilise safely with aid of wheeled zimmer frame with close supervision of one staff***
    f. ***For outdoor mobility – nursing staff to mobilise Doris outdoors in wheel chair"***

84. We note that during the MDT handover on 9 October 2020, the physiotherapist also says she discussed making a referral to the orthotics department for a helmet for my mum to minimise a head injury due to the falls risk. Something which we found out was only followed up on 12 October 2020, when my mum was already in critical condition and dying in hospital.

Fatal fall

85. The events that led to my mum's fatal injury are said to have transpired as follows:

a. 11:50AM – the physiotherapist emailed Ruby ward staff with her recommendations (i.e. that my mum should be supervised closely by one member of staff when mobile indoors)
b. 12:00PM – my mum was seen by HCA [I/S] *"[going] to her room from the dining area without any concern"*
c. 1:33PM – an email was sent from ward manager to the Ruby ward team informing them of the physiotherapist's assessment and mentioning that my mum should remain on level two observations
d. 3:00PM (approx.) – the physiotherapist speaks to RMN [I/S] regarding her recommendations. The RMN then repeats the recommendations to team leader ward manager
e. 3:21PM – Dr [I/S] assesses my mum's legs which are now swollen – the plan is for staff to help her keep them elevated and moisturised
f. 4PM – the care plan is updated. My mum is noted as *"not being particularly amenable to the assessment but able to understand how to use the frame"*
g. 4:27PM - my mum had reportedly travelled to her room from the dining area *"unaccompanied*" saying she wanted to rest.
h. 4:50PM - she is recorded in the observations as *"sitting in her chair"*.
i. 5PM – my mum is found on the floor of her bedroom having fallen (unwitnessed) and banged her head on the door.

86. [I/S] (HCA support worker) says he was alerted to the incident by other patients who had heard her fall. He recounts having rushed to the room and pressed his personal alarm when he saw her on the floor of her toilet with blood pouring out of her nose and head. Once the alarm was pressed, [I/S] followed and attended the scene. She says she attended to my mum's injuries with HCA [I/S] while SN [I/S] called for an ambulance. An ambulance was called as blue-light emergency. Dr [I/S] was also bleeped by [I/S] [I/S] (deputy ward manager).

87. At 5:07PM, paramedics arrived, my mum was presenting with head trauma, confusion, prior loss of consciousnesses and blood coming out of her nose. Despite the injuries, she did become more alert, vital signs were within range and she began interacting with the paramedics. According to the root cause analysis

report, Dr [I/S] did not arrive until after the paramedics had already assessed my mum.

88. **The RMN** then notes in her witness statement submitted for the inquest, that the paramedics advised that my mum could stay on the ward. She says she felt uncomfortable with this idea and so pushed for a hospital admission given the state of my mum's injuries. Dr **[I/S]**, **the RMN** and the paramedics then all agreed that she should be taken to hospital.

89. At 5:30PM, paramedics, along with **HCA support worker**, took my mum by ambulance to Broomfield hospital.

90. There are crucial parts of the witness statements we have considered regarding what happened on 9 October 2020 that we wish to highlight here. In particular, we note the account provided by **the RMN** to be of the most significance:
"In the afternoon, approximately between 1500 – 1600hrs, the physiotherapist approached me and told her recommendations for Doris. Doris had been given a frame and advice was that Doris was to walk under staff supervision. I approached team leader **[I/S]** *who was standing by the recommendation area and repeated these recommendations to her.* ***As the ward already had other patients on an enhanced level of observation, additional staff would have been required."***

91. This issue about being short staffed, we later found out at the inquest was a complete fabrication as the ward next to Ruby ward was closed, so in fact they had plenty of staff working at that time.

"Following discussion with team leader **[I/S]** *she suggested that the ward should manage with current staffing.* ***Doris bedroom was an AT room****, she had a walking frame, staff were to maintain her on level 2 observations and when Doris was walking, staff should walk with her. In aim to also support Doris with her mobility, with staffing level at the time,* ***a suggestion was that a communal area nurse would supervise Doris while she was walking****….****I voiced this to two HCA, HCA*** **[I/S]** ***and HCA*** **[I/S]** *who I had seen in the communal area and I do recall seeing staff walking with Doris in the dining area.*

92. Regarding my mum's actual fall, she says:

"Afternoon hours are also the busiest time on the wards. Staff numbers would have been reduced temporarily as some staff would have been on breaks. Due to the mix of patients on the ward at the time, dining area was noisy and some of the patients were unsettled*. Patients started to arrive to the dining area in preparation for dinner at 1700hrs.* ***it was during that time that Doris managed to walk to her room unaccompanied and had a fall****".*

93. She then goes on to recount an alarming fact:
"As ambulance crew arrived, ***I voiced my concerns about her head trauma.*** *Ambulance staff carried out a set of observations…appeared to be within the normal range. Doris was now fully alert and interacting with ambulance crew. Due to her presentation, ambulance crew suggested that Doris could remain on the ward.* ***I felt pressurised by this, as indeed, at that time, she was interacting with them without hesitance. Due to the severity of the head injury I did express my concerns about Doris wand suggested that she should have further examinations to rule out any internal bleed. the ambulance crew agreed with this and Doris was transferred to Broomfield hospital****."*

94. The root cause analysis report notes the following:
    a. My mum's level of observations should have been increased at this time in line with the Trust's falls: Safe and supportive observation guidelines. Specifically the report says *"Mrs S should have been placed on level 3 observations at all times due to very high risk of falls, new walking aid and recorded confusion"* – as we can see, this was yet another occasion when the opportunity to reassess my mum's observations was missed, despite the multiple recent falls and head injuries that would have only made my mum's condition more critical and more fragile. It is beggars' belief why there was no-one that had the sense to want to reassess whether she needs to be more closely monitored, and we cannot understand why;
    b. The falls care plan was also not *"robust enough to prevent falls"*;
    c. It was not documented throughout the day on the chart that the four observational checks that were done per hour, were in fact consistently completed – an issue which occurred the day before also;
    d. Between 4:31PM and 5PM, the crucial period in which my mum fell, she was left alone in her bedroom and mobilised without supervision or assistance – in direct contravention of the recommendations **the physiotherapist** gave again, and only a few hours earlier; and

e. It was also not documented whether the AT was switched on whilst my mum was in bed.

95. We would go further and note:

a. It is reported that my mum was accompanied to hospital by paramedics and *"staff nurses",* but this seems to have not been the case as only [I/S] [I/S] recounts going with her in the ambulance, and he is not a staff nurse, he is a bank staff HCA support worker and admits to being less qualified.

b. The RMN 's statement that they were short staffed that day was a lie and serves as a stark reminder that my mum's safety was actively placed at risk and that there was a frank indifference by staff as to whether there was anything that could have been done to prevent a problem occurring;

c. It is also concerning that paramedics suggested my mum should remain on the ward after the fall on the 9 October, and the RMN says she felt pressured by this advice. Again, we are concerned about whether there was a sort of carelessness and underappreciation that patients like my mum were extremely vulnerable and were relying on medical staff to protect them from harm. We are concerned that there was even a suggestion that she did not need to be checked when blood had been pouring out of her nose and head moments prior to her assessment, let alone the factors that occurred before that date that should have made any new injury a big concern. Furthermore, it is not lost on us that the paramedics suggested my mum was fine, and yet she went on to die from her injuries a few days later!

96. In hospital my mum's condition deteriorated, she was admitted to Heybridge ward for a CT scan on 10 October 2020. At 9:27AM, a ward round was completed, and my mum was reportedly unresponsive to verbal or physical stimuli. The hospital records note that Consultant, [I/S] at that stage asked for the *"next-of-kin to be informed of the likelihood of further deterioration due to multiple areas of cerebral trauma".* We wish to note that, that conversation never happened, with either myself or Anna. In fact, we were called that morning by [I/S] on Ruby Ward who told us that my mum was ok and would be moving to Meadowview ward soon. I can see from the records that the confusion may have occurred because the surgical emergency ward at CGH informed [I/S] personally that my mum's initial scans were normal and that she would be

monitored for 24 hours before discharge. However, this was either false or there were a second set of CT scans that were not discussed with them. In any event, the information relayed to both Ruby ward and therefore to us was false and ought to have been known to be false given the consultant's record at 9:27AM.

97. On 11 October 2020, Heybridge ward confirmed that the CT scan of my mum's brain showed a bleed (a subarachnoid haemorrhage and multiple small SAH).

98. Doctors deemed her unable to survive intervention and end of life support was initiated. We were informed of the same on the same day.

99. The records note that my mum was then discharged from her section on Ruby ward by Dr [I/S] and Dr [I/S] after a discussion with Dr [I/S]. We have a letter that was sent to my mum's address from EPUT, dated 12 October 2020, advising that a Form 133 under Section 23 of the Mental Health Act had been completed and that she is formally discharged from her section 3.

100. The physiotherapist notes in her statement that her orthotic referral was completed by the ward doctor on 12 October 2020, and says she then sent the referral to the orthotics department at Broomfield Hospital on the same day.

101. It is concerning that a referral for a helmet that was deemed so important on 9 October 2020 was only actioned on 12 October 2020 when my mum was already in critical condition in hospital and when Ruby ward knew she had been put on end of life support the day before. Examination by this inquiry ought to uncover the supposed attempt to cover tracks in this regard and the total failure to act with any promptness or urgency in my mum's case, when the helmet could have in fact saved her life.

102. My mum died in hospital on 14 October 2020.

Section 3: Concerns and complaints; the quality, timeliness, openness and adequacy of responses to concern

Inquest proceedings

103. The Inquest into the death of my mum, was opened on 23 October 2020. We had been contacted the day before, on 22 October 2020 by [I/S] of the Coroner's office who spoke to us to get a full history. He explained that there

would be a post-mortem which could take up to a week but that he would keep us updated.

104. On 28 October 2020, the post-mortem was undertaken, **the Coroner's office** relayed to us that a *"head injury and fall"* were the main reasons for death, however that *"dementia, frailty and coronary atherosclerosis"* were contributing factors.

105. The inquest opened and then was adjourned until the new year. We were informed that we could seek legal representation but we did not feel it was necessary at the time, we had been so involved in my mum's care that we felt sufficiently able to engage in the process ourselves, which we did.

106. From November 2020, we dealt with someone new at the Coroner's office called **[I/S]** She explained how the process would work and became our direct liaison on all matters from then on. I mentioned to her that we wanted to submit a formal complaint against EPUT but she told me we could discuss this after the inquest.

107. The inquest proceedings took place between 23 January 2021 and 27 January 2021. Anna and I were interested persons and participated unrepresented. EPUT were designated an interested person – they were represented by Hempsons solicitors.

108. The Coroner recorded the cause of death on the Record of Inquest as follows:

"1a – Head injury
b – Fall
Dementia, Frailty, Coronary Atherosclerosis"

109. In the narrative, the coroner was highly critical of EPUT's care and made some helpful findings in sections 3 and 4 of the document:

Section 3:
"Doris Joyce Smith had a fall in Ruby Ward on the 9th of October 2020. As a consequence, she suffered a head injury and was taken to Broomfield General Hospital. Subsequently, she was diagnosed with a subarachnoid haemorrhage and after consultation with Addenbrookes, it was confirmed that her injury was

not operable and not survivable. Doris Smith was placed on an end of life pathway care plan and passed away on the 14th October 2020.

The falls risk assessment was only completed 12 days after Doris' admission onto Ruby Ward. Under policy guidelines and procedures, it should have been completed within 24 hours after admission by a nurse. It was finally completed by a Senior Health Care Assistant instead but had an incomplete medical history.

Subsequent errors and omissions with regard to the updates of the falls risk assessment. No evidence of the physiotherapists advice of close monitoring during mobilising being implemented by staff. Confusion regarding observation levels, e.g. 1, 2 or 3, and inadequate frequency of both neurological and ward observations."

Section 4:

"Doris Joyce Smith died as a direct result of the fall on Ruby Ward on the 9th October 2020. Had Mrs Smith been observed and monitored as she should have been, the fall on 9th October 2020 would either have been avoided or there would have been a staff member present to break her fall. Had the fall been broken, it is likely that Mrs Smith would have avoided injury, or her injuries would have been less severe. The fall suffered by Mrs Smith on 9th October 2020 caused her to suffer a traumatic subarachnoid haemorrhage, which led to her death on 14th October 2020."

In addition, the falls risk assessment and the level of observations were inadequate. There is no evidence of effective communication between the different professionals as to the correct care Doris Smith should be receiving. As well as the lack of implementation of correct and accurate record keeping. Evidence heard as to inconsistencies between staff on Ruby Ward as to which were the correct levels of observations, especially following the falls on the 1st, 8th and 9th October 2020. All of these factors led to the incorrect observation of Doris Smith which contributed to the circumstances leading to her death."

110. The Coroner also issued a Prevention of Future Deaths Report[1], which was published on the Courts and Tribunals judiciary website on 7 March 2023, and echoed the strong condemnation that the coroner gave in the Record of inquest.

111. The Coroner said the following regarding his concerns about the risks of future deaths posed:

(1) "Essex Partnership NHS Foundation Trust staff:

a. delayed the completion of a falls risk assessment

b. completed the falls risk assessment with inaccurate information to assess Doris Smith's risk and updates were also inaccurate

c. did not follow the advice of the physiotherapist that would have required Doris Smith to mobilise only with assistance of staff and whether her level of observations should have been changed.

(2) Neurological observations following a sustained head injury were not completed as required

(3) Doris Smith had falls on the ward and her level of observations was not reconsidered in light of advice from the physiotherapist after each fall.

(4) The Trust Observation Policy is used in different therapeutic settings and is confusing as to the Levels of Observation required and the focus is on risk for mental health rather then physical healthcare issues that may arise.

(5) Quality of record keeping:

a. The Trust medical records recording system is electronic and evidence was heard that the window on the screen used for staff to type their records is very small and difficult to use.

b. There were significant examples of cut and paste including out-of- date information recorded in the medical records

(6) Lack of effective communication as to the care and treatment required for Doris Smith between Trust staff and the levels of observations required to keep her safe on the ward."

112. We agree entirely with the above and would like to know what action has been taken to address these issues, what learning has been done to improve future services and whether any repeat issues continued to be a problem after my mum's passing.

[1] Doris Smith: Prevention of future deaths report - Courts and Tribunals Judiciary

Serious Incident investigation

113. The Inquiry has asked about the quality of investigations undertaken or commissioned by the Healthcare Providers in my mum's case.

114. We first received a Letter of Apology from EPUT on 3 November 2020 confirming that the SII was now opened.

115. Among other things, the letter stated the following:

"I would like to assure you that the Trust aims to provide a high-quality service to all our patients…as part of the investigation we will try and establish whether we could have done anything different and aim to identify any opportunities for learning".

116. We received the final report by email on 11 December 2020, yet the report itself was dated 5 November 2020. EPUT had completed their investigation in just two days. I also recall, Anna had to chase and chase for an update on the report.

117. The investigation made the following limited observations in their *"lessons learnt"* section:

a. Observations levels must be considered with MDT in huddle post fall incidents
b. Nuero observations must be continued for 24 hours period
c. Patients should be referred for head scan following any suspected head injury
d. Physiotherapist and MDT must work closely together and consider observation levels post fall, particularly if the recommendation is that mobility is supervised-Enhanced level 3 or 4 observations would be the only safe option for ensuring this.

118. The good practice section notes:

"Guide to Action Took updated on 9 October post fall on 8 October, timely physio review post fall. Ward manager contacted family in the morning, with regards to fall incident on 8 October and discussed fall risk and management plan. Care plan updated post fall on 8 October by key worker and included physio's advice from 9 October, this was updated one hour prior to fall. In retrospect and as a learning curve, the entry could have been more detailed with more consideration given to observation levels."

119. Although some criticisms have been made, we believe that the investigation failed to address the magnitude of failures exhibited in this case, starting from before 8 October (which included the fall on 1 October among other issues). It accounted for only a limited number of *"lessons"*, and did not include for example:

a. An investigation into why an initial falls risk assessment was not completed within 24 hours of my mum's admission
b. The failures by staff to adhere to the physiotherapist's recommendations about closely monitoring my mum when she walked;
c. Comments made by the RMN regarding the ward staff's inability to adhere to the physiotherapist's recommendations in any case due to staff shortages;
d. Any explanations for why my mum was left unattended in her room on 1 October, 8 October or fatally on 9 October where she suffered her falls;
e. An investigation as to why the policy on CT scans, 24-hour neurological observations and reconsidering the level of observations was not followed in my mum's case;
f. Why the orthotics referral made by the physiotherapist was only actioned on 12 October 2020, 3 days after my mum's last fall; and
g. Anything about the AT issue and whether it was fully functioning in my mum's room or not, and if not, why not?

Root cause analysis investigation

120. A root cause analysis investigation commenced in 2021; we were invited to attended a meeting with the investigation team on 28 April 2021. The final report was provided on 18 June 2021. We were pleased that this report went much further in terms of the failures identified in my mum's case.

121. The recommendations were as follows:

a. **"Recommendation 1**

The investigation found that following the unwitnessed falls of the 08/10/2020 and 09/10/2020 the required frequency for neurological observations were not correctly implemented. Therefore, copies of the 'Post Falls Protocol' (page 17 of CG58 Slips, Trips & Falls Clinical Guidelines should be made widely available and explicitly referred to by staff when responding to the needs of a patient following an unwitnessed fall. The actions for this recommendation should include clinical record

keeping of the event should explicitly refer to its use in informing clinical decision making.

b. **Recommendation 2**

The investigation found that despite CG58 (Falls Safe & Supporting Observation Guidelines) and CLPG8 (Engagement and Supportive Observation Procedure) required the level of Engagement and supportive observations/Safe and supporting observations to be reviewed at ward handover, MDT, safety huddles, this did not occur. Therefore, The Falls and Observation Pathway (Appendix 1 of CG58) must be followed and the clinical rationale for deciding on the level of observations required must be documented as required by CG58 and CLPG8.

c. **Recommendation 3**

The investigation found that even when staff training was up to date, knowledge-based errors continued. Missed opportunities for learning continued and potentially effective opportunities to optimise care (such as safety huddles and hot debrief) were not effectively utilised. Therefore, the investigations report and findings should be shared with falls panel in order to reduce patient falls by implementing strategic goals for effective system-focused strategies and which avoid ineffective person-focused recommendations such as 'sending out staff reminders' or 'staff to attend training'.

d. **Recommendation 4**

The investigation found that there is no Trust process on the use of assistive technology or any training programme which complied with CLPG17 – Medical Devices Procedure requirements. Therefore, the Trust should effect a process and procedural guidance on the use of AT and ensure that training is provided for the end user."

122. The root cause analysis report went much further than the Coroner's investigation and the SII investigation, we were pleased that there had been a more through analysis but devastated to learn of the many failures that went unnoticed and unaddressed in my mum's case. Failures that led my mum to have three unwitnessed falls, injuries and ultimately caused her death, all of which ought to have been avoidable.

Other legal proceedings

123. We also later instructed a firm called BMTK solicitors who assisted us in pursuing a civil claim against EPUT for my mum's wrongful death. The claim was successful, EPUT ultimately settled and we donated some of the money to a cat foundation in my mum's memory.

Section 4: My views

124. Anna and I would like to say that, ultimately the issues with regards to my mum's care began in the community with the HTT. There is no doubt in our minds that had her support been adequate in those key months between April 2020 and August 2020, she would not have ended up needing to be admitted to Ruby ward under a section. She was exhibiting clear signs of a mental health deterioration throughout those months and every time we tried to provide this context, to explain that her behaviour was not like when she was well, that her symptoms were worsening and that she needed a proper evaluation, our concerns were minimised and managed away. Nothing got better, everything got worse – the inaction led to my mum's frequent admissions to the emergency department with various injuries and ultimately led her to becoming completely helpless by August 2020.

125. That is not to excuse the events that transpired at Ruby ward, for which there was widespread criticism, even by the Coroner who issued a PFD report following this case. The events that led to my mum's death on this ward were appalling. She was neglected in our view by those who were responsible for her care and died as a result of their actions.

126. What might be one of the most painful parts is the fact that we genuinely thought, when she went to Ruby ward that she was in a place of safety, finally. We think all the time about what else we could have done to protect her, we blame ourselves for pushing her to go to the hospital, but we thought it was the best place for her, and it should have been.

127. Those who work in the medical profession need to always remember that these are real people. They should be doing everything they can to help them through their illness, no matter their age or circumstance. We, as family

members, need to be able to trust that those we love and care about are in safe hands.

Section 5: Recommendations for change

128. I submit the following recommendations for the Chair's consideration:

a. **Consideration of family's views** – what would be most important to us, would be to see a recommendation regarding the crucialness of family views. There needs to be room for a family's involvement in the care and treatment of their loved one particularly when there is a long medical history involved. We feel particularly aggrieved about our interactions with **my mum's care coordinator** Is it not telling that in the period between April and August 2020, when concerns were being raised and my mum was being repeatedly hospitalised, that not one formal mental capacity assessment was done of her? Something **the AMHP** also said when she saw the condition my mum was in by August 2020. We kept being told by **the CC** that everything was in hand and that she was behaving normally, but **the CC** did not appreciate what "normal" was for my mum. When my mum was well, she was happy, pleasant to be around and she always kept her surroundings clean and tidy. There was a gradual and significant change in the early part of 2020, and we noticed straight away. All we needed was for those in charge, who were professionally responsible for her medical care, to listen and not make us feel like we were exaggerating or an inconvenience, not only were we correct about our concerns, the events that transpired could have been avoided if a more inclusive approach to her care was taken by those in the decision making roles.

b. **Patient-centred service** – Anna and I agree with other core participant families who have raised this as a recommendation; it is about ensuring each patient is treated as a unique and individual case where each patient has a dedicated team committed to understanding *their* distinct needs and who can build a care plan that caters to their circumstances alone. A one-size-fits-all approach can never be taken when it comes to mental healthcare, as each person's mental health is specific to them. When you are catering to the masses, you are catering to no-one. If instead a team treats each case like a mission, and the mission is to get that person to the best health they can be, perhaps we would not be seeing repeat cases of death and serious harm in such great numbers. We believe the

Chair should prioritise making this recommendation known in any interim or final report.

c. **Assistive technology** – the AT system was in operation at Ruby ward at the time of my mum's admission, however it is frustrating that staff could not explain why it had not been turned on until 8 October 2020, and only after my mum's second unwitnessed fall. We urge the Chair to consider the following as part of any recommendations for its future use:
    i. Promote its widespread use in all older adult frailty units in the UK where falls risks of patients are usually very high;
    ii. Urge wards to ensure any decisions regarding AT are communicated to all relevant staff at pivotal times throughout the day, such as handover and safety briefings / huddles;
    iii. Implore with wards that where AT is in operation, it must be fully functioning, and where repairs need to be made, they must be done expeditiously and, in the meantime, high risk patients must be moved to rooms in where the technology is functioning so as not to be placed at unnecessary risk in the interim; and
    iv. Identify that staff members MUST respond to alerts immediately and always attend to the person's needs / reasons for getting up and not just return the person to the bed or chair.
d. **Investigation report follow up** – we concur with the RCA investigator in our case that each report and its findings, after an investigation has been completed, must be shared with the requisite panel, staff and managerial teams involved, in order to reduce repeat instances happening again. There should also be deadlines put in place, in ALL cases, for those targeted to complete and respond to investigator's recommendations, this will ensure those responsible are learning lessons and making changes accordingly.

List of documents for the Inquiry to obtain

129. In APPENDIX 1, we have outlined the documents in our possession that we have specifically referred to/utilised to formulate this rule 9 statement. There are however further pertinent records that we do **not** hold that we consider should be requested from EPUT as part of this inquiry's investigatory process. We list them as follows:

1) CCTV footage retained covering my mum's admission to Ruby ward between August 2020 and October 2020 (particular in relation to her falls and staff supervision);
2) EPUT's following policies:
    a. CG58 (Slips, Trips and Falls Clinical Guidelines)
    b. CG58 (Falls Safe and Supportive Observation Guidelines
    c. CLPG8 (Engagement and Supportive Observation Procedure)
3) All written correspondence between Ruby ward staff members and independent medical professionals regarding my mum's care;
4) All minutes of meetings between Ruby ward staff members and independent medical professionals regarding my mum's care;
5) All written communication and correspondence held by the Older Adult Home Treatment team regarding my mum's care (in particular the complete communications sent to and received by **the CC**);
6) All minutes of meetings held by the Older Adult Home Treatment team regarding my mother's care;
7) Copies of all EPUT crisis team records regarding the decision to leave my mum in her house following the incident on 21 May 2020;
8) The national guidance in place in 2020, regarding the use of Assistive Technology in Older People Inpatient services.

Statement of Truth

I believe the content of this statement to be true.

Signed: **[I/S]**

PAUL RUCKLIDGE-SMITH

Signed: **[I/S]**

ANNA RUCKLIDGE-SMITH

Dated …01/09/25……

WITNESS STATEMENT OF PAUL RUCKLIDGE-SMITH PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

APPENDIX 1 – LIST OF DICUMENTS WHICH I HAVE

I. Inquest bundle

Document	Date
Record of Inquest	Undated
Prevention of Future Deaths Report	27.02.2023

II. Witness Statements

Document	Date
Witness Statement of [I/S] (Ward manager)	20.01.2021
Witness Statement of [I/S] (Healthcare assistant)	26.01.2021
Witness Statement of [I/S] (Deputy ward manager)	22.01.2021
Witness Statement of [I/S] (Registered Mental Nurse)	25.01.2021
Witness Statement of Dr [I/S] (Consultant psychiatrist)	04.05.2021
Witness Statement of Mrs [I/S] (Senior Physiotherapist)	07.05.2021
Witness Statement of Dr [I/S] (on-call doctor)	23.04.2021
Witness Statement of [I/S] (Band 2 Bank Staff HCA Support Worker)	22.01.2021
Report of [I/S] (ADHD nurse specialist)	13.02.2023
Factual Report for Doris Smith in relation to her contact with the Approved Mental Health Professional Service (AMHP), prepared by [I/S] (Service Manager)	18.01.2023
Witness Statement of [I/S] (UGI Consultant)	03.11.2020
Dr [I/S] (Acting Consultant in Emergency Medicine)	17.12.2020

III. Medical Reports, Policies, Procedures, Training and Other Documents

Document	Date
Datix Reports – September and October 2020	
Essex Partnership University NHS Foundation Trust - Information for families following a bereavement booklet	Undated
Reports and Trust communications (Coroner bundle)	Undated
Falls Guidance (Coroner bundle)	Undated
Dementia Care Wards Operational Policy	Undated
Serious Incident Investigation Report	03.12.2020
Datix and Safeguarding documents	Undated
EPUT assessment documents	Undated
Root Cause Analysis Investigation Report	18.06.2021

IV. Medical Records

Document	Date
Mid and South Essex medical records	17.02.2021
EPUT medical records	03.12.2020
East Suffolk and North Essex - Patient Medication Record Card	Undated
Chronology of key events	Undated
Form 133 under Section 23 of Mental Health Act 1983	12.10.2020

V. Correspondence

Document	Date
Letter from EPUT to Paul and Anna - Serious Incident Investigation Report	03.12.2020
Client handwritten notes from Inquest	Undated
Letter of Condolences from EPUT	03.11.2020
Client email correspondence with Coroners Officer	April 2021
Client handwritten note of issues	Undated