WITNESS STATEMENT OF HEIDI BANKWALA
PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

INTRODUCTION

1. I, Heidi Bankwala **[I/S]** the mother of Darian Bankwala [DOB: 3 November 1998, and DOD: 27 December 2020], provide this statement to document the memory of my son, his mental health struggles, and the systemic failures that I believe led to his tragic death.

2. This statement is based on my memory and my legal team's analysis of the documents that they have been provided with in connection with Darian's inquest, civil claim, and this inquiry.

3. This statement does not address all the Rule 9 questions, such as those pertaining to the substantive details of Darian's mental health treatment and care, complaints processes, and investigations and proceedings after Darian's death. I have found it too distressing to revisit these topics in extensive detail, and instead, I adopt the core participant evidence of my husband, Kobad Bankwala **[I/S]** **[I/S]** on these matters, which is provided in his witness statement. I have no reason to doubt his account of memory of matters which I am therefore happy to stand by to the best of my knowledge and belief.

4. I have taken this opportunity to provide the Inquiry with my commemorative account of Darian, which begins at Paragraph 5 below. I missed the opportunity to do so when the Inquiry was hearing the commemorative evidence of other core-participants in 2024. This is because I was denied core-participant status by the Inquiry until 18 March 2025 **[ILT letter to Hodge, Jones & Allen, 18 March 2025]**.

COMMEMORATIVE STATEMENT

5. Darian was born as my fifth son. Darian was a vibrant, warm, and happy person who loved deeply and was full of enthusiasm for life. We took him on holidays, sometimes three or four times a year. He adored those family trips.

6. When Darian was happy, he was truly overjoyed. He wore his heart on his sleeve. He did not have a mean or cruel bone in his body. Darian was incredibly generous, and his bond with his older brother was filled with laughter, mischief, and love.

7. Darian had an enchanting and unforgettable presence. His laughter was not just a laugh — it was a full-hearted guffaw that would fill the room and make everyone around him smile. He had a brilliant sense of humour. He was hilarious. His mischievous streak made him endlessly entertaining to be around. He loved to play pranks and catch people off-guard. He found joy in making others laugh. There was something truly magical about the way he could lift the mood of those around him, even in the darkest moments. Darian was our sunshine.

8. Darian had a deep curiosity about the world. He had a real passion for science and meteorology. He loved learning about the galaxy and its stars and planets. He was so good with these subjects, but sadly the school system never nurtured these qualities. Despite the obstacles, Darian managed to gain some qualifications at college. He even began learning to drive. He worked briefly at Domino's Pizza, which gave him a sense of independence before he became too unwell to continue.

9. In the last year of Darian's life, when circumstances were incredibly difficult due to his mental health needs, we tried to create moments of joy. When the 'Eat Out to Help Out' scheme was running during the COVID-19 pandemic, we took Darian out to restaurants three or four times a week to gently encourage him to be out in the world, even if he was withdrawn or silent.

10. There were still flickers of the old Darian even in the darkest times: his sudden laughter, a joke, or a shared moment of light. These moments reminded us of the incredible person he was – someone so loving, bright, and beautiful inside and out.

11. The transformation in his final year was so painful to witness because it was the polar opposite of his true personality. No matter how ill he became, he was always my Darian.

12. I loved him with all my heart.

Darian's mental health history (c. 2000 – 2019)

13. From around the age of two, we noticed that Darian was showing signs of developmental delays. For example, he was late to potty train, and he was very emotionally attached to his routines and rituals. One of his comforting daily rituals which he insisted on was chanting a song while I stirred his chocolate milk. He was also a very picky eater and mainly had chocolate milkshakes. On our holidays to Turkey and Egypt, I would take boxes of his favourite chocolate milk powder to make sure he was comfortable.

14. Darian started school at the age of five. He struggled profoundly with it. I had to withdraw him from school for around two years because of the distress it caused him and the difficulties he had with integrating.

15. At around the age of nine, the education authorities forced me to re-enrol Darian in school. Darian would describe school as *"hell".*

16. Darian attended William de Ferrers School in South Woodham Ferrers from the age of 11 for secondary school. Throughout his studies here, Darian was placed in the Special Needs Unit. This was known as 'F Block'. It was physically separated from the main school. This separation made Darian feel abnormal and excluded from potential friendships. He hated being on this block because it made him feel isolated and different.

17. Darian had school absences, for which I was penalised because this was regarded as a parental failure. There were different reasons for his absences which I expand on below. Briefly, Darian was bullied by the other students – he was called *"dumb"* and a *"retard F-Blocker";* he would constantly get sick from his anxiety (and any other mental health issues he had at the time that were undiagnosed); and the teachers would focus on him being too skinny which to him felt like his teachers were accusing his parents of starving him.

18. When Darian was 11, I withdrew him from school again because of the ongoing distress that it was causing him and the continued absences. In response to this, the education authority took legal action against me which resulted in a fine, and further legal action.

19. Under this intense pressure, I was again forced to put Darian back into school. Darian reported to me that he was being bullied and chased by other pupils. He would sometimes leave the school without their permission, but he always informed me when he did this so that I could collect him.

20. Between the ages of 12 and 13, Darian continued to struggle with further school absences, and he would often travel to Wickford from there or return home alone. I was forced to withdraw him again from school for a period before he entered secondary school. Rather than acknowledging Darian's difficulties and supporting the situation effectively, his school blamed his absences on poor parenting.

21. Concerns about Darien's low weight were also raised by a teacher, suggesting that he might have not been eating. I met with the school in response to this concern and I told them that Darian was provided either packed lunches or money for food during schooltime. Despite efforts to encourage Darian to eat at school, his anxiety made it difficult, and he continued to have special lunches and takeaway meals. I assured the school that Darian ate well at home. Darian was referred to a nutritionist at Chelmsford Hospital and was monitored for a year. Although Darian remained underweight, he experienced a growth spurt of nearly two feet, indicating a high metabolism rather than neglect.

22. I understand that Darian's medical records show that on 17 October 2008, it was recorded that I had reported that I '*felt like some of Darian's behaviour at home was potentially on the Autistic like (sic)*' **[GP Records, p. 181]**. This diagnosis was only confirmed on 3 November 2020 **[EPUT Bundle 2, p. 528].** I have no words to describe how it makes me feel that it took this long for a diagnosis. As his mother, I could see that there was a problem with him that needed to be addressed. But the mental health services were not helpful and no one was listening. They blamed us, as Darian's parents, instead. It is just beyond disappointing. Perhaps if action had been taken earlier to conduct a proper assessment and get a diagnosis, we might have been in a different place today.

23. I understand that the medical records show that on 3 December 2008, Darian was '*DNA'd again for medical advice for statutory assessment. He did not attend the initial appointment on 29th September 2008 and also today on the 19th November 2008*' **[GP Records, p. 24**]. Darian did not want to go to these assessments, whether at school or at the GP. Kobad and I tried to get him to these appointments. We were not offered any reasonable adjustments to enable Darian to attend and participate in such assessments. Instead, it seemed that for the services, the situation was black and white: if you did not turn up to the appointment, you were a no-show.

24. I remember that, at some point, there was a meeting with Darian at his school which I attended. Someone at the school, I presume a psychologist, said in the meeting that Darian would never be able to get a job or participate in mainstream life. I remember being so angry that they wrote my child off like that.

25. All I remember from this period is being fined by his school, Kobad and I being taken to court by them for his school absences, and Darian always being at the sick bay at school (he would make himself sick and then I would pick him up from the sick bay). I remember one occasion when Darian was at the sick bay at school which I attended too, and the school nurse was screaming at me that she did not want to deal with Darian anymore. She said that she did not like the

smell of his vomit. The situation was not working for anyone but the school did not offer any alternatives to us to manage his situation. For example, after the incident at sick bay, I complained to the school at reception about the nurse. To my knowledge, the school did not escalate this any further.

26. I understand that Darian's medical records show that Darian was due for an appointment with the CAHMS service on 18 March 2015 **[GP Records, p. 104]**. I understand that the records show that on 7 May 2015, *'a referral to Sycamore Renew Counselling for Darian which [was] a local young person's counselling* service' was mentioned **[GP Records, p. 26]**. I do not remember Darian receiving any counselling at all.

27. To summarise Darian's mental health history from 2015 until his episode in 2019, I remember that he would sometimes get triggered by events or circumstances, but he did not display any threatening behaviour. For example, he would become anxious around the school holidays when his mind was idle.

28. When Darian left school and started college, we saw a positive change in him. Darian enjoyed the freedom and independence that this gave him and he chose to attend himself. Darian made new friends during this period and became closer to his brother, CSB who was a key support to Darian.

29. Darian finished college around 2017. I was working part-time. Darian and I would spend the days together, when I noticed he started to pull away emotionally. Darian got into a friendship with someone who I immediately identified as a negative influence, and because of his association with this individual, Darian was questioned by the police on one occasion. This individual was manipulative, threatening, and even physically abusive towards Darian.

30. During this time, Darian's anxiety increased. He was prescribed medication, but his friends persuaded him against taking them, so he did not take his medication. Darian's behaviour became erratic. He disappeared for long periods, sometimes losing his phone and money, and requiring police intervention to find him.

Mental health deterioration between 2019 and February 2020

General reflections on events in 2019

31. Darian's underwent a sudden and harrowing transformation in 2019. His presentation was the opposite of who he was: a warm, kind and loving person. It was as though the light in him extinguished overnight, and what followed was a period of escalating terror, confusion, and heartbreak in our home.

32. Darian was overwhelmed by fear and anxiety, retreating to his bed and remaining there for days. He would refuse to eat, sleep, wash, or even speak for long stretches of time. Darian ended up withdrawing from family contact and he would sleep in unsafe places such as train stations and the shopping centre.

33. Darian also began exhibiting very disturbing and frightening behaviours. He could no longer tolerate basic sounds. He screamed if the television was on, or if we were simply speaking around him. He became intensely paranoid and controlling. He once told me during an anxiety attack that he did not love me anymore.

34. Sometimes, Darian would lunge behind me as I walked, pretending to stab me in the back with an imaginary weapon, like an axe or knife. At one point, Darian made threats to *"skin [me] alive"* or to *"skin the cat alive"*. These statements were completely out of character. Yet, Darian delivered them with a blank and chilling intensity that made it impossible to just dismiss.

35. There were moments when Darian looked at me with such rage and torment that I feared he truly wanted to hurt me. Not because he hated me, but because he was so deeply unwell.

36. I stayed awake most nights, either from fear of our own and Darian's safety or simply because Darian was pacing around the house into the early hours.

37. Sometimes Darian would run around the house naked, screaming at night, often without any recollection of this the next morning. I was in a constant state of hypervigilance, having to hide anything that Darian could use to harm himself. I would think, *"What is he going to do tonight?"* He would threaten to hang himself, so I hid all the items with cords away. I worried about whether he would have a psychotic episode in someone's room and start getting angry and bang his head on the walls. I was even worried that he would make off to the train station by himself because he would ask us to take him to the train station.

38. These behaviours affected the rest of the household too. For example, Darian's relationship with his older brother, CSB which had always been loving and close, sadly became strained. CSB became increasingly frightened of Darian's unpredictable behaviour and eventually felt so unsafe that he installed a lock on his bedroom door and began locking himself in at night. Even though Darian was extremely thin and had never harmed anyone, his presence could be very intimidating in these moments due to his mental state and his height.

39. I witnessed Darian repeatedly twisting his own hair causing bald patches, trying to pry his mouth open with his hands, banging his head against the wall, and threatening to jump out of windows. He became increasingly suicidal, often saying to us that he wanted to die. I deal with our contact points with mental health services during this time further below.

40. One memory that will stay with me forever is walking into his bedroom and finding him lying unresponsive, in what I can only describe as a stupor. Darian would often drift into these states where he was unreachable – almost as though he was simply not there. On this occasion, I sat beside him, stroked his head, and whispered to him, over and over, how much I loved him, how I just wanted to help him, and that we would find a safe place where he could be supported. But I think he was far too gone, and that he could not process my words. It was as if the real Darian had vanished behind an invisible wall, and no matter what I said or how hard I tried, I could not reach my child.

41. I was desperate to get my child the help he needed but I was utterly powerless: I was constantly told by professionals that he *"had capacity"*, and he did not get the treatment he needed.

42. As a family, we were living in a state of absolute crisis, and we were completely abandoned by the system. I was watching my child disintegrate before my eyes, doing everything I could to save him. No matter how loudly we shouted for help, no one came. These months were nothing short of traumatic and they marked the beginning of a long and painful descent into the deepened mental illness that Darian never recovered from.

43. I also remember a number of other events that took place through 2019, the dates of which I cannot remember, but I think are important to mention. I remember that a GP came to our house to see Darian once at mine or Kobad's request. Another time a GP came to our house and sat by the door of Darian's bedroom but Darian got very angry and would not talk to her.

44. I remember another occasion when I called for an ambulance because of Darian's behaviour and I spent about one hour on the phone, asking them to please send someone with psychiatric training to our house. Someone from the Ambulance Service did attend but he said that he was not trained in psychiatric cases. He checked Darian's physical presentation and said he was fine. Darian was not 'fine'. He weighed around 7.5 stone and was 6 ft. 2" tall. I remember calling the ambulance a few times during this period, but it never resulted in a hospital admission.

<u>February 2019</u>

45. I understand that Darian's medical records note that he attended hospital on 7 February 2019. I think this is when he collapsed in a park in London. I cannot recall why this was but maybe it was due to him having not had anything to eat or drink. Kobad and I attended the hospital and when we asked whether the professionals could do anything to help with his mental health problems. The

clinician tried to talk to Darian, but he would not engage, and they let him leave the hospital.

April 2019

46. Darian was in a fragile mental state and we thought that the system, in this case the DWP, would support him if we just followed their procedures. However, Darian would not look for a job, and he would not attend his GP appointments for a sick note. He was too terrified, overwhelmed, and unable to trust medical professionals by that point to attend the appointments.

47. In response to this, the DWP sanctioned Darian by cutting him off from his allowance, which meant that he would have to re-apply. I think this happened a few times. Darian's GP records show that on 26 April 2020, it was noted: *'Not claiming benefits as refuses to go to GP for sick note.'* **[EPUT Bundle 2, p. 73].** As Darian was an adult and refused to give consent for DWP to deal with us as his family, the DWP kept him in this vicious cycle where he was not mentally able to engage with their processes because he would get triggered and this would make him go into his stupor mode or he would pull his own hair out, but we were not allowed to act on his behalf, so he would continually get sanctioned.

48. The DWP never put in place reasonable adjustments considering that Daniel was so unwell to assist him to engage with their processes – which involved attending the GP for sick notes. I also question why Darian was not given the Limited Capacity for Work-Related Activity support. This situation caused Darian, and us as his family, enormous distress.

49. In April 2019, I encouraged Darian to get out of bed and to attend the Jobcentre because we were desperate not to lose what little financial support he had coming in (I think he was claiming Job Seekers' Allowance or Universal Credit – whichever was in place then). It was very hard trying to get him to the appointment – he became aggressive to me, he chased me, and then he collapsed. I called an ambulance and the operator asked me if they could speak

to Darian on the phone. Initially, Darian refused to speak but eventually he did. The operator talked to him and then told me that it was a mental health issue – but no follow up action was taken. So, we attended the appointment at the DWP late and Darian was very angry.

50. After the appointment, when we returned to the Chelmsford multi-storey car park, Darian appeared very depressed. He kept running up to the edge of the car park walls, gesturing to me that he was going to jump. I tried to talk him down and keep him safe, but I needed help so called an ambulance. This was one of the many occasions when I called an ambulance due to Darian's suicidal behaviour. The paramedics briefly spoke with Darian and quickly came to realise that he was experiencing a mental health episode, not a physical illness.

51. This would become a repeating cycle: Darian's life-threatening distress, our pleas for help, professionals recognising the risk but insisting their hands were tied due to Darian's *"capacity"* and refusal to consent. It was a system completely unequipped to help people who were too unwell to know they needed help.

    No one ever properly explained what 'capacity' meant, how it was assessed, and why him having capacity meant that nothing further could be done. At the time, I used Google to look into the issue of capacity and I remember understanding that a person would be deemed to have capacity if they knew some basic information such as what the date was. Darian was not eating, he was behaving erratically, he appeared psychotic – but, he knew what the date was.

November 2019

52. In November 2019, Kobad and I decided to take Darian on a family holiday to Tenerife to celebrate his 21st birthday, hoping it might offer a moment of joy and connection for him. We went as a whole family, determined to create a positive memory for him. Darian's continued deep mental illness was clear from the outset. He was unable to gather his belongings, disorganised and

overwhelmed, He refused to get into the taxi to Stansted Airport, frozen with anxiety and confusion. I had to coax him in, using what felt like reverse psychology — he would only respond when I told him I did not mind if he came or not, and because of this he came along.

53. When we arrived in Tenerife, Darian's situation worsened. He completely withdrew from us, locked himself away in his hotel room, and refused to speak to anyone. On his actual birthday, he did not allow us to give him his birthday presents. At one point during the trip, he tried to jump off a cliff, and I had to physically restrain him.

54. Towards the end of our holiday, after an altercation with a hotel maid — the details of which I do not remember — something suddenly shifted in Darian, and he began saying he was *"fine"* and *"in control."* It felt false, like a performance, but we clung to the hope that perhaps he was turning a corner. On returning home from Tenerife, we saw a brief improvement in Darian. He was more stable and functioning a little better, and for a moment we hoped things might genuinely be getting easier. But within a few weeks, he was triggered again, and the cycle of decline began all over.

<u>February 2020</u>

55. By early 2020, Darian's mental health had rapidly deteriorated. He stayed in bed almost all day, stopped eating, had suicidal thoughts, and made violent threats. He kept saying he wanted to see his father hang. I regularly found knives in his bed and tucked in the sofa.

56. In February 2020, we took him to the Accident & Department ("A&E") twice. Kobad's statement in response to your Rule 9 request addresses the specific circumstances of those admissions and the unsafe discharge, even when Darian admitted to the doctor that he wanted to harm Kobad and me. Darian was eventually sectioned, following the second A&E attendance, as Kobad's statement details.

57. I think that if Darian was sectioned sooner, then he could have been helped. He was so acutely ill by the time he was sectioned. I think that when a person reaches that point, it is extremely difficult to be pulled back out of such a deep well of depression and psychotic symptoms.

Southern Hill admission

Admission and assessment

58. Darian was sent to Southern Hill Hospital in Norfolk. This was far from our home but Kobad and I visited almost daily.

59. Darian was withdrawn, unresponsive, and hated the isolation. At some point, probably after the first week of being in Southern Hill, we were informed that a specialist visited Darian and put him on Section 3. She described Darian as being *"very ill"* and told us he would needs years of hospitalisation, which is why she had put him on Section 3.

60. I made it clear from the outset that Darian had long been anxious about being perceived as autistic, and that being labelled as such was deeply triggering for him – this was something that had contributed significantly to his deterioration.

Ward environment

61. Kobad and I were not allowed on the ward itself. We were only allowed in the reception area. I recall that at visiting times, the areas of the hospital that I could see were overcrowded. I was always trying to find space between myself and the other visitors. But in the evening visiting hours, there was hardly anyone around. When visiting hours were ended, Darian would be taken through a door with a care worker, and the door would be locked behind them. This reassured me. The hospital also had a high fence in the garden, around 30ft to 40ft tall, and it was surrounded by fields.

62. When Darian was at Southern Hill, I recall that he did not want to do much in terms of activities. The staff tried to encourage him to cook, but he did not want to. The staff encouraged me to bring in cards, but he did not want to play with them. Darian had a TV which he could watch movies on. Beyond this, there was nothing engaging for him to do and there were no organised sports activities that I recall. Because he was unwell, he did not have any leave but was told that if he got better then he might be able to go out on leave with someone. He was in the middle of nowhere, without any meaningful activities, and even in terms of non-hospital food, there was probably only one take-away nearby.

63. Kobad and I kept up our long visits and would remain on the phone with Darian for hours while we travelled back home from our visits, sometimes with him just silent, but listening to Kobad and I speaking.

Diagnosis, care and treatment plan

64. For the first two weeks of Darian's admission, I recall being told by the staff that Darian did not want to take his medication. I think he received medication for the first time around two weeks after admission, only after the staff threatened Darian that they would inject the medication if he did not take it.

65. Darian often spoke negatively about the doctors at Southern Hill, especially one who he felt was too forceful with his medication. Although Darian was being medicated, he sometimes claimed he was not taking it and once insisted that his veins were green. When I asked him to show me, they were clearly blue. When we visited, he would often sit with his head down, withdrawn and disengaged. He hated being in Norfolk, irrationally believing that the area itself was harmful to him. He repeatedly begged to be moved closer to home, near Southend, and this became a major concern and point of advocacy for us as his family.

66. Darian's mental health remained very unstable. I saw no improvement in him during this admission. He would get out of his bed which, I suppose, was one

notch up from his previous situation, and he would eat the KFC takeaways which we took for him as he did not like the food in hospital. Beyond this, Darian was a shell of himself in this admission.

67. On multiple occasions, he called me while distressed, once claiming he could get into the minds of the staff and make them harm themselves. He also made strange, delusional claims that he would become a major drug baron in Norfolk, despite having no history of drug use or drug involvement. Unfortunately, these statements appear to have been taken literally and recorded in his notes, possibly leading to an inaccurate theme in his assessments, which Kobad's statement details. He also showed paranoid thoughts - for example, accusing staff of planting deer to cause me to crash on my way to visit him. Once, Darian rang me in distress and threatened to slit my throat when he was released. I know that this reflected his deep agitation and fear.

68. I recall meeting with around three psychologists during this admission, but they said very little. It broke my heart to hear such things from him and to witness how profoundly unwell he remained, despite being in hospital for months.

Safety incidents

69. I remember one occasion when Darian rang me around midnight to tell me that he had a rope and was going to hang himself with it. I immediately contacted the ward. The person who took the call was very stand-offish with me and said she would go and check. I received a call back from her to say that there was no rope in his room but that they would begin five-minute observations. I have no idea if they did check for the rope or if they did conduct those observations.

70. On another occasion, Darian told me when we were on the phone that he could not breathe. Perhaps this was his anxiety. I phoned the ward and the nurse who picked the call up was aggressive on the phone, and she said that she could see Darian and he was *"fine"*.

71. I recall Darian explaining to me after he left Southern Hill that there was some violence in Southern Hill, and that prison would have been better.

April 2020: transfer to Linden Centre

72. Darian was transferred from Southern Hill to the Linden Centre in April 2020. Kobad and I were never informed of this plan by professional or staff member. Instead, I came to learn of this transfer through Darian himself, on the morning of the scheduled transfer. Darian seemed upbeat about this transfer as he hated Southern Hill.

73. Before Darian was moved to the Linden Centre, he did say that he really did not want to go Chelmsford – he emphasised that he really did not want to go there. I think he mentioned this around March 2020 when he was at Southern Hill. He explained that there was another patient at Southern Hill with him he did not get on, who was nasty to Darian, and who had left a mark on Darian's hand after scratching him. Staff never informed us about these problems themselves. I asked Southern Hill not to send him to Chelmsford because of this concern. But given that he was moved to the Linden Centre, based in Chelmsford, it is clear we were not listened to.

Linden Centre

Assessment

74. Darian was admitted to the Linden Centre on 18 April 2020. I do not remember being consulted to provide any input into any of Darian's mental health or risk assessments. No one asked us as his family what Darian liked, disliked or what would trigger him.

Ward environment and staffing

75. Darian was moved to the Linden Centre during one of the COVID-19 pandemic lockdowns. This meant that visits were restricted. We were not allowed on the

wards. I remember that the reception area where we waited was dark. I never heard any information about any activities on offer for patients, but I think I once saw someone watching TV. Darian had nothing to do there it seemed, but he enjoyed ordering take-aways.

76. I have concerns that Darian was also subject to violence at the Linden Centre. On 3 June 2020 (which involved an incident that I expand on below), I took a photo of Darian's hand which had scratch marks on it **[Photographs of Darian's hands].** He told me on this day that a male support worker at the Linden Centre did this to him. I was never informed of any such incidents by any staff members during his admission.

Diagnosis, care and treatment plan

77. As above, Kobad's statement provides the substantive details on this topic. I take this opportunity to make additional comments.

78. I remember leaving a message for Dr G who had overall clinical responsibility for Darian during this admission. I cannot remember if this was by e-mail or phone. I expressed that Darian was wondering around into other hospitals and that I was concerned that he was able to go out anywhere on his own. Dr G said that Darian could not be detained and that he would need to come off section. I remember pleading with him, asking how this would be possible given that Darian was still so ill. He was not answering my questions, and would instead in response ask me questions – for example, "*Why do you feel like that? What makes you think that?*"

79. I assumed at this point that Dr G had taken Darian off section, but I understand from my legal team that Darian was still sectioned when he was transferred from the Linden Centre to Rochford Hospital on 5 June 2020, and he was taken off section on 11 June 2020.

80. Another concern I had about Darian being able to roam around without supervision, bearing in mind that he was doing so at the height and beginning

of the COVID-19 pandemic, was that he was doing so without a mask. He was not just roaming around the mental health unit, but he was going through the main corridors of Broomfield Hospital, where physically vulnerable patients were located. I raised this concern multiple times with the staff, but they did not take me seriously.

81. On 7 May 2020, I wrote two e-mails to the Linden Centre from Kobad's e-mail account, which outline my collective concerns:

a. *'As much as I would be prepared to have Darian home, I could not do this without certain conditions being implemented, one of those would be Darians own accommodation, even if that meant in the long run. He would also need counselling/therapy and medication to be enforced if there came a situation whereby he declined his medication. Without these in place, I feel Darian would end up back in a psychiatric [h]ospital within a small time frame. I would also like to point out that Darian has not had the relevant testing for; I.Q and autism. Without this testing, I feel we are all rather in the dark when it comes to putting a relevant care plan in place for Darian. This is an extremely important point as how are we supposed to help him when we don't know how? If he is autistic for example, he may need a very different care plan. Previously we have been trying to treat Darian without a relevant diagnosis of his condition so I feel we were running around clueless as how best to support him. … Darian is only 21 and I feel he should not be written off, he's still very young and this is the first time he has been sectioned. This is why the care package for Darians (sic) care after he leaves [h]ospital is so very important.'*

b. *'I have to consider the other people that live in the house. If Darian were to go back to the height of his problems then I think we would not be able to cope. Darians siblings would probably move out and I think I may end up on my own here caring for Darian. I certainly wouldn't be able to enforce him taking medication and I remember how difficult it was to get Darian sectioned so I am really concerned for the future. Darian can be amazingly strong and can easily overpower me (and has). My husband is 12 years older than me, he is now 64*

and he has underlying health issues so I could be in a situation where I'm caring for two people.'

Absconding incidents

82. Darian absconded a few times when he was at the Linden Centre.

83. I understand that the first record of him going missing was on or around 31 May 2020. I think the first time he absconded, the ward contacted us – but I do not remember exactly. I just remember being in an absolute state, learning that he had gone missing. There was no sense of urgency. We were looking around for him everywhere we could think of – we went to car parks searching for him thinking that he might have hanged himself. We even drove to Southend. Darian was not answering his phone. The British Transport Police advised that he if went to the train station, that he would be picked up. When Darian was eventually located, he said that he had gone on a train multiple times. Thankfully, Darian was found on the same day that he went missing; but it happened again, and again.

84. I understand that the second record for Darian going missing here was on 1 June 2020 around 17:30, with a return date of 3 June 2020. I was beside myself. I drove around for hours through the night, frantically searching multi-storey car parks, convinced that Darian might try to hang himself in a dark and quiet place. I understand that the records show that Darian was returned to the ward by police at 02:40 on 3 June 2020 after an anonymous caller called the police when he was on the streets in a nearby town **[EPUT Bundle, p. 552].**

85. I recall a third incident, the date of which I do not remember. It was only at around 08:00am or so on the following morning that I received a phone call from Darian. He told me that he had spent the night at Brentwood train station, and thankfully, he was physically unharmed. I eventually found him in Southend, dishevelled and exhausted. With great difficulty, I managed to persuade him to return to the Linden Centre.

86. In preparing to respond to this Rule 9 request, I have learned that the records state that on 1 June 2020, just three hours before Darian absconded, staff had been informed by Darian that he was going to run away. I understand that this information comes from a DATIX report from that date stating that, *'Staff later reported that he had mentioned during the day around 14:00 that he was going to run away.'* **[EPUT Bundle, p. 551].** No one from the ward informed me of this, either when he made the threat, or after he absconded.

87. Darian was returned on 3 June 2020. Darian later told us about how easy it was for him to escape from the Linden Centre, and that he had simply hidden in the hospital's garden, where he could hear staff nearby laughing and smoking, completely unaware that he was just a few feet away. He told me that he was not pursued and that after a few minutes of staff looking for him, the staff left. Clearly, there was no serious effort to try to find and protect him.

88. Out of deep concern for the safety of other patients, we reported this incident to the Linden Centre. We warned them that the next patient who escapes might not be so lucky.

89. Distressingly, on 23 October 2020, our worst fears were realised. Despite our warnings to EPUT in June 2020, Jayden Booroff (a 23-year-old patient) managed to escape from the Linden Centre and tragically died after being hit by a train. A Prevention of Future Deaths report, available in the public domain, was sent to EPUT in 2023, outlining:

> *'The layout of The Linden Centre in particular the areas around the main doors was not appropriate for ensuring the safety of its more vulnerable patients. Procedures around the use and allocation of Pinpoint alarms was inadequate. The Policy recording and reporting absconsions from The Linden Centre was not clear enough and led to a lack of awareness and a delay in addressing the flaws in the system. Responsibility for Jayden was not in line with policy and this contributed to a reduction in observation levels and inconsistencies in prescribed medications. Communication between all healthcare professionals involved in*

Jayden's treatment was unsatisfactory, with mistakes being made in updating key documents. Risk assessments were not updated accurately enough or in good time, and failed to capture important information, including historical and emerging information.'

90. It is incomprehensible that, despite our clear warnings and previous incident involving Darian, no urgent safeguarding measures were put in place to guard against patients escaping from this ward. These were not isolated lapses. They point to a wider culture of complacency and systemic shortfalls. That two severely unwell young men could walk out of a mental health unit in such a short space of time despite our warnings, and come to such harm, is a damning reflection on the Linden Centre's practices — and one that, heartbreakingly, may remain unaddressed.

Police station incident

91. Shortly after Darian was returned to the ward on 3 June 2020, on the same day, there was an incident at the Linden Centre which resulted in Darian being taken to the police station.

92. The first I heard of this incident was when a nurse from the Linden Centre called me. She was irate on the phone, and she alleged that Darian had spat at a nurse and kicked another patient and that the police were involved.

93. I accompanied Darian to Basildon Police Station. Darian was extremely distressed, trembling, shaking uncontrollably, confused, and unstable. I immediately knew that he had not had his medication (bearing in mind he had been AWOL from 1 June 2020 until 3 June 2020 too without any medical supervision). He looked like he was convulsing. Based on Darian's condition, I told the duty solicitor that I did not think that the police interview should go ahead.

94. The solicitor contacted the Linden Centre who wrongly assured the solicitor that Darian had received his medication. I think Kobad spoke to the Linden

Centre and asked if Darian was medicated when he was returned from going AWOL on 3 June 2020, and he was told that he had not. When I returned home from the police station, I called the Linden Centre and asked again whether Darian had received his medication that day. The staff member I spoke to said he had not been given any medication.

95. Darian was then transferred to a holding cell. I was not provided with any information as to where the holding cell was located, what organisation or public body was responsible for its running, what their contact details were, what conditions he would be held in, or what medical supervision there would be. I told Darian to keep in contact with me by calls and texts using his mobile.

Rochford Hospital

Transfer to Rochford Hospital

96. Darian was transferred to Rochford Hospital ("Rochford") on 5 June 2020. This was located near Southend, and it was a placement that we as a family had fought hard for previously due to Darian's strong emotional connection to Essex and his distress at being hospitalised in Norfolk.

97. Upon our arrival at Rochford to see Darian, he appeared elated. Despite prior warnings from Dr G (of Linden Centre) that Rochford was a *"terrible place",* the hospital appeared clean and well-maintained when we visited. In respect of Dr G s comment, I remember he said that during a phone call with me. To paraphrase him, he explained that Rochford was a place for the acutely unwell and for people with drug issues. He made Rochford out to be like it was an ugly and horrible place, so I had visions of it being run down. We drove up there to have a look there and we discovered that it was in fact clean.

Ward environment and staffing

98. We were not allowed to enter Cedar Ward, which had locked doors. So, I did not get to see what it was like on the ward, but I saw the foyer area and just

outside the ward. The patients were usually eating, smoking, or just sitting around in the area where women and men sat together, sedated.

99. I remember there was a staff member whose name began with [I/S]. He was lovely. The other staff at Rochford did not speak to us or give us feedback on how things were going when we were at Rochford. I do remember one occasion though when a nurse asked, *"How can you not want your son back at home?"* I cannot remember who this nurse was, but she might have been **the care coordinator.** To me, this comment demonstrated a lack of knowledge about Darian's condition and medical history – indeed, a lack of knowledge that he kept saying that he wanted to see Kobad hanging, and holding knives at his family.

100. It turns out that Rochford was the worst place for Darian. He was very unhappy here. He always had his head down.

<u>11 June 2020 – mental health assessment</u>

101. Darian was due to meet the psychiatrist responsible for his care on 11 June 2020. Her name was Dr **H** **[I/S]**

[I/S]

102. Darian rang me on 11 June 2020 and asked if I could take him a Subway sandwich. He was happy and cheerful on the phone. I wrote his order down very carefully and I went to Southend to get it for him, hoping that this would be a small comfort for him. By the time that I got to Rochford with Darian's sandwich, I was told that Darian was not at hospital. I was horrified to see police cars pulling in, bringing Darian back to the ward.

103. He looked highly distressed and psychotic – he was shaking and crying. This was traumatising and confusing to witness, especially as no one had informed me that anything significant had happened. When I asked the staff what had happened, they said things like, *"We knew he shouldn't go out",* and yet he had been allowed to leave the hospital grounds. This seemed to be a clear

safeguarding failure, and it was the first time I witnessed him in such a severe psychotic episode. I understand that within minutes of seeing Dr H Darian became severely triggered and made an immediate suicide attempt.

104. Kobad and I were allowed to sit with Darian for nearly two hours, thanks to the support worker who was very compassionate and gave us the space and time we needed. Darian was crying and overwhelmed with shame, saying things like, *"I'm broken."* Darian said that he had a meeting with Dr H in which she called him *"autistic",* and this crushed him.

105. I kept trying to reassure him that there was nothing to be ashamed of, that he was ill, that we would help him get through it, and that *"we [would] put [him] back together again."* The heartbreaking truth is that I could not put him back together again, and that moment has haunted me ever since. It was one of the most defining and devastating memories in this situation - seeing Darian so broken, knowing he was slipping away, and feeling so powerless to stop it.

Diagnosis, care and treatment plan

106. Kobad's statement outlines the substantive details of Darian's treatment and care at Rochford, and again, I am only adding some further comments.

107. Despite knowing the depth of Darian's mental illness, Dr H wrongly attributed his psychotic symptoms to drug-induced psychosis. This was deeply upsetting for us, especially since Darian had no history of drug misuse. She once claimed that *"there was nothing wrong with him."*

108. As a result of Dr H 's misjudgement, Darian was granted open access to the hospital grounds, which heightened his distress. He was terrified by the lack of structure and boundaries. Darian felt unsafe.

109. I understand that Dr H took Darian off section on 11 June 2020. He absconded on the same day, as I outline below. I understand that Dr F supported this decision, in a second opinion on 18 June 2020.

110. Concerned by this decision, we requested an urgent meeting with the psychiatry team. I understand that the medical records show that this took place on 20 June 2020. We were told that **Dr H** was unavailable, so we were seen to by a more junior doctor called Dr **I**. Dr **I** took this meeting with Kobad, our son **CSB**, and I. During this meeting, Dr **I** dismissed the seriousness of our concerns about Darian's suicidal ideation. Dr **I** assessed Darian and she was manipulating Darian's responses by asking Darian closed questions, *"You're alright, aren't you? Otherwise you won't be allowed out for a smoke. So you're alright, yes?"* I recall that she was very close to Darian's face and was being relentless. I remember feeling that I could not believe what I was seeing and hearing.

111. In that meeting, Kobad and I kept on challenging her assessment that Darian had capacity. We kept on saying that they had to section him, even under Section 5, and that he was going to die. Darian told us directly in front of Dr **I** that he was going to hang himself. He also warned that if he was not sectioned, *"it would be too late."* Dr **I** said that just because he is suicidal before it did not mean that he was suicidal now. She said that he can have capacity minutes later. The professionals leaned on the word 'capacity'. This minimisation of Darian's condition was extremely concerning for us.

112. Around this time, Darian pointed out fast trains from Rochford to Chelmsford, stating plainly how easy it would be to end his life using one.

113. I also recall that Kobad was asking if Darian could have a brain scan to see if there was any adverse impact on his brain. I believed that there was probably some physical damage to Darian's brain based on some signs I saw. For example, when Darian was discharged from hospital in July 2020, he would repeat himself when he was talking to those he knew about having just been in hospital. He did not make any sense.

114. Darian was not ever assessed for autism. From my perspective, the professionals had a theory that his mental health problems were drug-induced. This is the theory that came from Southern Hill when he said that he wanted to

go to Suffolk by the beach and bring all his friends there and take over. Care coordinator [I/S] described this as a fantasy – but Dr H was always pointing the finger at Darian about drug-induced psychosis. Kobad's statement expands on this theory and the lack of evidence supporting it.

115. I remember on one of our visits to hospital, another patient, whose name I do not know, told me that Darian was unhappy and that she worried for him.

116. Due to our concerns about Darian's treatment and safety at Rochford, and the hospital continually giving Darian unescorted leave, Kobad and I waited outside hospital every day and night so that we could collect Darian ourselves in the mornings and spend the day with him. From memory, I do believe that we did this every day from 09:00 when the doors opened to 19:00 when the doors were locked. I cannot remember how long we did this for during his admission. On this point, I asked the staff to let Darian know that they locked their doors at 19:00 every evening because it seemed to help ease Darian's symptoms to know that he would be locked in.

Absconding / unescorted leave

117. I have already outlined the circumstances surrounding the first time that Darian went missing from Rochford Hospital on 11 June 2020 after he had his first assessment with Dr H which distressed him.

118. On 15 June 2020, I tracked Darian's location on Snapchat and saw that it was tracking Darian's phone to the middle of a road. I was extremely alarmed by this. I called him repeatedly. The police picked Darian up and took him back to Rochford (more details are provided about this incident and interaction in Kobad's statement). I think it was a passer-by on the street that saw Darian and called the police.

119. After this, I was on hyper alert. I would look outside the window asking myself when a police car was going to turn up to tell me that my son is dead. It was not a question of 'would' this happen, it was only a question of 'when'. Kobad

and I continued to go to the hospital from 9am until 7pm when the ward doors locked – either with the patients or in the car park.

120. On 20 June 2020, Darian was again allowed on unescorted leave. I was frantic that he was allowed on unescorted leave again despite the incident five days prior. Having tracked Darian's location on Snapchat to a railway station, we called the police. I understand that the British Transport Fatality review states that the officers called Darian's phone, who said he was at a pub and: *'[Darian said] that he had not been on the tracks and was showing on GPS location there due to the fact that he was on a train from ROCHFORD to RAYLEIGH. When asked why he left he stated that he wanted to go to the woods in RAYLEIGH to hang himself.'* **[BTP Fatality Review]**.

121. I remember that Darian was freaked out by the fact that he was allowed on unescorted leave. He wanted to be on section.

Discharge from Rochford Hospital

122. Kobad repeatedly told care coordinator that if Darian was to be discharged then he would have nowhere to live. I do not remember ever being informed about there being any assessments planned under the Care Act 2014 to consider post-discharge support for Darian and/or for us.

123. To this, I understand that the Root Cause Analysis states that on 22 June 2020, it was assessed that: *'[Darian] could not live independently without significant support and that a Decision Support Tool was needed and to refer to Social Care for placement in intensive supported living. Family and Mr B were unwilling to accept him returning home and his needs were such that the council would not agree to house him in temporary accommodation'* **[RCA]**. I was not aware of this assessment.

124. On 3 July 2020, Kobad and I attended a meeting on Zoom with **Dr H**, which Kobad's statement details. I felt like I was walking on eggshells because it seemed as though she was going to flip at us. I remember she made a

comment about Darian's trousers when he came in looking dishevelled. I cannot remember the exact words she used but I remember that I found it nasty. I did not feel that we were listened to in that meeting but I knew that we had to try to stay on Dr H 's right side, otherwise I felt that we would give her an excuse to discharge Darian because I believed and I still believe that she was trying to find an avenue for that.

125. At no stage before Darian's discharge on 7 July 2020 to our home did any professional contact me to conduct a home risk assessment, despite the concerns we flagged about his and our own safety. The hospital knew that historically Darian was not compliant with his medication, and they should have appreciated that he would not take his medication at home. Not one professional gave me any advice about how I could encourage him to have his medication.

126. On 7 July 2020, I rang Darian. He told me that the hospital was discharging him. He was distraught. Kobad rang the hospital. The hospital said that Darian was being discharged and that they had given him train ticket or something he could use to travel on the train with. Kobad told the hospital that they could not do that because he has previously tried to commit suicide on the railway line. The hospital said they would call Darian a cab instead. Kobad and I rushed to the hospital. As we arrived there, we saw Darian holding his bags. Kobad ran up to the taxi and told Darian not to get in.

127. It is soul-destroying that Darian was discharged from hospital without accommodation. I cannot recall exactly, but I think it was at the inquest into Darian's death that it was said that Dr H could have kept Darian in hospital for 10 to 12 weeks until accommodation became available for him to be discharged to.

Continuity of care and treatment in the community

128. Darian stopped taking his medication immediately. He was street homeless until around the end of July. When Darian did return home, he disappeared frequently.

Care coordinator interactions

129. I cannot remember when it was that care coordinator first contacted us or Darian after his hospital discharge. I remember Kobad was desperate and was eventually in contact with her asking for her advice on what we were going to do in this situation. His care coordinator said she was concerned (as explained in more detail in Kobad's statement).

130. The care coordinator's visits to Darian were minimal and, from my perspective as Darian's mother, ineffective. We exchanged texts which I exhibit for the Inquiry's consideration **[Text messages between Heidi Bankwala and care coordinator].** To me it felt as though there was on her part no sense of urgency during our text exchanges when I raised concerns about Darian. For example, I would tell her that Darian was not eating anything and in response she told me to keep a food diary and then send it to her. I remember that her visits triggered Darian. At the end of one of her visits, she said to me that Darian was *"wading through treacle"* – which in the context of our conversation, I think meant that he was stuck, but not suicidal.

Psychiatrist home visit and treatment plan

131. At home, Darian's behaviour worsened. He was angrier, refused to eat, slept late, would pace around, and was agitated. His aggression towards me increased too. For example, on one occasion, he locked me in a room and threw objects at mine. I think it was my son CSB who called the police. They did not turn up until the following day, but we were not in. They returned to our home a few days later when we were in. The police asked what had happened and I explained the situation and that I had threatened Darian to knee

him away to get him off me; and so the police asked Darian if he wanted to press any charges against me – which he did not. Darian also held bottles up against my head. He pointed knives towards my stomach. I was frightened for Darian because he was so ill.

132. A consultant psychiatrist, Dr J visited Darian at home but he refused to section Darian despite his erratic behaviour during the visit. I think this was the visit referenced in the medical records as having taken place on 18 September 2020. I saw Darian leaping around on the floor like a frog in front of the doctor, jumping, and laughing erratically. I thought at that point that the doctor would see that Darian was psychotic. But the psychiatrist left the house that day without sectioning Darian and I did not hear from that psychiatrist.

133. I remember care coordinator had previously said to Darian that if he did not take his medication then they would have to section him. He was not taking his medication, and he had become even more violent and erratic, but he was not sectioned and medications by injections were not discussed. I therefore consider that psychiatrist's visit to have been a box-ticking exercise.

134. I understand that on 3 November 2020, Dr J noted on Darian's care plan: *'Diagnosis: Autism Spectrum Disorder, No clinical evidence of psychosis or mood disorde*r' **[Page 528, EPUT Bundle 2].** This is confusing because they did not carry out an autism assessment and the home visit they carried out was short – I think it lasted around 30 minutes to 40 minutes. I think that if they noted that he was also displaying as psychotic then he would need to be sectioned, so they did not add psychosis.

135. In November and December, Darian showed fleeting moments of improvement. However, by mid-December, Darian expressed that he hated Southminster and he had suicidal thoughts. At this point, he would bang his head against walls, try to rip his face open with his hands, and displayed other cries for help.

27 December 2020

136. On Christmas Day, Darian opened some presents that he had chosen. Otherwise, he seemed uninterested and despondent.

137. On Boxing Day, Darian refused to join our family outing. He was unreachable by phone. He returned home with soaked clothes, possibly having walked railway lines. I bought Darian KFC, which he loved, and he ate it quickly, appearing to have a good appetite.

138. On 27 December, Darian got up early and got dressed. I came downstairs to see him lying in the lounge. He was clearly unwell. He told me that he did not want to be buried in Southminster. I was very alarmed by this comment. I told him that it was not right to speak like that. Darian became angry and he started to throw cushions at me. I walked away from the lounge.

139. I could hear Darian shouting and asking where his shoes were. I offered to help but he told me to stay where I was. I heard Darian shout *"Bye!"* as he left the house.

140. I was very worried about Darian. I was particularly troubled by his comment about not wanting to be buried in Southminster. I remembered another comment that he made when he was in Rochford Hospital about how the train that goes to Chelmsford is really fast, and that it was a good one.

141. I felt panicked but neither Kobad nor I knew what the best thing to do in that situation was. We did not know whether to call the police or the ambulance. In the end, we did not think that either of them would help, so we tried to find him ourselves.

142. I was able to track Darian's location on Snapchat to Southminster, up until around 13:30 when he disappeared. I wanted to call Darian to check if he was okay. Kobad said it might not be the best idea because this might trigger Darian to do something rash.

143. At around 14:00, Kobad and I decided to drive to all the local train stations to see if we could find Darian. We could not find him. We arrived at Wickford Station at around 16:00 but we could not see him.

144. We kept driving around hoping and praying that we would find him. We were growing increasingly frantic. We finally decided to return home in the hope that he would be there.

145. We stopped at Burnham Station on the way and noticed that what we considered was the 'Star of Bethlehem' was visible in the sky. I prayed that this might be some sort of positive sign. I took a photograph of this for Darian. Darian was very interested in astrology and this star was one that he had wanted to see for a long time. The photograph was taken at 16:42, which would turn out to be the exact time that Darian was hit by the train.

146. We got home around 17:30. I tried to call Darian again. I was desperate to hear from him. I had a feeling something was wrong. Kobad and I kept trying to reassure ourselves that there would be a good explanation – for example, Darian might have met up with a friend. We decided that if he was not back by around 22:30, we would call the police.

147. Darian did not return home by that cut off point, so we called the police. As we waited for information from the police, we were growing increasingly agitated, so we decided to go back to Wickford Station.

148. We did not get very far from home before our son, CSB, called us. He said to come back immediately because the police had arrived at our house. When we got home, CSB said that the police were looking around in Darian's room. The police told us that they were investigating Darian going missing and said we should go to bed. I was not registering what they were saying. I knew then that Darian was dead. I remember telling the police that but the police reassuring me otherwise. I think the police left our house at around 01:00am.

149. We went to bed on autopilot mode, but it was impossible to sleep. The police returned at 04:00am. As I heard the knock on our front door, I felt an acute sense of dread. I did not want to answer the door.

150. It was the British Transport Police. They said that Darian was hit by a train at Wickford Station and the police had found his *"dismembered body"*. The word *"dismembered"* kept reverberating in my head. Images of Darian's *"dismembered"* body kept flashing through my mind.

151. In the last two years of his life, Darian always wore olive green joggers and hoodies. This is the image I have when I picture Darian at the train station on his final day. At the time that my son died, it was cold and dark and he was alone in complete isolation.

I will never know exactly what was going through Darian's mind in that moment, but I know that he felt compelled to do it. By then, he had lost trust in me and his family – and he could not ask for help anymore. The idea that he died thinking that he had no way out and no one to turn to is something that will haunt me forever.

After Darian's death

152. Kobad's statement details the events that took place after Kobad's death.

153. In addition, I want the Inquiry to know about a conversation that I had with care coordinator after Darian's death. Darian was very bad with his money – for example, his associates in the past would take money from him. So, Darian's money would come into my bank account, and I would limit his money. On one occasion when care coordinator visited our home when Darian was alive post-discharge, with reference to our sofa, she asked if our sofa was new. I told her that it was old. She responded with something along the lines of, *"I have to check as you're receiving his money and need to spend it on Darian."*

154. Before Darian died, we sought changes to the bathroom for him. A couple or few days after his death, care coordinator came to our house as a counsellor. She appeared cheerful and smiley when I opened the door. I cannot understand how anyone with empathy, who had worked with Darian and ourselves for some time, could turn up at our house when Darian had just died – in that way. She told me during this visit that she had cancelled the bathroom works due for Darian – I was not even thinking about the bathroom. Her visit caused further upset to me as a recently bereaved mother.

My views and recommendations for change

155. Throughout Darian's at Southern Hill, Linden Centre, and Rochford, I experienced a consistent and deeply distressing pattern of what I consider to be care failures. Staff frequently blamed Darian for his *"lack of engagement"* with treatment and support.

156. This was particularly harmful for several reasons. Darian was often too mentally and emotionally unwell to meaningfully engage with the care and treatment being offered. His refusal or inability to engage was a symptom of his illness, not a deliberate choice or fault on his part.

157. Despite this, hospital staff repeatedly used his supposed lack of engagement as evidence that he was not cooperating with them, without fully acknowledging the severity of his mental state.

158. At the same time, they asserted that Darian had the capacity to make decisions about his care, even though his profound illness clearly impaired his ability to do so.

159. This created a devastating and endless cycle: because Darian was deemed to have capacity, the hospitals would not override his refusal of treatment, but because he was not engaging, they concluded he was non-compliant.

160. This approach led to what I perceive to be the neglect of Darian's real needs, with no effective intervention, accelerating his deterioration, and I think this contributed directly to his ongoing decline and tragic death. This includes the following circumstances:

a. We repeatedly raised concerns with clinicians, but our pleas were dismissed or ignored
b. Darian's capacity was not appropriately assessed in the context of the symptoms of his illness
c. Tailored support was not provided to Darian
d. There was a lack of coordinated care
e. Darian was discharged unsafely and without social care assistance or support

161. I recognise how deeply misunderstood and underfunded mental healthcare is. There is still so much stigma attached to mental health. It is especially heartbreaking now to see some public figures opening up about being autistic or neurodivergent – including people Darian admired and looked up to. If only he could have seen this and known that he was not alone. I think he might have felt like he belonged. It hurts me to think that he did not get to hear those words or see some of the growing acceptance while he was still here.

162. Mental healthcare needs to change. I think this will happen over time. These movements always take time. I do not think it will happen in my lifetime. It will take courageous people – families, professionals, and survivors – to push forward for change.

Impact of Darian's death on me

163. Before Darian died, as desperate and helpless as I often felt, there was still faint hope. The belief that somehow help might come and he might recover kept me going. After Darian's death, all my hope vanished. The world became unrecognisably dark.

164. I was utterly bereft. I could no longer eat properly, sleep, or even hold a conversation. I did not want to be alive anymore. The only thing that stopped me from ending my life was the thought of my immediate family. I could not bear the thought of them carrying my loss on top of Darian's loss.

165. I spiralled into deep and severe depression. This was undiagnosed. I did not seek help. Shortly after, I sought the support of a charity that care coordinator mentioned to me. I think they dealt with cancer. I think someone called me, but I remember that they were not very good, and I think it did more damage to me. I believe Kobad had a conversation with EPUT's Paul Scott, who said that EPUT would get the whole family support.

166. However, it turns out that EPUT wrote to me using an incorrect e-mail address for me. They then texted me later to apologise for sending an e-mail to the wrong address. I contacted them to ask where I should go for support. I was asked to contact 'Denver' who Paul Scott worked with. I wrote to Denver from my Gmail account. I never got a reply from Denver. I spoke to my GP to try to get some support, but they did not cover bereavement. I received no therapy.

167. For almost three years, I lived in a fog. I barely moved from the sofa or got up from bed. My energy, will, and identity were all gone. I began to feel like my grief was no longer just something I carried – it defined me. I could feel it radiating from me and I knew it was too much for those around me. But I did not know how to change it.

168. In early 2023, I was trying to claw back some structure and purpose. I took a job delivering parcels. I quickly found that I could not cope. The strain was overwhelming. I was not ready. After just one month, I was involved in a serious car accident when I crashed into a tree when driving at 50mph. This reflected how mentally unwell I was.

169. As Darian's mother, I am emotionally broken. Every day, I carry the unbearable weight of knowing that despite loving my son deeply and always having his back, I was powerless to save him. I feel I let him down. I encouraged

him to go into a psychiatric unit because I truly believed it would help him – that it would be a place of safety, healing, and expert care.

170. Instead, what we witnessed was the opposite. I now believe that the very system that was meant to support Darian did more harm than good. The trauma he experienced in those hospitals – the dismissiveness and what I perceived to be neglect and failings – seemed only to deepen his suffering. I cannot forgive myself for pushing him towards something that may have made him worse.

171. I do not want to fall into using clichés, but the truth is, what happened to my son has left me traumatised in a way that I do not think I will ever recover from. I live in a constant state of fear and hypervigilance now. My mind always jumps to the worst-case scenario, because I know now, having learnt it in the most the most painful way, that the worst can happen. I see everything through the lens of loss and failure. The failure not just being my own – but of a system that was supposed to help him and did not.

172. There are things that Darian said that will echo in my head for the rest of my life. He once told me, *"I say I'm okay, but I'm not okay."* This line sums up the silent agony that Darian was living with – the mask he wore for others while being tormented inside.

173. When you have lived through losing your child – you cannot go back to how you were. I am a shadow of who I was. I am alive, but I am not living. A part of me died with Darian.

List of Documents which I have:

Please see the Annex of Documents

Statement of Truth:

I believe the content of this statement to be true

SIGNED [I/S]

MS HEIDI BANKWALA

DATED 17/03/2026

Annex of Documents

ILT letter to Hodge, Jones & Allen, 18 March 2025

GP Records

EPUT Bundle 2

Photographs of scratches on Darian Bankwala's hand, undated

E-mail 1 from Heidi Bankwala to EPUT, 7 May 2020

E-mail 2 from Heidi Bankwala to EPUT, 7 May 2020

British Transport Police, Fatality Review

Root Cause Analysis

Text messages between Heidi Bankwala and **the care coordinator**