Witness Name: Samantha Reains

Statement No: 1

Dated: 2nd July 2025

THE LAMPARD INQUIRY

Witness Statement of Samantha Reains

I, Samantha Reains, will say as follows.

Preliminaries

1. My full name is Samantha Louise Reains.

2. I am making this statement about my uncle, Keith Stubbings, who was born on 12 May 1957 and died on 24 April 2019 at his home in Chelmsford.

3. In November 2024, I gave a commemorative statement to the Inquiry about Keith's life. I subsequently met with members of the Inquiry team, on 7 May 2025, to talk about the care and treatment that Keith received from Essex Partnership University NHS Foundation Trust ('EPUT'). I now make this statement to the Inquiry to address the matters that I raised during that meeting.

Keith's mental health history and diagnosis

4. As a child, Keith liked everything to be neat, tidy and well-presented. I understand from my mum (one of Keith's four siblings) that he had difficulty

fitting in with the other boys at school for this reason and, despite wanting to be liked and accepted, was severely bullied.

5. On 3 August 1981, when Keith was only 24 years old, his dad unexpectedly passed away in a road traffic accident. As a family, we believe that this is when Keith first started to struggle with his mental health. He was supposed to have been travelling with his dad that day, and often questioned why it had happened and whether the outcome would have been different had he been present. As the eldest of five siblings, Keith also felt that he had to take on the responsibilities of the family, and this included going with his uncles to identify his dad's body. The accident, and feelings associated with it, were not spoken about and processed in the way that you might do now, and I believe that Keith held onto this tragic event over the years that followed.

6. In general, and in keeping with his childhood, Keith was very particular; everything had to be a certain way. He was also a big worrier and would often get quite anxious. On reflection, there were signs that Keith was struggling with his mental health but at the time we, as a family, just thought that it was Keith's personality.

7. Over time, Keith's mental health struggles became more apparent. He would worry about others having road traffic accidents or leaving him, and express that he was not worthy of love.

8. After struggling with these thoughts, Keith had a breakdown in around 1999/2000. He went to his GP where he was diagnosed with depression, and prescribed propranolol. He also attended private counselling sessions with his wife, which I understand helped slightly.

9. In early 2003, Keith suffered another breakdown following the loss of his cat. I believe that it triggered memories of losing his dad, and Keith took himself to a corner in his kitchen and would not come out. Although we did not have a close relationship with Keith's wife, she did contact us at this time to ask for help.

10. Shortly after this incident, Keith went to see his GP and was referred to Dr **[I/S]** a Senior House Officer at the Linden Centre in Chelmsford. Keith was

assessed and diagnosed with endogenous depression and anxiety. I did not attend Keith's assessment and do not know what matters were covered during the assessment but I saw the official diagnosis in a letter that was sent to Keith following the appointment. Keith was then referred for cognitive behavioural therapy, family therapy (also attended by his wife), behavioural psychotherapy and anger management classes.

11. Between 2003 and 2006, Keith attended therapy sessions at both the Linden Centre and the Chelmsford & Essex Centre. Keith was proactive, attending workshops and completing written exercises, and was genuinely committed to getting better. The sessions allowed him to explore and understand his feelings, including bouts of anger that he would experience. During this period, Keith's mental health improved, and I understand that his wife also saw an improvement in their relationship.

12. Despite this, in around 2006 Keith was notified via letter that his therapy sessions would be discontinued. As far as I can recall, no explanation was given though I wonder whether Keith had just received his quota and the NHS was not able to offer anything further.

13. I understand that, on receipt of this letter, Keith contacted a psychiatric nurse to ask whether he could continue with his therapy sessions as he felt that they were doing him good. He was not able to and was, instead, given a number to call when he was feeling down.

14. In 2007, following another visit to his GP, Keith was referred to a mental health service called 'Beating the Blues' which involved completing worksheets and questionnaires. Although it did not appear to be as helpful as his therapy sessions, Keith was willing to do everything he could to improve his mental health and fully engaged with the process.

15. During this period, and more generally, we as a family were not always aware of the struggles that Keith faced. He was an extremely private person and did not want to be a burden to anyone. I got the impression that he would have felt like a failure if he admitted to us that he had problems, and there were a few years where Keith pulled away from the family and we weren't in

close contact with him. We wanted to respect Keith's desire to deal with things on his own, though he would have known that we were always there for him.

16. As far as I can recall, Keith continued to take medication and have mental health / medication reviews between 2007 and 2018 but did not otherwise engage with mental health services. He became increasingly isolated and more controlled in who he would speak to and what he would say. I understand that his marriage also became increasingly strained though we as a family do not really know what went on behind closed doors.

17. Keith's wife ended their marriage in around October 2018. Although I was not aware at the time, I understand that he became very unwell towards the end of 2018 and into early 2019. By this time, Keith was living alone in rented accommodation having moved out of the marital home.

Admission to Mayflower Ward, Broomfield Hospital in March 2019

18. On 26 March 2019, Keith attempted to take his own life by making a laceration on his right wrist. He was found in his kitchen by a friend of his ex-wife. They informed his ex-wife who, in turn, informed us. Keith was taken to the A&E department at Broomfield Hospital, where he was admitted to the Mayflower Ward (a surgical unit). On 28 March 2019, Keith underwent surgery to repair damage caused to [I/S] his arm.

19. While in hospital, Keith was referred to the Mental Health Liaison Team (which I understand was based at the Linden Centre) for an assessment. None of Keith's family were present during the assessment on 29 March 2019 but, as far as I am aware, he reported feeling depressed due to the breakdown of his marriage and stated that the decision to harm himself had been 'a moment of madness', assuring the team that it would not happen again. A decision was made not to admit Keith, and instead provide 'urgent brief intervention' via the community-based Access and Assessment Team ('AAT') although Keith did not know what this meant, and I never saw any kind of discharge plan or written information to explain what it would entail.

20. I do not believe that this was the correct outcome; Keith was not mentally stable, had a recent and serious suicide attempt and needed a safe environment in which to get better. There was an opportunity to admit Keith for inpatient mental health treatment and the system failed him in not doing so. I also do not believe that Keith had capacity to make decisions about his treatment and, given the situation, I would have expected any mental health assessment to have involved Keith's family.

21. Due to a shortage of beds on Mayflower Ward, and following treatment of his physical injuries, Keith was discharged on 29 March 2019 at around 6.30pm. The decision was made despite requests by Keith to remain in hospital and receive treatment for his mental health. I understand that Keith expressed that he felt safer in hospital which I think should have raised alarm bells with the team on Mayflower Ward, particularly given the severity of his suicide attempt.

22. We as a family were not informed of Keith's discharge, and I do not believe that his ex-wife, who was his recorded next of kin, was either. Keith ended up walking three miles from Broomfield Hospital to his home in Springfield alone and in a vulnerable state, across busy roads, fields and a deep river. I do not think it was appropriate for Keith to be discharged at this time, and certainly not in the evening without notifying family who would have arranged to collect him.

23. The family were concerned as we had been unable to contact Keith and so my mum phoned the Mayflower Ward at Broomfield Hospital. The ward staff were unable to give much information due to confidentiality reasons but did confirm that Keith had attended Broomfield Hospital and had since been discharged. My mum then phoned the AAT at the Linden Centre to understand whether they knew where Keith was, but they were not aware that he had been discharged. It was apparent that there had been no communication between the Mayflower Ward and the community mental health team.

Community care

24. During the period that followed, the family all pitched in in visiting and supporting Keith. My focus was on getting Keith out of the house to attend appointments and it was difficult trying to convince him to do so. He had trouble sleeping at night so would sleep through the day with the curtains closed and did not want to socialise. During visits from family, he would often express that he was tired and wanted us to leave. Keith became increasingly isolated and, on one particular day when the sun was out and his neighbours were having a BBQ, he got upset because he did not understand why he could not enjoy himself like they were doing.

25. The AAT visited and telephoned Keith on several occasions between March and April 2019. Both the visits and the calls seemed to occur at random; there was no consistency, and Keith was never sure when and whether someone would be coming to see him. I understand that the purpose of the visits and calls were to see that he was okay but it was immediately evident that he was not well, and I feel that more should have been done by AAT to give Keith the help that he needed. It also appears that visits by the AAT were only prompted by my mum calling to register her concern for Keith's wellbeing, and I wonder whether any support would have been given at all had she not done so.

26. I have set out below a summary of AAT's contact with Keith between March and April 2019, which includes information I have since learnt from the 'Root Cause Analysis Investigation Report' produced by EPUT following Keith's death as well as care notes obtained via a subject access request. I note that there is information missing from Keith's care notes, including details of his mental health history in the 2000's. I also note that, at the time, Keith's mobile was broken and so there were instances when the AAT were unable to reach him although my family were in the process of getting this resolved.

27. On 31 March 2019, the AAT contacted Keith following my mum's call to the team. As he did not answer the phone and was also found to have missed a GP appointment scheduled for 29 March 2019, the AAT called the police to request a welfare check. The police declined to assist because there was no

''immediate risk to life' so [I/S], a nurse from the AAT, visited Keith at his home address. I can see from Keith's care notes that he eventually came to the door and the meeting was recorded as a 'successful contact'.

28. On 2 April 2019, my mum phoned AAT to express concerns about Keith's wellbeing. We as a family could not understand why Keith had been left to walk home from hospital alone, and she felt that he needed more mental health support than had been given. My mum had visited Keith the previous day and had found him to be very unwell and dishevelled and wanted to know what had been put in place for him moving forward. The AAT would not give my mum any information without Keith's express consent, though it was agreed that AAT would phone Keith to check in. I can see from Keith's care notes that the team tried to contact him five times that day with no response, and a plan made for the case to be reviewed by a Band 7, a contact letter sent to Keith and an update provided to his GP.

29. On 3 April 2019, following two further unsuccessful attempts to contact Keith, [I/S] a nurse from the AAT, visited him at home. The care notes state that the cold call was made following "*concerns... raised by a Sister of Keith's that he had no support and the Family thought he was at risk*". I understand that all curtains were closed and there was no initial response. Keith eventually appeared at an upstairs window and opened the back door, appearing unkempt. My aunt (one of Keith's sisters) happened to arrive at Keith's house while the AAT were visiting. I understand that she vocalised her concern about Keith's wellbeing but the AAT nurse was not welcoming of her input. For example, when my aunt asked about the possibility of Keith returning to work, I understand that the nurse smirked as if to mock my uncle. I have no doubt that this would have deeply hurt my uncle, who loved his job as a train driver and was eager to return.

30. During the visit, Keith reported feeling low and worthless, and accepted that his current thinking put him at risk of suicide. He also expressed that he was worried about his marriage breakdown, his finances, potentially losing his job as a train driver because of his recent injury, and his wife and daughter moving out of the area to live with his wife's new partner; he felt that

everything had gone wrong since the breakdown of his marriage. Keith agreed that he could benefit from a medication review and someone to talk to and consented to a referral to the AAT employment specialist. It was also agreed that Keith would receive further support from AAT via 'Brief Intervention' though, again, it was not clear to Keith or my aunt what this would involve.

31. On 9 April 2019, [I/S], a nurse from AAT, attempted to call Keith several times but was not able to reach him. [I/S] then visited Keith at home. Keith reported that he was doing reasonably well considering what had been going on in his life but remained concerned about his job, finances and accommodation, having had to sell his family home. He explained that the self-harm incident was impulsive, and that he regretted what he had done.

32. On 16 April 2019, [I/S] visited Keith at home. Once again Keith reported that he felt better but remained concerned about his job and impending divorce. He was particularly concerned about the divorce papers arriving in the post and was advised to have a friend or family member with him when he opened them. Keith reiterated that he had harmed himself impulsively and that he had been overwhelmed at the time and regretted his actions. I understand that he denied ever feeling suicidal and expressed that he had no thoughts or plans to harm himself again. Keith's care notes document that actions were agreed for him to take forward, including contacting his work to discuss an occupational health referral and seeking legal advice in respect of his divorce. Given Keith's mental state at the time, he needed a lot of help to do certain things (for example, attend appointments and keep up with household tasks) and I do not think that it was helpful or a good use of time for him to be told to action certain things and then left to do those things by himself.

33. At some point, although I cannot recall exactly when, I took Keith to Broomfield Hospital for an outpatient follow-up to check how his wound was healing. Although Keith did not want to attend the appointment, the nurse who saw him was very helpful and lovely and Keith immediately felt

at ease in her company. To mitigate Keith's growing concern about his job, I asked the nurse whether she could provide a letter confirming that he was okay to return to work. The nurse was extremely empathetic and said that she would do so, so long as I promised that Keith was getting help. I was grateful for her concern and, in all of my interactions with EPUT, felt that she was the only person to be kind, considerate and sympathetic to Keith's situation.

34. I visited Keith for the last time on 22 April 2019. That day he didn't want me to leave but I had to go and pick up my son from school. Before I left, he gave me a big hug and I clearly remember him saying, "*I would cut my throat, but would do that wrong as well*". Looking back, I think that this was a cry for help and believe that he was trying to warn me. I know that he also saw his daughter that day; she took him for a haircut, and they had gone out for pizza.

35. On 23 April 2019, **[I/S]**, an occupational therapist, attempted to contact Keith by phone but he did not answer, and a message was left. I did manage to speak to Keith that day and, when I asked how a call with his manager at work had gone, he replied "*not very positive*".

36. On 24 April 2019, Keith took control of his life and decided to end it. He locked himself away so that nobody else was affected, until the time came that my husband sadly found his body. I understand that **[I/S]** made a further attempt to contact Keith on this day and later made a visit to his home though took no further actions after not being able to make contact. My mum subsequently phoned the Linden Centre to let them know what had happened.

37. As far as I am aware, staff from the AAT did not speak to Keith about his medication, beyond acknowledging that a medication review would be helpful. I was surprised by this; Keith relied on medication to cope and I would have thought it would form an important part of any welfare check. At the time, Keith did not have a GP as he had recently moved, and I was helping him to register with a new surgery. We had managed to book a GP

appointment, which was scheduled for 25 April 2019. Given that Keith did not have a GP, we assumed that the AAT would be monitoring his medication, including checking in to make sure that Keith was taking it. He had been prescribed sertraline in 2018 and was due for a review in February 2019. However, I don't believe his medication was discussed when he was admitted to the Mayflower Ward, and I am not aware of any reviews having been carried out. My mum later found a large supply of his medication in a cupboard and, when asked, Keith admitted that he had not been taking it because he did not feel that it was working. I am left wondering whether there would have been a different outcome had the AAT paid more attention to Keith's medication.

38. I also feel that more consideration should have been given to Keith's home environment, and whether it was a safe space for him to be. I can recall hiding certain items when I went round to visit, and I am surprised that more attention was not given to this by the AAT and those that discharged him from Broomfield Hospital.

After Keith's death

39. Following Keith's death, my family were contacted by a member of staff from the Linden Centre. We were asked to be involved in an investigation into Keith's death, and I agreed to be the main point of contact.

40. Although I cannot recall exactly when, I attended a meeting with a family liaison officer ('FLO') at the Linden Centre. The purpose of the meeting was for the FLO to introduce himself and for me to ask any questions that I had. The meeting was extremely difficult for me and felt like a box ticking exercise. I went alone, feeling quite intimidated, and did not find the FLO to be supportive or friendly. When asked how I felt, I expressed that I was proud of Keith for taking control of the situation and was met with no empathy or understanding from the FLO. I do not think that the FLO had ever met Keith or been involved in his care but at one point he said, "*we could have brought Keith here but he still would have done what he did*". When an alarm went off during the meeting, he said, "*Do you know what that is? That's someone*

trying to do it". I found this to be insensitive and inconsiderate and, on reflection, I am glad that Keith was not admitted to the Linden Centre if this is the level of care he would have received. We were putting Keith to rest at the time and so I did not lodge a formal complaint against the FLO. However, in my view, the FLO should not have been working in that role.

41. In around June 2019, I went to a meeting at the Linden Centre to discuss the care and treatment that Keith had received from EPUT. The meeting was attended by [I/S] (Consultant Psychiatrist), [I/S] [I/S] (Head Occupational Therapist), the FLO and my aunt (Keith's sister). The panel welcomed our input and my aunt and I were able to express how we felt let down by the care provided to Keith. In spite of this, we found the meeting to be cold and unfriendly and the other attendees to be unapproachable.

42. Following the meeting, I was sent a copy of the 'Root Cause Analysis Investigation Report'. It contained numerous inaccuracies, including that Keith's daughter had found his body on the morning of 24 April 2019. I reported these to the FLO as it was important to me that the report was accurate and was subsequently sent a corrected version.

43. In the report, the Trust acknowledged failings in the care that was provided to Keith and identified areas where things could have been done differently. The following recommendations were made:

    a. to confirm a patient's next of kin at their initial assessment and update patient records; and
    b. to facilitate a medication/medical review as soon as it is identified as being required and, if this is not possible, for reasons to be clearly documented in patient records.

44. After the investigation process concluded in July 2019, I did not receive any further communication from the FLO or EPUT. I am also not aware of any investigations conducted by any third party, other than Keith's inquest which was held in November 2019. Ahead of the inquest I was in contact with a lovely and accommodating woman at the coroner's office. She took me

through the process and provided information and support that I felt I needed to work through my grief.

45. In contrast, as a result of the investigation process, I became aware of how unsafe the mental health system is and how unfriendly and unempathetic some staff working within the system were. It felt as though there was little recognition or understanding of the fact that we were grieving the loss of a family member.

Reflections

46. I believe that services need to work with families to make decisions about appropriate mental health care and treatment. We as a family were not engaged with in any meaningful way and, at the very least, I think it is essential for services to make sure that family members are aware of the care plan in place and for a family's support network to be utilised to ensure a patient's safety. For example, my family could have been a means of contacting Keith when he was not picking up calls from the AAT, and we could have collected Keith from Broomfield Hospital to avoid him walking home vulnerable and alone.

47. I also think that services should look at the qualifications and training of their staff. It is essential that staff are trained in how to appropriately talk to patients and their family at what is such a difficult time.

48. As referred to in the Root Cause Analysis Investigation Report, it is also essential that medication reviews are carried out without delay and considered as part of any welfare checks in the community.

49. I do not think that you ever get over the suicide of a loved one. There are so many questions that you are left wondering like, had I done something different, would there have been a different outcome? You also think that people are safe because they are under the care of mental health services and that is not the case.

50. I do not want to see other families lose their loved ones in the way that I have lost my uncle, and I hope that the system can change so that patients are provided with adequate support and treatment in the future.

I believe the facts stated in this witness statement are true.

Signed: [I/S]

Samantha Reains

Date: 2nd July 2025