Wednesday, 18 September 2024

(10.00 am)

(Proceedings delayed)

(10.19 am)

THE CHAIR: Good morning, everybody.

MR GRIFFIN: Thank you, Chair. Today we continue to hear commemorative and impact evidence. As I've said every morning and I will repeat every morning whilst we hear this evidence, we will be hearing about some distressing and difficult matters and I refer again to the emotional support service that is available. It's run by the Inquiry's chief psychologist. Counsellors are present here today. There's one at the back -- if she would just put her hand up -- wearing a black lanyard, so please feel free to speak with her and her colleague. Information about further services, including for those watching by the live link, is available on the support services page of the Inquiry's website, lampardinquiry.org.uk or by asking a member of the Inquiry team. We're wearing the purple lanyards. As I've said before, we want all of those engaging with the Inquiry to feel safe and supported.

May I ask, Chair, that Alan Oxton come to the table, please?

THE CHAIR: Good morning, Mr Oxton.

MR GRIFFIN: Alan will be speaking about his father, Stephen Oxton, and may I ask that the photograph is put up?

MR OXTON: Morning, everyone.

Statement by ALAN OXTON

MR OXTON: My dad, Stephen Alan Oxton, died in The Lakes on 1 April 2012, when he barricaded himself in his own room and hung himself. My dad was born on 1 November 1958 at St Heliers Hospital in Sutton. He emigrated to Australia in 1961, travelling on board the SS Strathaird. He moved around Australia with his family, living near to Brisbane and Adelaide, and as a young child he brought up an orphan baby kangaroo called "Joey".

My dad moved back to London in 1971 and wanted to support a local football team. He decided to support Arsenal as they were in the FA Cup Final at the time.

In 1974 my dad met my mum, Julie, who he later married in 1987, and they moved to Colchester. My dad followed in his dad's footsteps by becoming a removal man. He worked for various companies, such as Pickfords and Bishops Move, and would regularly travel overseas for weeks at a time. I really enjoyed the school holidays where I could go away with him in his lorry overseas.

When he was home, he would take me to watch Arsenal. We would get there early into the ground and stay late so we could try and get autographs of players either warming up or leaving the stadium. He would also watch me play football. He enjoyed collecting Arsenal programmes as well as model lorries.

One of my favourite memories was taking him to the stadium tour for Christmas, being hosted by a player called Charlie George, who scored the winning goal in the FA Cup Final in 1971, which he returned from Australia to watch.

In January 1998, a few weeks after spending Christmas with us, my grandad, my dad's dad, was stabbed to death in London following a disagreement in a pub. The landlord of the pub which he was drinking in referred to my grandad as "the gentle giant" in the media, a trait my dad also shared. I remember on one occasion a friend of my grandmother was struggling financially and my dad decided to buy two weeks' worth of groceries to ensure that she didn't go without.

At the time of my grandad's murder, my dad was in Germany for work and had to be flown back to the UK. The death of his own dad had a massive impact on my own dad and the dad I knew and loved had changed. My dad suffered with PTSD and depression -- it went back to

identifying the body of his dad post-murder -- and was seen by the Trust between 2000 and 2009.

His own mental health was the primary reason why my parents separated and then divorced in 2000, resulting in myself being the primary carer for my dad until his death. My dad spent a significant portion of time trying to keep his dad's killer in prison. One morning we woke up to the news that he had suffered a heart attack in prison. I thought this might allow my dad to move on and, as a result, I might get a proportion of my dad back. However, his mental health deteriorated further and he tried to obtain treatment from the Trust in 2010 and again in 2011, but these cries for help were both refused. It took my dad to attempt to take his own life in 2011 before the Trust would re-admit him for treatment. My dad then tried to take his own life on two further occasions, again in 2011 and in 2012.

On the morning of 31 March 2012, I was asleep following a nightshift. I received a voicemail from my dad, of him screaming down the phone saying he wanted to kill himself. He was taken by police to Shannon House, Harlow, after he tried to take his own life on the railway tracks. He was subsequently transferred to The Lakes in Colchester.

At the time I lived in Manchester and was intending to travel to Essex to ensure my dad received the adequate care he deserved. I recall being told by staff at The Lakes on the phone that he was in a place of safety. Due to this reassurance and having travelled at short notice before on previous suicide attempts and incidents, I decided to stay and work my last nightshift before travelling back down to Colchester the next day.

The next morning I was getting a few hours' sleep after my nightshift before travelling to Essex and I received the call from my dad's girlfriend telling me that he has taken his own life and that he is being rushed to A&E. I realised my conversation with the staff in The Lakes where they reassured me that he was in a place of safety was a false reassurance. I feel utterly betrayed and devastated by the realisation.

During the internal investigation by the Trust, it became apparent that at least one staff member at Shannon House had lied, with staff members providing conflicting reports how it came to be that my dad had access to his belt which he had used to hang himself. There were other concerns and issues raised by the panel conducting the investigation. I understand that the Inquiry will consider this evidence later, but I want to describe the effect that not knowing the full truth has

had on my own mental health.

The truth surrounding the details of my dad is something I feel I need to be able to achieve some kind of closure. I obtained a copy of the report from the panel who conducted the internal investigation. The investigation provided more questions than answers and identified multiple failings in his care. I fail to understand why they did not seek to obtain the truth at the time of the internal investigation, with a sense it was to protect the Trust from scrutiny and any adversity. This has resulted in myself having little faith and trust when under care for my own mental health by the Trust.

The day after my dad took his life, my dad's girlfriend went to The Lakes and questioned staff about why he had been left unsupervised with opportunities to ligature. She was told by staff that he would have killed himself in another way if not this particular way. I was horrified when she told me about this, the callous excuse for the staff's failures. I felt as if they did not care whether my dad lived or died.

There was an inquest which returned a narrative verdict, which stated that there were multiple failings by the state to protect my dad, which contributed towards his death. I understand that these details will

be considered later by the Inquiry, but I want to say at this point about the hollow feeling I felt when I saw everything confirmed in writing by the coroner. Three failings were mentioned and each one felt like a body blow to me.

The death of my dad has left a catastrophic effect on my own life, with each one of his four suicide attempts having a profound effect on my own mental health, worsening each time before his eventual suicide on the fourth attempt. This has resulted in myself having suicidal thoughts and still taking anti-depressants, which I started taking two months after his death and still take today. I have been prescribed four different types of anti-depressants over the years. Each anti-depressant has gradually increased to the maximum dose until I have found no benefit and then had to change to a new one.

I have had multiple courses of treatment for depression, the prime focus being my dad's death and having suicidal thoughts myself. I have been treated as an outpatient by the Trust for mental health in 2013, then by another mental health service, Suffolk, in 2017 and 2018. In 2019 I sought private treatment, where I was diagnosed with recurrent depressive disorder. The most recent occurrence of depression started

in April 2023, last year, resulting in treatment from the Trust which only ended last month, in August 2024, so I'm still struggling today.

In addition to the medication and mental health treatment above, between 2012 and 2017 I regularly attended a support group called "Survivors of Bereavement by Suicide" on a monthly basis. At the time of my dad's death I was living in Manchester with my girlfriend. The subsequent deterioration of my own mental health caused this relationship to end eight months after his death. I have since struggled to open up in relationships and instead have been very withdrawn, resulting in difficulties with girlfriends, family and friends.

I have been through two police investigations, directly after his death and the other, corporate manslaughter with other families, private litigation against the Trust and the HSE investigation. All of these investigations and legal proceedings, I am still none the wiser to what actually happened on the days in question and call for this Inquiry to establish the facts for myself and the other families who have suffered and to stop more preventable deaths in the Trust's inpatient facilities.

At the end of each investigation I say to friends

and family, "This is my last time I will be a participant in an investigation due to the negative impact it has on my mental health as I have to relive the whole thing again". However, as each investigation has never identified and established the truth around my dad's death, I have always returned to join the next investigation, to relive it again. I hope this Inquiry will establish the truth in regard to my dad's death and all the other families who have lost loved ones so they do not have to go through the trauma of another investigation to seek the truth about their loved ones.

MR GRIFFIN: Could you put up the remaining photographs, please?

(Images shown)

That's the last photograph.

MR OXTON: Thank you very much.

THE CHAIR: Thank you very much indeed, Mr Oxton.

MR GRIFFIN: Could I ask that another chair is added to the table, please?

Chair, we'll now hear Martha Gaskell read her commemorative account about her daughter, Marion Turner. Sitting next to her will be Priya Singh, her legal representative.

MS GASKELL: Good morning.

THE CHAIR: Good morning to you. Thank you for coming.

Statement by MARTHA GASKELL

MS GASKELL: Marion, also known as "Maz", was my first-born child. She was born to me and her dad, John, on 25 November 1972 at Colchester Military Hospital. Marion taught me a lot about how to be a parent but also how to be a mum. It was a happy time for our small family. Marion was a happy baby and was always smiling but at times was a very sickly baby. When I look back over my three other children's milestones, I realise that Marion did a lot of her first milestones quite early. She walked early and potty-trained early.

Marion's dad was in the army and luckily got to spend time with her in the first few months of her life. When Marion was five months old, he was deployed on a tour of Northern Ireland and, not long after arriving there, I got the dreaded knock on the door and told he had been injured by a bomb blast. I was then supported by army personnel, who flew with me to be at his bedside in Northern Ireland, but sadly, not long after, while at his bedside, he died.

As a young widow at the age of 17 and no family member to support me, this was a very difficult period and changed my life forever. It was just me and Marion for a while. Looking back, I wonder how I did it, but I did. It was difficult bringing up a baby on my own as

well as trying to grieve and it's not till years later and maturity I realised how difficult this would be for me.

Within 90 days of my husband's death we had to move and start a new life away from the army and all I knew. I don't recall how I did it, but we had to move from our married quarters to a civilian house on our own and start the next chapter of our lives.

Two years later I met a new partner and had a daughter and called her "Melanie". Both Maz and Mel were very close. I used to love to dress them in the same clothes and would always get asked if they were twins. They loved playing grown-ups in their dolls' houses and being mummies to their dolls, taking them in their prams for walks in the garden. Both Marion and Melanie went to King's Ford Primary School in Colchester.

As a young child, Marion was happy and enjoyed going to the park, especially feeding the birds at Castle Park. She also enjoyed swimming. My older sister had a son and on occasion we would take the children to Walton or Clacton for the day out.

My mother also used to spend a lot of her time in Walton, in a caravan, and several of her grandkids would get to spend time with her at the seaside, going on the

amusements, swimming in the sea and, as they got older, playing pool.

Marion took an interest in majorettes so I got her enrolled in the classes and she joined a majorettes team, which involved taking part in many of the routines. I remember on one occasion she was in a parade marching through Colchester town centre in her uniform, which was a white skirt and blue top. I was so proud of her.

In 1979 I gave birth to my third child, a boy, who I called "Michael". Marion would have been seven when he was born and she loved her little brother. They had a lovely sibling relationship and Marion was a very caring, loving little girl, who took to being a mummy to her little brother like she was with her dolls, but now she had a real-life baby to play with. We enjoyed again, as a family, going to different places and trips to the zoo and amusement parks. Marion loved being a big sister and would spend a lot of time doing family stuff together.

While living in Colchester, we lived in walking distance for Marion to attend her high school with her friends. When Marion started Charles Lucas Comprehensive, she made lots of friends, one in particular who stayed in contact for many years, after

they both became mums themselves. Over the years I heard from her childhood friend, who tells me the stories about Marion and how they used to compete with each other over different things, like their hairstyles, boys and things in general. The one thing Marion's friend said stood out and what they laughed about was how Marion still sucked her thumb, something I knew Marion did well into her adulthood, when she was a mum herself.

She talked about how sporty Maz was and how she would win cross-country sports and was also ahead of everyone. They would have a lot of fun and memories as kids. While attending Charles Lucas, Marion showed an interest in netball and played goal defence. She loved the game and played for her county. She also enjoyed lots of various sports. Marion's younger sister, Gemma, is also very sporty and she took part in cross-country and also loves netball and played for her county. Gemma spent a lot of time growing up with Marion.

In 1983 I met and married a soldier. On the day of our wedding Marion would have only been 11 or 12 and took it upon herself to ask her stepdad if she could call him "Dad". This meant so much to her as she never knew who her dad was as he had been killed at a very early age and she was too young to know who he was and

I think she missed that role of a dad in her life. We moved away from the area we lived in at the time when she was able to walk to her school.

Getting married to a soldier enabled us to live in army accommodation in Colchester, which meant moving away from her friends, but she was able to get a bus from our new home to allow her to stay at the same school and keep in touch with those friends. As a child of a military family, I knew how difficult changing schools would be on her. I moved all over the world with my father and it did not help me academically.

In 1986 my ex-husband's regiment was posted to Fallingbostel in Germany. Marion would have been 14 and it would also have been a difficult time for her, moving schools at that age. Not long after arriving in Fallingbostel I found out I was pregnant and gave birth to Gemma, who was going to be my last child.

Living in Germany was so different for us. We went camping, we went to safari parks, boats in lakes, outdoor swimming pools, barbecues and so much more. It was a different way of life in a different country, something we were all new to.

We were based in Germany for six years. Marion attended Gloucester High School in Hohne. It was another hour's bus journey to her school. She did enjoy

school and she came away with her GCSE exams successfully. She made friends as most of the friends' parents were the same regiment as our family.

After leaving school, Marion got a few little jobs. She would go out socialising with her friends and went on to meet a boyfriend who was a soldier. She was happy and they would spend lots of time together. As a big sister, she would take Gemma out with them. Marion got a job in the army cookhouse where her boyfriend was a chef and they spent a lot of time together inside and outs of work and got engaged while we, myself and her stepdad, were on leave in the UK, which was a big surprise to us, but she seemed very happy. They spent a lot of time together. They would just enjoy time going to the safari parks and enjoying life together.

With all Marion's siblings, she was very motherly towards them all. It was something I saw in her from a young age, while growing up, and it was also in her nature to be kind and very caring. She was meant to be a mum. As a young woman, Marion would spend a lot of time socialising with me and her stepdad as after leaving school she lost friends and was mostly friends with my friends. I think this is the bubble we lived in as the army family. Everyone knew each other. Her partner was in a different regiment to us and would be

away a lot, so when he was away, her time was spent with us.

My husband and her boyfriend were deployed for a minimum of six months to Iraq. This was a war zone so was a very worrying time for both of us as we didn't know what was happening over there. We just had each other and other family members to support us. On their return from Iraq, I don't recall how long it was, but Marion and her boyfriend got married. This was in the army garrison church in Fallingbostel. It was a lovely day and a lovely wedding. Marion would have been 19 when she got married.

Not long after they married, my husband's regiment was posted back to the UK, leaving Marion on her own -- well, it felt like I was leaving her. We arrived in Germany when she was 14 and we were leaving her there as a wife to start her new life as a married woman. Within a year of us leaving, Marion got pregnant and had her first child. I recognised, when talking to Maz on the phone, which we did daily, that she was struggling but was not sure what was wrong. I felt I needed to fly over to be with her and the baby, which I did. Marion was diagnosed with PND and was struggling, so I stayed in Germany, supporting her and the baby. She was an amazing mum and I always used to tell her she was the

best mum and a better mum than I was, and I used to remind her of how good she was as she doubted herself.

I spent a lot of time with Marion and her son and she seemed to get back on her feet, so I returned to the UK. I made several more visits to Marion and the children.

Three years later, Marion and her family had moved back to the UK and she gave birth to twin boys. Again she was diagnosed with post natal depression. Being an army wife, the majority of the time you're a single parent as your husband spends a lot of his time either on exercise, tours of duty or deployed to war zones. As a mother and wife you're left to cope a lot of the time on your own.

As a wife of a soldier, Marion, married for 22 years -- Marion and the children had to move to so many different parts of the country as well as abroad when her husband had to. Some of the places she moved to were Tidworth, Yorkshire, Catterick, Colchester, Northern Ireland and Germany several times.

As Marion got older, she found it difficult to make friends as she didn't find it easy. Her family were her world. She did everything for her children. From an early age she was very creative and this showed with her children. She would always cut all her children's hair,

make them costumes for fancy dress, loved playing quiz games with them. She loved baking and also won a prize for cake decorating.

Five years after the twins were born, Marion gave birth to a long-awaited daughter, Shanice, the baby girl she was desperate to have. She also knew this was going to be her last pregnancy.

Marion was so loving, devoted and loyal to her family and friends. Her children were her world and what she lived for. Marion had a lovely relationship with her family. You knew Marion loved you as she showed it so much, even if she was not happy with you at times. I can honestly say she was the kindest person you could ever wish to meet and would do anything for anyone.

Marion got posted to Northern Ireland with her husband, a place she didn't really want to go to as it carried memories of her dad's death, especially as she was stationed at Palace Barracks, where there is a memorial garden for soldiers killed in action. It was there that Marion had arranged with the military to have a service for her dad and she lay a stone in his memory.

While in Northern Ireland Marion's husband went to Afghan. She was struggling and she phoned and asked if I would come over. I flew to be with her when she was

in Ireland as again she was on her own. At the time Marion worked for the local authority and her job was a lollipop lady. She seemed in her element, talking to the kids every day.

Marion did not have much time for herself, bringing up four children, and when she did have time, she liked keeping fit and she would go through different stages of either running or joining a gym. She needed something for herself.

Wherever Marion was in the world with the army, we would always visit each other; more so me as she had four children and it was easier for me to travel on my own.

Both Marion and myself were married to soldiers and lived in different parts of the country so there were times when she wasn't able to get to family celebrations, but she was able to make her youngest sister's 18th birthday and my 50th, which I have such fond memories of. Marion and I spent a lot of our time socialising with my friends when she visited me with the children.

Further information about Marion's mental health problems: the first time I had an insight into Marion's mental health affecting her is when she gave birth to her first son. Many times over the years while they

lived in Germany there wasn't a day when I didn't receive a call from her. I knew and I could hear she wasn't mentally well. I was so worried, so I would go over and spend time with her and the children. It was difficult for me to keep a check on how she was doing as we lived in different parts of the country and she was trying to get on with her life with four children.

Maz moved to Northern Ireland, and not long after arriving, when her husband was sent to Afghan, again she was on her own and, I feel, very vulnerable and in a strange place. I received a call from the army welfare with concerns that Marion's mental health had escalated and she had been admitted to a hospital in Ireland. So I flew straight over and arrived at the hospital to see my daughter looking so ill.

I was concerned they were going to discharge her. I begged them to admit her as I was worried that she would be discharged. Finally she was admitted to a mental hospital for a few months, where she was sectioned several times. I didn't want to leave her as I was not happy with how she was. This was very frightening for me as her mum as she just wanted to die and I couldn't help her or stop her from feeling that way.

Before moving to Colchester, Marion was living in

Ripon. She had a psychiatrist and was under a mental health team. She was working at the time and wanted to stay in Ripon as she felt her mental health had stabilised and it had helped that she was working. Her husband put in for a posting to Colchester as it was the end of his army career.

Over the years I knew Marion's mental health was affecting her life. There was times she was functioning and she was employed. It is when they were posted back to Colchester that I noticed Marion's mental health worsened and she didn't seem to have many periods of stability. I dreaded the phone ringing. She was admitted many times to the mental health facilities in Essex. It caused me to be very worried about my daughter. I feel very strongly, with my involvement into Marion's care, that she did not get the care she needed.

THE CHAIR: Would you like to take a break?

MS GASKELL: My beloved daughter, Marion, died by hanging at her home on 18th of the 1st, 2013, whilst under the care of Essex Partnership University NHS Foundation Trust. I was working for the military at the Queen Elizabeth Hospital. At the time I had just finished my shift and gone home. I got a knock on the door. At the time I thought it was my colleague coming home from work.

I went to answer the door and just walked away from the police, who were stood at the door. I didn't think they were there for me but also felt like I didn't want to hear what they were going to tell me, having had a lot of involvement with the police because of Marion's mental health.

All I remember is, on entering my home, they told me my daughter was dead. To this day I don't recall the conversation they had with me. I was distraught and couldn't believe what I was hearing. I was in profound disbelief and shock. I travelled to Colchester the night I was told Marion died. The following day I met with the police family liaison officer and another police officer. I was with my daughter, Gemma, and a colleague from the army. The female police officer was very abrupt with me and said, if I was going to be defensive with her, she would end our meeting. The reason she was abrupt was because I had said to her I wanted to come down and identify my daughter's body. She was not willing to wait for me to get there. The police officer said that it had to be done straightaway, which I later found out was incorrect.

Marion was separated from her husband and I did not want my grandson to have to identify his mum as I knew that would be a memory that would stay with him forever.

In the meeting my younger daughter had said to the police officer, "My sister has died and you're speaking to my mum like this". After a bit, things calmed down. The police officer went on to say that when they were called to the property and broke into Marion's house, her house was really clean. He said Marion was a very clean person. The police officer showed me physically the position Marion was in when they found her. I was so shocked and this has never left me. I gave Marion a teddy while she was in hospital to hug, and when I now sit it on my bed, its head falls to one side and all I see is the position Marion was in when they found her.

It was not until the next day they allowed me to see my daughter in the mortuary. I was so scared. There was a police officer on the door. He did not speak to me. When I went in, Marion had a long cloak on her. She just looked asleep, like when I saw her in hospital in Ireland, so I needed to cuddle her. And when I did, the cloak came down a bit and all I could see were the ligatures that had been left on her. I don't know why I wasn't warned about this. Even now, seeing those items remind me of the way she died, which I do regularly as they're an everyday item, it takes me to that horrible memory. Why did they not tell me or warn me? Why? I do not want to have these images in my head

anymore.

The impact. In 2012, I was at Staffordshire University, doing a degree, but with Marion's mental health getting worse, I had to end my course as I was not coping very well and needed to wait until her health improved. I know how proud Marion was of me as I was going to be a professional graduate as a counsellor.

In 2014, at Marion's graveside, I told her that I would do it for her as she had said how proud she was of me and that I can do it. I enrolled at Essex University that year. It was the most difficult thing I have ever had to do, especially after losing my beautiful daughter. My current counselling business is in her name and I've a photo of Marion in my practice room, looking at me when I see my clients.

I moved to Colchester after Marion's death as I just felt I needed to be near her grave. After five years in Colchester I moved back up north to be near my other children and grandchildren. Leaving Marion was the most difficult thing I have had to do. On returning to Staffordshire, I started years of counselling and this is still ongoing.

I was initially not able to say or hear the way in which Marion took her life. I could not hear anyone

else use a particular word relating to how she took her life. If the word was said, I would panic and it would make me shake and feel sick. I was diagnosed with PTSD, and only eight years after of therapy and breathwork I was able to say how she died, although it still feels uncomfortable in my body.

I have spent a lot of time being angry. I feel frustrated, angry and very hurt that I was never listened to as her mother. I was told to stop making contact. All I wanted was my daughter to get help I knew she needed and never got. Breathwork and therapy is helping me and this is ongoing to this day.

When I was first diagnosed with PTSD, I couldn't speak about Marion's death without crying and still find it hard. I find it very difficult if I see a police car and get anxious when I get unexpected knocks on the door, especially when it's the police. I still can't watch TV programmes if there's anything to do with suicide on as it triggers lots of emotions. My daughter's death has completely changed me as a person and I will never be the same.

When I moved to Colchester after Marion's death, I was finding a lot more out about failings into her care by the Essex Partnership University NHS Foundation Trust. I spent from 2013 to 2018 trying

to get answers as to why my daughter was failed by them. I went to the papers. I had many meetings with many, many professionals. I raised complaints that I was told would be investigated but was never told of the outcome or even if they were ever investigated. I was told by one professional, "Things will happen internally but you won't ever get to see or hear of it". Finally they told me that they had brought someone in to talk with me that was not from Essex Partnership. I still did not find anything out. It was just a cover-up all the way through.

My own mental health was being affected and I ended up on medication. I had to make the decision to move back up north as I felt I was never going to get the answers I needed.

Marion was a beautiful person inside and out. All she wanted was to be with her children and be happy and well. There's a chapel in the cemetery where she's buried, and after her death they put a photo of the person that has died on the wall. Not long after Marion died, my sister died, and the chapel staff told one of their volunteers to put a photo of my sister next to her niece, Marion. When the volunteer did, she recognised Marion. I later found out that both the volunteer and Marion had been inpatients at the same time in The Lakes

and became friends. The volunteer and her mum have become good friends with me since Marion died. They now clean Marion's grave for me when I'm away.

I have a letter from another patient detailing their experiences and I hope this Inquiry will consider this at a later phase of the evidence.

Marion's sister, Gemma, has written a small piece that she wishes me to read on her behalf:

"My sister Marion was a very maternal, kind and loving person who even loved looking after me when she was a teenager and taking me out for days. She had the biggest smile and loudest laugh. She loved to laugh even through her struggles. I always felt so loved by Marion. She had her struggles but that didn't take away what a great mum she was and what a caring person she was. I love her very much and I always will. Love her little sister, Gemma."

I would like to read out the last Christmas card I received from Marion in 2012. It reads:

"Dear Mum, Merry Christmas and a very happy new year. I love you with all my heart and never intentionally mean to let you down or seem like I don't appreciate all your help and support because I do. It's just hard at times. Next year is a new year and I'm going to try my hardest to fight off whatever comes my

way. Hopefully 2013 will be a better year. I love you and miss you and I couldn't be more prouder of you. Lots of love, Marion [as read]."

18 days later she died.

Thank you.

MR GRIFFIN: We have a video to show.

(Video played)

And we have I think some photographs as well to show.

(Images shown)

That's the last photograph.

THE CHAIR: Thank you very much indeed for telling us about Marion. It was very moving. Thank you.

MR GRIFFIN: May I ask that another chair is brought up to the table, please? Could we change the water as well?

Chair, in fact, may we take a break for ten minutes at this stage and be back at 20 past 11?

THE CHAIR: Yes.

MR GRIFFIN: Thank you very much.

(11.10 am)

(A short break)

MR GRIFFIN: Chair, we will now hear the account of the family of Barry Sargent. It will be read by Counsel to the Inquiry, Rachel Troup, and Tracey Sesto and Della Innocent, Barry's sisters, are sitting next to

her.

Statement by DELLA INNOCENT AND TRACEY SESTO (read)

MS TROUP: "Barry Gordon Sargent, 2 July 1970 to 6 April 2010.

"Our dear Brother/Son/Father/Grandad/Uncle/Nephew/Cousin and Friend.

"Barry was born on the 2nd July 1970 and was a very wanted adopted baby and precious addition to our family.

"Our parents had already adopted Tracey in 1965 and Della in 1967.

"Barry was a red head with lots of freckles and we recall him fondly loving his Raleigh Chopper bicycle from a very early age.

"We have so many wonderful childhood memories of Barry growing up, it is impossible to mention them all.

"Barry was a happy child and Della and Barry spent many long summers off out on bicycles (the Chopper). We took picnics with us and enjoyed the local countryside where we grew up.

"Tracey recalls fun times on our triple swing set in our garden and our mum taking us to Wrabness shore to swim with the jelly fish.

"Later in life Tracey covered for Barry, dropping him off at a nightclub in Frating and taking him secretly to the coach station to go off and see Frankie

Goes To Hollywood.

"Our Dad kept vintage tractors and we spent many years as children attending tractor rallies and country shows throughout the summer months.

"Dad always referred to Barry as 'Barry bo bo fly' and Tracey and I always felt he was the favourite! But the reality was at that point he was the only son. Our parents adored us all and we grew up in a working class home with strict but very loving parents.

"We believe Barry felt as thankful as Tracey and I at having been adopted by such special people.

"We all felt that it took very special parents to nurture, guide and love other people's children in the way that our parents have. Barry adored our wonderful parents.

"We had wonderful summer holidays in Devon, Wales and Great Yarmouth throughout our childhood and Barry dressed up and entered competitions on the holiday camps.

Christmas was a special family time, spent with our Grandparents, Aunt, Uncle and cousins with lots of party games and Barry always had a good appetite for all the delicious food.

"We also had special times with our grandparents every Sunday afternoon when they came for tea, which

Barry always enjoyed.

"In December 1980, our parents were blessed with the arrival of their first biological son Andrew, a very welcome addition to our family. We were all very excited to have a baby brother.

"As a teenager Barry loved the TA ... which was held in our local village and he had some good friends locally on our estate that he used to play with.

"Barry always enjoyed family time, and eagerly joined in at family gatherings, whether these were christenings, birthday parties, and Della and Barry celebrated their 18th and 21st together with a joint party in our village.

"We have very fond memories of the closeness we shared as children and this continued for us into adulthood.

"Barry left the family home at the age of 20 and moved to Colchester and shortly after he met the mother of his two lovely daughters who he adored from the minute they were born.

"Sadly the relationship broke down and contact with his daughters at that time became difficult. But when he was able to see his daughters, he would take them out and bring the girls to our parents' home, he always remained a very devoted Dad and adored his girls, they

were his world.

"Barry loved his girls spending time with their grandparents and especially their cousins and it gave him great pleasure to see them all playing together as we did ourselves as children.

"As an adult, when he visited our parents, he loved to take the girls and the dogs out over the fields. They would walk for miles.

"At the end of 2009, as a family we had a wonderful day celebrating Tracey's wedding. Barry was so proud to be able to give a wonderful speech for his eldest Sister. Tracey thankfully has video footage of the speech as it's the last really happy memories we have of Barry as sadly his mental health rapidly deteriorated shortly thereafter.

"Barry was admitted to Colchester General Hospital on 19th March 2010 following a tragic attempt on his own life. Barry was assessed by a Mental Health professional on the 22nd March and deemed fit to be discharged. Later that same evening the Duty Doctor advised the medical ward at the Hospital that Barry was 'at risk' and needed to be picked up by Police on a section 136 of the Mental Health Act. Barry was subsequently admitted to The Lakes ... on 22nd March 2010 as an informal patient. According to

the investigation into our darling Barry's death he was let off the ward by a student Nurse with the consent of the Nurse in charge at approximately 1.30 pm on 6th April 2010. Barry tragically took his own life approximately one hour after he left the hospital. Just after midnight a concern for welfare was raised to the Police as no contact with Barry had been made.

"No goodbyes, no warnings, no letters. Barry was clearly very unwell. To end his life at the age of 39 in the tragic way he did will always haunt our family.

"Barry was failed by services that should have been able to help and protect him while he was suffering with such poor mental health. Barry was after all in the care of an acute hospital, where it appears to us he was able to freely walk and tragically end his life. This should never have been allowed to happen! Barry was the life and soul of any party, adored his daughters, parents, siblings and extended family.

"Following the investigation into Barry's death, we were advised that there had been no failings in his care. We believed that. Barry's coffin was closed. We were not allowed to see him because of how he had died. We were not able to say goodbye.

"Barry lives on in his beautiful daughter Hannah, who not only looks so much like him, but has so many of

his characteristics. But it breaks our heart that he sadly never got to meet his grandsons.

"We will always be your voice darling Barry, and you will always be in our hearts."

Chair, there is now a second account from Barry's daughter, Hannah:

"Well where do I start!

"I have the most amazing precious memories of my dad and I wish I was able to have made a lot more especially him with his gorgeous grandchildren.

"He was always happy when I was with him, someone who would always say hello to people passing. He was so warm and loving, nothing was ever too much, the bond I've always felt with my dad is incredibly strong, unbreakable no matter what we went through.

"My dad was massive on family. When I went to visit we would always go and see our nana and grandad, aunties, uncles, cousins and great auntie and uncle, we always had the best time playing lots of board games, laughing, joking and messing around.

"We often went for nice long walks and over to the park, we would spend ages just playing on the climbing frame and swings, my nana and grandad had a little park just near to where they live. It had a massive seesaw in it. Dad always used to be on one side and me and my

sister on the other, we would go so high. I always remember smiling.

"Dad liked to treat us when we were with him whether that be sweets, a new game or something ... to wear. I remember dad bought me the best gift in the world, my little monkey. He is the cutest monkey in the world and I still have him now. My boys protect him every night and they know how precious he is to me. Me and my boys would always grab little monkey when we spoke about dad, as if dad was my little monkey he can still be with us.

"Cuddled up to dad on the sofa watching 'who wants to be a millionaire' they were the best evenings, all safe, cuddled up in dad's arms trying to be a millionaire. (I miss this).

I know my dad was adored by everyone and he adored them all too, there wasn't one bad bone in his body, he thought a lot of everyone that came into his life, I just wish he knew how much he meant to me.

"Dad would have been the best grampy ever just like he was the best dad, my 2 boys would have adored him. I just wish he had had the chance to have been able to make memories and meet his grandchildren but unfortunately this couldn't happen. He was failed, let down. He should have been safe where he was, but this

wasn't the case. The pain is still raw, the upset is still there, my heart will forever ache ... my dad taught me to be strong and I will forever fight for him.

"My dad's memories live with me forever and his handsome looks and beautiful smile shine through my beautiful boys!

"We love you dad!"

MR GRIFFIN: And would you play the remaining photographs, please?

(Images shown)

That's the last photograph.

THE CHAIR: Thank you both very much indeed for letting me hear about an obviously much-loved man. Will you pass on my gratitude to Hannah as well? Thank you.

MR GRIFFIN: Chair, we're going to take a break now. May I suggest we return at 12.00 pm?

(11.38 am)

(A short break)

(12.01 pm)

MR GRIFFIN: Chair, we're next going to hear from Lydia Fraser-Ward. I invite her to go to the table. She will first give her commemorative statement about her sister, Pippa Whiteward. We may at that stage have a short break. We're going to see how things go. Lydia is also a core participant and at our suggestion she

will give her opening statement after the impact evidence.

THE CHAIR: I understand. Good.

MR GRIFFIN: May I ask that the photograph is put up, please?

MS FRASER-WARD: Chair, thank you very much for letting me give evidence today.

Commemorative statement by LYDIA FRASER-WARD

MS FRASER-WARD: So Pippa Whiteward, born Philippa Fraser-Ward, in January 1980 was an intelligent, funny and beautiful young woman who died tragically young, aged only 36 years old, after taking her own life in October 2016.

When she died, she left behind her loving husband, two young children, then aged five years old and four months old. Her death also affected her much larger family, including her mother, three sisters, brother and numerous other extended family members and countless friends who all miss her greatly.

She was a much-loved member of her community in South Woodham Ferrers, near Chelmsford in Essex, where she was an active volunteer and a local parish counsellor. Her suicide came as a great shock to all who knew her and even now, eight years on, many still feel the pain and sadness of her loss.

Pippa spent most of her life in Essex. She was born in Basildon Hospital and grew up first in Wickford, then in Southend, before finally moving to South Hanningfield in Rettendon, where she spent most of her youth. She attended St Hilda's School in Chalkwell as a young girl, with me, her sister Lydia, only 18 months younger than her, and when we moved to Rettendon in 1987, we attended Elm Green Primary School together in Danbury before moving to Brentwood School for our secondary education together.

Even though Pippa excelled in her academic studies and actually received a bursary to attend Brentwood, she dropped out of school just before her GCSE exams due to stress. She took a year out of formal education before returning to take A levels at SEEVIC College in Benfleet, where once again she demonstrated excellent academic skills.

She secured a place at Birmingham University in medieval studies but quickly realised it wasn't for her and chose to return back to Essex. She would later go on to obtain many GCSEs as an adult as well as complete teacher training qualifications at Anglia Ruskin University.

During her 20s she volunteered in Indonesia, teaching and working with deaf children as part of the

VSO, which is the Voluntary Services Overseas programme, and she spent several months travelling in Australia and New Zealand before returning to the UK to work as a teaching assistant in a private school in West London.

In 2006 she moved to Reading to live with her boyfriend, before they finally settled in South Woodham Ferrers, got married and started a family. After the birth of her first son in July 2011, Pippa continued to play an important role in her community, working at nearby Marsh Farm, caring for the animals, running educational activities for school children as well as volunteering with local conservation and wildlife projects and being a regular member of the local what they call SWATS group, which is the South Woodham Amateur Theatre Society, performing regularly at local venues and theatres. She was also elected to the South Woodham Parish Council, where she acted as Treasurer, and she was passionate about supporting local residents and delivering projects which would benefit the neighbourhood as a whole.

During the Christmas holidays of 2015, Pippa and her husband announced to her family, including myself, the fantastic news that they were expecting their second child and the pregnancy progressed normally with no medical complications. However, Pippa went into labour

early at 34 weeks and gave birth to her baby son at Broomfield Hospital in June 2016. Due to the premature birth of her baby, the baby required colour therapy treatment, which led to an extended stay in hospital, where Pippa began to display a certain degree of anxiety and was not her usual jovial self. Lack of sleep due to the frequent noise on the ward exacerbated this stress and, shortly after returning home with her new baby, Pippa began behaving strangely, as if responding to voices and people who weren't there. She demonstrated signs of puerperal, ie post-partum, psychosis and within a few days of being at home her husband had to call the emergency services. After being sectioned on 23 June and a short and unfortunately traumatic stay in Broomfield Hospital A&E department, she was transferred to a mother and baby unit hundreds of miles away as no beds could be found closer to home.

Her treatment continued for several months, which showed peaks and troughs in her recovery, including breaks at home and a transfer to another MBU 120 miles away, once again, due to lack of beds at the MBU close to her home. Finally she secured a bed at an MBU at Broomfield Hospital in Essex in October 2016, where she was due to be transferred on Monday, 31 October. The MBU she was in decided to discharge her three days prior

to this to spend the weekend at home, even though she had a failed suicide attempt by strangulation only two days prior on the ward. She had also contracted a vomiting and diarrhoea bug whilst on the ward, which had led to her being quarantined in isolation that week and she had begged clinicians to let her go home as she greatly missed her family.

After returning home to be with her husband, mother and children on the Friday, they also unfortunately succumbed to this same contagious bug that she had carried and all the family members were extremely ill throughout the night.

In the early hours of Saturday morning, 29 October, whilst her family attempted to sleep and recover from the illness, Pippa quietly absconded from the house and headed towards a train station. A friend who was walking their dog nearby approached her and attempted to intervene, but she took her own life. Pippa's death was a tragedy and it is still felt by family and friends today. Had she received more localised, continued and appropriate care, there's a good chance she would still be alive today and it is important that the Lampard Inquiry highlights and investigates how such critical mistakes were made during her care so that they cannot be repeated with any other patients in the

future.

MR GRIFFIN: Thank you. Would you put up the remaining photographs, please?

(Images shown)

That's the last photograph.

THE CHAIR: Thank you very much indeed for that. It is much appreciated.

MR GRIFFIN: Would you like a break or would you like to continue?

MS FRASER-WARD: I'm fine, thank you.

MR GRIFFIN: Shall we move, Chair, to the opening statement?

Opening statement by LYDIA FRASER-WARD

MS FRASER-WARD: My name is Lydia Fraser-Ward and my sister, Pippa Whiteward, died in October 2016. As just mentioned, in the early morning of Saturday 29 October, Pippa crept out of her house as her husband, mother and two young children slept, walked down to her local train station at a level crossing, threw herself in front of a passing train, dying at the scene. She was 36 years old.

Prior to her death, Pippa had been receiving treatment over the last four months for puerperal psychosis and post-partum depression after the birth of her second son in June 2016. Puerperal psychosis is an uncommon condition and leads to maternal death very

rarely, usually affecting one in 1,000 women after birth. In this case, my sister was that one person.

Although my sister lived in Essex, the majority of her care took place outside the county due to lack of beds in mother and baby units locally. It is my opinion that this distance from home and inappropriate early discharge from the MBU where she was receiving treatment significantly contributed to her death. An inquest which was carried out by HM Coroner's Service highlighted a number of oversights in her care which took place across multiple hospitals in three different regions across the country and recommendations were made for lessons to be learnt so that patient care could be improved going forward.

Although this opening statement does not go into the details and context of her care within various NHS trusts, I make reference to elements of her treatment in relation to the provisional List of Issues. This is to contextualise my questions and request for further investigation by the Lampard Inquiry.

I would like the opportunity to provide further information about my sister's medical treatment as evidence in this Inquiry as well as provide additional documentation for consideration. These include the Coroner's report into my sister's death, an account by

her husband of her treatment in a letter to his local MP and a poem that my sister wrote about her treatment in Broomfield Hospital A&E after she was sectioned under the Mental Health Act 1983.

Although much of it was treatment conducted outside of Essex, it is precisely because her care was carried out so far from her home that it continued to fail and contributed significantly to her death. She should never have been discharged home for the weekend when she died, but clinicians felt that she could receive more effective care from her family at home than within a specialist hospital unit. They failed to properly risk-assess her release. They failed to consider how a contagious illness that she was carrying at the time and which she contracted whilst on their ward would impact her family's ability to care for her whilst also effectively being on suicide watch.

The lack of care in the community provided by Essex-based mental health teams during her short stay at home meant that her obvious signs of stress and anxiety went unnoticed by clinical staff as well as the family's inability to care for her whilst violently unwell themselves. They were expected to care for her with no local support or provision, even though she clearly posed a risk to her own safety, having attempted suicide

only 48 hours previously whilst in hospital care.

As part of this essential Inquiry, I would like you, Chair, to consider the deeply dangerous risks that are posed by lack of care in the community that can contribute to the death of mental health patients in Essex. As her sister, I firmly believe that if Pippa had not been discharged home that weekend and instead had been transferred directly to Broomfield Hospital as planned, she would be alive today and could have made a full recovery.

With regards to the provisional List of Issues in relation to my sister's treatment, I would like the Lampard Inquiry to consider ...

MR GRIFFIN: And I'll read out the List of Issues which are in the opening statement. The first is B4:

"Where an assessment for detention under the Mental Health Act 1983 took place, was it carried out appropriately and in accordance with legislation and the Code of Practice?"

MS FRASER-WARD: So I would like to request that this Inquiry investigate what written records are being kept by Essex NHS hospital trusts and what protocols are in place to effectively inform family members that this form of detention has taken place. If the patient is not of sound mind and unable to be advised of their

detention, what is being done to ensure that information on this process is shared with family members and what provision is in place to support them going forward, particularly in cases where children will be directly impacted?

MR GRIFFIN: B10:

"How were decisions as to admission made? What factors influenced where a patient was admitted, and to what extent was this justified?"

B11:

"What policies and procedures were followed when an inpatient was admitted onto a ward? Were these sufficient and appropriate in the circumstances?"

MS FRASER-WARD: So I would like to ask how will this Inquiry ensure that patient safety is paramount when admissions are made and that they are supported emotionally as soon as possible? How are mental health services being engaged within A&E departments and what targets are in place in terms of time elapsed following admission to ensure that patients receive specialist care from a mental health clinician and that their safety is not compromised? What provisions are in place to ensure that a detained patient is able to contact their family and broader support network for reassurance?

MR GRIFFIN: B15:

"What, if any, impact did the ward environment (including, but not limited to, ward layout and/or the use of technologies on a ward) have on inpatients?"

MS FRASER-WARD: So in my sister's case, clearly the maternity ward conditions at Broomfield Hospital after the birth of her son contributed to the lack of sleep she experienced, which some research suggests can be known as a trigger for puerperal psychosis, especially in patients with bipolar disorder.

MR GRIFFIN: I think you provide a link to some literature. We will ensure that the written version of this statement, including the link, goes on the website.

MS FRASER-WARD: Thank you.

My sister was diagnosed with bipolar disorder after the birth of her first son, and this information in her medical notes, combined with observations of her lack of sleep on the ward, should have been addressed and she should have been identified as a high-risk patient with a reactive care plan put in action. With the appropriate provision and planning for sleep protection in place, it is possible that her puerperal psychosis may have been prevented had medical staff at Broomfield Hospital taken account of her existing medical condition.

I would like this Inquiry to investigate what is being done to ensure that patients who are at a higher risk of serious mental health illness are given appropriate ward conditions and adaptations following childbirth. Can private rooms located further away from significant noise sources be prioritised for patients at a higher risk of psychosis?

MR GRIFFIN: B16:

"How, and to what extent, was an inpatient's privacy and dignity retained?"

MS FRASER-WARD: Having discovered my sister's poem very recently as part of my preparation for this Inquiry, my sister was clearly traumatised by her stay in Broomfield Hospital A&E and it suggests that staff providing her treatment did not ensure her privacy or dignity were maintained. What safeguards are being put in place to protect vulnerable patients being sectioned in A&E and what specialist mental health staff will be made available to support them during their stay?

MR GRIFFIN: B18:

"Was the treatment provided to mental health inpatients both appropriate and adequate?

"(a) Specifically how was medication administered and managed?

"(b) How was risk managed and was this properly

balanced with therapeutic care?

"(c) How were comorbid issues dealt with?"

MS FRASER-WARD: Although my sister's medication was prescribed by an NHS Trust outside of Essex, more could have been done by local mental health services to ensure that her ongoing medication was appropriate for her recovery. It is known that the drug she was prescribed has side effects which include suicidal thoughts and the risk this posed to her ongoing recovery should have been assessed by local clinicians whilst she was discharged home between MBU admissions. What provision is in place with regard to community mental health assessments following discharges from MBUs to ensure patient safety is maintained?

MR GRIFFIN: B20:

"How did providers deal with requests for leave (supervised and unsupervised)? What information was considered? Was this appropriate?"

MS FRASER-WARD: I still maintain that it was inappropriate for my sister to be permitted to leave her MBU to come home so soon after a suicide attempt whilst in care. I would like to know what protocols are in place to ensure that patients are protected from early discharge where it is inappropriate. Is there a minimum stay required for patients that have attempted suicide whilst

in hospital care? What processes are in place to ensure that appropriate liaison and agreement with local mental health teams is secured with other NHS trusts to ensure that community-based mental health support is in place before supervised or unsupervised leave is permitted?

MR GRIFFIN: B25:

"How were decisions as to risk and observation levels made? What information was considered? To what extent were such decisions appropriate and adhered to?"

MS FRASER-WARD: The Coroner's report that investigated my sister's death concluded that the risk assessment for her discharge from the MBU was inadequate and that the risks posed to her family via contagious diseases were not considered with regards to the impact it would have on her care. At the time of discharge, my sister was still recovering from that vomiting bug I mentioned that she had contracted on the ward and consequently all of her family fell extremely ill. It was whilst they were recuperating that she was able to abscond from the house and take her own life. So I would like the Lampard Inquiry to investigate what protocols are in place within Essex NHS Trusts to ensure that similar safety measures are in place with regards to contagious infections regarding care of patients at home. How are observation levels decided and what is being done to

ensure that high-risk patients receive home visits by community-based mental health teams in Essex following discharge from both local and non-local NHS Trusts?

MR GRIFFIN: B27:

"What consideration was given to the Deprivation of Liberty Safeguards for those who lacked capacity?"

MS FRASER-WARD: As evidenced in the Coroner's report into my sister's death, no written records have been made available to her family regarding her care at Broomfield Hospital A&E. We cannot know what consideration was given to her safety whilst she lacked capacity. What is being done to ensure that an appropriately trained member of mental health staff is always assigned to detained and/or sedated patients in A&E departments to ensure their safety is maintained and that their needs are met?

MR GRIFFIN: B28:

"When any type of restraint (manual, mechanical, chemical or seclusion and long-term segregation) was used, was it used and recorded appropriately? If not, why?"

MS FRASER-WARD: We know that my sister was physically restrained with handcuffs whilst in Broomfield Hospital A&E and that she was sedated, but no written medical records have been made available to her family regarding

her stay. What is being done to ensure that information and transparency around the care of incapacitated patients is being shared with family members whilst balancing this with the need to maintain patient privacy? What explanations are being provided to family members for why physical restraints are used instead of alternative methods to keep them safe?

MR GRIFFIN: B32:

"How were decisions as to when an inpatient should be transferred to another unit/setting made? What factors were taken into account? To what extent were such decisions appropriate?"

MS FRASER-WARD: The significant distance between the hospitals where my sister received her care and her home played an undeniable role in the slowing and ultimate failure of her treatment. Puerperal psychosis is a condition which, with the appropriate care provision, sees most patients make a full recovery. Because Pippa was transferred to units located so far away from her home, both her mental and physical conditions were made worse. She was able to attempt suicide whilst on an MBU ward due to inadequate safety measures around ligature risks and clinicians were only made aware of her attempt because she volunteered the information herself. Therefore I would like the Lampard Inquiry to

investigate what processes are in place to ensure that non-local hospital trusts and MBUs are in regular liaison with local community mental health service provision in Essex. What is being done by Essex mental health teams to ensure they are keeping track of local patients receiving appropriate care with other trusts and that their safety is being maintained?

MR GRIFFIN: C33:

"When and how did providers start discharge planning?"

C34:

"What discharge procedures were in place and were they followed?

"(a) To what extent was statutory guidance abided by?

"(b) Were second opinions appropriately sought?"

C36:

"To what extent were decisions around discharge appropriate? Was all available and necessary information known at the time of a decision relating to discharge? If not, why not?"

MS FRASER-WARD: As previously stated, it is my belief my sister should not have been discharged on 29 October 2016. I would like the Lampard Inquiry to clarify what protocols are in place to ensure that local mental

health teams in Essex are consulted by other NHS trusts before patients are discharged for supervised or unsupervised care in the community in Essex. Are risk assessments also being carried out by local teams in parallel with other NHS trusts providing patient care?

MR GRIFFIN: C37:

"Was any community-based support, set up by providers, sufficient and appropriate in the circumstances?"

D40:

"How, and to what extent, did providers co-operate with others to plan, commission and deliver safe discharge plans and aftercare? Was this sufficient and appropriate in the circumstances?"

MS FRASER-WARD: To my knowledge, no community-based support was in place locally for my sister's discharge. Based on the findings in the Coroner's report following an inquest into her death, two phone calls were made to her home on Friday 28 October to check on her condition. But these were made by medical staff at the MBU where she had been discharged, which was several miles away -- many hundred miles away. Had a home visit from the local mental health team been provided, a far more thorough assessment of her worsening condition could have been made, plus staff would have been able to

observe her family members becoming unwell and she could have been re-admitted into care.

So I would like the Lampard Inquiry to investigate what the current protocols and provisions are with regard to home visits in the community following the discharge of high-risk patients. Is there a mandatory requirement to visit these patients in person within their home settings? If so, is there a target for how quickly this is carried out following their discharge?

MR GRIFFIN: D38:

"From the point of admission through to discharge, what level of information was communicated to and/or obtained from inpatients, their families, carers and/or other members of an inpatient's support network during their time on an inpatient mental health ward?

"(a) What provisions or measures were in place to ensure that this information had been properly received and understood? Were necessary adjustments made to accommodate those who had known difficulties with communication?

"(b) How, and to what extent, was this documented?"

E47:

"What information and/or guidance was provided to inpatients, their families, carers and/or other members of their support network and staff to explain how they

should raise concerns about their own, or another person's, safety?"

MS FRASER-WARD: Although updates and information on my sister's care were provided to her husband during her treatment, no information was provided to other family members. Considering her husband was working full-time, looking after their five-year-old son and frequently driving hundreds of miles to visit Pippa and care for their baby during her treatment, it was difficult to expect him to also keep other family members regularly updated on her progress as well. If mental health teams and hospital clinicians had considered how other family members could have been integrated into her care plan, Pippa could have benefitted from much more support. Also, to my knowledge, no advice, either written or oral, was provided to other family members about how best to support her whilst she was on leave at home. I was completely unaware of the severity of her condition whilst she was receiving treatment and only found out about her suicide attempt at the MBU after her death.

I would like to know what recommendations the Lampard Inquiry will make to Essex mental health teams for engaging with broader family networks to inform them of patients' treatment, involve them more in their care

and to what extent advice to these members is made mandatory to support patients after they are discharged back home.

MR GRIFFIN: D41:

"How, and to what extent, were inpatients who suffered serious harm, their families, carers and/or other members of their support network supported by providers following the incident? Was this sufficient and appropriate in the circumstances?"

E45:

"Did inpatients feel safe when they were on mental health wards? Did families, carers and/or other members of an inpatient's support network have any concerns about their safety?"

E48:

"Were patient and/or staff safety incidents appropriately reported? If not, why not?"

F49:

"What data was captured during an inpatient's stay on a mental health ward?"

MS FRASER-WARD: To this day I am still unsure of the treatment that my sister received at Broomfield Hospital A&E. Having discovered her poem since her death and knowing that she lost her phone and all of her contacts during the short stay, it is my belief that she may have

come to harm during this time. No documentation of her stay has been made available to me and, as far as I'm aware, no support was provided to her next of kin following this stay.

I would like the Lampard Inquiry to investigate what protocols are in place to ensure that medical records of treatment in A&E departments are shared with next of kin when a patient is sectioned under the Mental Health Act 1983 and detained due to the lack of mental capacity.

MR GRIFFIN: E43:

"What steps were taken by providers to identify, assess, evaluate and mitigate safety risks to (a) inpatients (including when on leave and on discharge); and (b) staff on mental health wards? Were these sufficient and appropriate in the circumstances?"

E44:

"Specifically, what crisis management systems were in place? How did these work in practice?"

I79:

"Was learning at ward level appropriately captured? To what extent was it shared internally and built on?"

MS FRASER-WARD: The Coroner's report into my sister's death concluded that the risk assessment carried out by the MBU upon my sister's discharge failed to consider how her contagious vomiting bug could be contracted by her

family and therefore impact on the care that they would be able to be provided for her. Due to lack of local provision from mental health teams in Essex to carry out a home visit or make contact with Pippa to assess her condition, I would like this Inquiry to find out what lessons have been learnt, how have risk assessments been made more vigorous and what protocols are in place to ensure that proper localised crisis management systems are in place to support patients on discharge or short-term leave at home.

MR GRIFFIN: I'm now going to ask Tessa to put the ninth page of the opening statement up on the screen. Could you expand from L93 down, please?

Can everyone see that? Yes. Do we see here L93?

"How, and to what extent, did providers respond to the following in relation to the provision of mental health inpatient care and treatment ..."

Then we see a series of matters, including, for example, (a), "Concerns and complaints", and (h), "Investigations by HM Coroners Service".

And M100:

"How did providers in Essex interact with external bodies, including (but not limited to) ..."

And again we see a series here of bodies and organisations, including, for example, (a) NHS England

and (c) "Other NHS Trusts".

Thank you. Could you take that down now, please?

MS FRASER-WARD: As information regarding my sister's stay at Broomfield Hospital A&E has not been made available, I would like to ask the Lampard Inquiry to investigate whether A&E service providers are actually contributing appropriate information to investigations by HM Coroner's Service.

MR GRIFFIN: M103:

"What recommendations, including from inquests, investigations, experts and any others within the professional or regulatory sphere were made to improve mental health inpatient care and treatment? Were appropriate steps then taken by providers to act upon such recommendations?"

MS FRASER-WARD: To my knowledge, our family has not been contacted again by HM Coroner's Service or by NHS Trusts involved in my sister's care since the completion of the inquest into her death, therefore I am unaware if any of the recommendations in the Coroner's report have actually been implemented at any of the NHS Trusts responsible for her treatment or indeed if these recommendations were even shared with Essex community-based mental health teams and Broomfield Hospital A&E.

I would like to ask the Lampard Inquiry to investigate if indeed these recommendations have been implemented into practice within broader mental health services within Essex. What is being done to ensure that families are being informed of any improvements in NHS care services following inquest recommendation?

MR GRIFFIN: And that is the end of your opening statement, but you provided details of some further evidence which you will provide to the Inquiry.

MS FRASER-WARD: Thank you.

THE CHAIR: Thank you very much indeed.

MR GRIFFIN: It will take just a moment because I know that the desk has to be arranged for our next speaker.

May I invite Melanie Leahy to come up to the table? Melanie has previously told you, Chair, about her son, Matthew. This time she will be speaking about her partner, Colin Flatt, and may I ask that the photograph goes up on the screens, please?

MS LEAHY: Good morning, Chair.

THE CHAIR: Good morning.

MS LEAHY: It is morning still, isn't it? Afternoon. I got a bit lost in your testimony. It's fabulous. You've done her proud.

Well, I didn't expect to be here once, but to be here twice, here we go.

Statement by MELANIE LEAHY

MS LEAHY: This is a commemorative impact statement that I'm making on behalf of a man that was in my life for 20-plus years, a very special part of my life, Colin Harold Flatt.

Colin died September 2021. I just have to start reading it, I'm afraid. As I stand here and say that name, I'm worried. I'm worried you'll hear the name of an older man and assume he died because he was old, that eventually death comes to us all, and you'd be right, but the way he died and what contributed to his death is why we are here today.

His death was not suspicious. I lived the experience with him and I saw exactly what went wrong, drastically wrong. I watched as the killing machine went into action and I was powerless to stop it, despite my knowledge of the system. Having experienced a multitude of failings in my son's care which led to his death, my fears and anxieties at Colin's admission to hospital multiplied and the end result proves they were totally founded.

Colin was a lot older than me, but despite his age he was a very fit man. He was self-caring, he cycled daily, he maintained our home, he took the dog out, he gardened -- it was meticulous -- and he was my partner

for close to 20 years.

Colin could have been your partner, your brother, your father, your cousin, your grandfather, your great-grandfather or your great-great-grandfather. He held all those titles in his life. It's just by the roll of a dice that he's not. If he had been, I'm certain you would have loved him as much as I did.

He was widowed, I was divorced. I was working in a marina on the east coast. Colin had a yacht in the marina. It sounds like something from a budget romcom film, I know, but we fell in love and in time we bought our first house together.

My son, Matthew, another of the deaths investigated in this Inquiry, Colin and I all moved in together. Colin had been born in Blythborough in Suffolk, in one of the cottages next to the church. He wasn't there very long as his father moved to London to join the London Fire Brigade. His dad was a firefighter during the war, and whilst all the other children were moving out of London, Colin was being moved in with the family, to serve our country.

Colin had been a footballer, a professional footballer, and to this day there are still football blogs that mention his name, despite that part of his career ending over 50 years ago. He played in the

finals at Wembley, he played for various teams, and was a bit of a legend both at Barnet and Leyton Orient.

Colin and I went into business together and he helped me start an advertising company. He gave me the confidence to do that. He taught me about accounting, invoicing, all that sort of thing. He was a successful businessman in his own right and ran a very successful freight forwarding company. A fantastic yachtsman, he won many, many cups and trophies, sailed regularly -- he sailed down to Spain and Portugal; thousands of miles of sea in his lifetime.

In our early days he suffered with asthma and he used to sing "All I need is the air that I breathe just to love you". That was one of his fun things that he would do. He had a good sense of humour, and it kept me and others that knew Colin smiling, even through the darkest times.

Lots of party tricks. One was standing on his head. He even did that when he was I think 79. That was probably the last time. And I recall like clearly on a cruise, it was so rough, yet he got up in the middle of the dance floor and was on his head. We could hardly stand but he'd be on his head.

Then the other side of Colin, he did like a moan and he found a community for that. They were called "The

Argumentative Society". It wasn't a real society. It was a group of men, they went to play golf, they'd have a good moan and a pint afterwards. But he never said a bad word about anyone. He wouldn't, even in private. He would champion people, support them. He loved going to the pub so he could just talk to people like you. The beer was, you know -- that was his bonus.

He learnt magic tricks. He used to like entertaining and, if he walked through the door, you were just happy to see him because you knew you was in safe hands. And you'd learn. You'd learn something from a conversation with him. He loved animals and that's Jed. Jed is 14 and a half now and probably -- yeah, he's the only real part of our life together that I have left.

In 2012, when Matthew died, Colin was there. He was by my side and I'm not sure I'd be standing here today if it wasn't for Colin, my friends and my family keeping me afloat. So how a man in his 80s ended up flanked by security guards, naked, lying in urine-soaked sheets at the bottom of a hospital bed, being held at 45 degrees, while suffering from severe infection and a haematoma is what has led me to being here today.

In early 2021, as the world was coping with the new normal due to Covid and the restrictions we lived with

infiltrated our lives, I noticed a difference in Colin. He would become a little confused in the early evenings -- I know not uncommon as we get older but it was concerning -- and a family member had recently gone into hospital, having had a heart attack, and in A&E he was told if his heart rate was critically low, under 40, it would be an emergency.

I had ordered a heart rate monitor for my brother. Two arrived by accident, so we used the second one and Colin checked his heart rate. It was 38 beats per minute. So as he'd been getting tired, he actually went down to the local GP surgery and they just advised we call 111. Paramedics came and Colin was taken in. He was taken into Broomfield Hospital and off he went in the ambulance. I remember I wasn't allowed to go because there was Covid. I sat down on the stairway and I just had this sinking feeling he wasn't coming home, but I could never have predicted why.

I wasn't allowed to see him for the first few days because of Covid and then I got a call to say, "Oh, he's up on a ward now". And I remember I went in -- I went into the main atrium at Broomfield Hospital and there he was. He was sat playing with a mobile phone, he had bruises all up and down his arms, which I have photographs of, and there was two security guards -- no, there's four.

He had been chemically restrained. He didn't know who I was. It turns out, I found out, that the doctor that actually began the chemical cosh on Colin ten years earlier I had reported to the NMC for over-medicating my son and he had been moved on to the elderly adult psychiatry.

Anyway, suffice to say, within 19 weeks my partner was dead. Helpless, I just watched the man I loved deteriorate in front of me, and I'm not trying to make you feel uncomfortable, but I just want you to imagine it, imagine how I feel.

I can't go into the appalling details of the so-called care he was provided with here because I understand it's not the appropriate forum, but I will share them later down the line.

I'd like to share that Colin's care came under three main umbrellas, which was Mid Essex Hospital, Essex Partnership University Trust and the North East London Foundation Trust. Two of these Trusts are known to the Inquiry. Colin had been chemically coshed, deprived of his liberty, abused, bruised. Ultimately Colin died whilst in the care of the state.

I still wait for the inquest into his death, three years so far, with a feeling of dread and deja vu, and I'm bracing myself for the nightmare I know it will be.

And I'm scared but, along with every family here today and in this Inquiry, need what went wrong brought out into the open to stop the same happening again.

After his death Colin lay in the mortuary for ten and a half months whilst police investigations were ongoing, and when eventually I laid him to rest, I did not get all of him. Samples still remain with Essex Police and I really hope to get those parts of him back in due course because I loved all of him, not just parts of him.

I've been asked by the Inquiry to write a summary of the impact of my partner's death on me and I just ask you to use your imagination. I lost my son to the brutal system in 2012, a system that was meant to keep him safe, and years later I've now lost my partner to that very same system; a man who I shared one-third of my life on this earth, 20 years together, and my world, yeah, changed forever, forever.

After my son died, I couldn't stay in our family home as it held too many memories. Colin and I moved from a place we both loved and lived in for 12 years and we set up a new home together in a different area in Essex. Having lost Colin, I tried to stay in this new home, but, again, so many memories kept surfacing and the fear and anguish took over and then I shut down,

I became numb. I started to experience pains in my chest and panic attacks and I was diagnosed with angina. I suffered extreme exhaustion and still to this day struggle to get a good night's sleep. Some days the memories still knock the wind out of me.

Friends moved in with me whilst they too had bereavements and we found a way of surviving together for many months. Yeah, everyone says, "You're so strong, Mel, you've got this", but honestly I'm not sure how I survived. Friends and family have been so, so supportive in my losses and I'm forever grateful to each and every one of them.

The reality is this is my pain to shoulder, my loss, but it's a sad, lonely and difficult journey and I live every day wondering how I'll get through it and then I remember that my boys would want me to. I miss them both so much more than words can say.

Every day is confirmation they are never going to return and, as I explained earlier in this testimony, I wish for the truth to come out. I know exactly what went wrong in my late partner's care and it needs to be brought out into the open to stop it happening to others. Thank you.

THE CHAIR: Thank you very much indeed.

MR GRIFFIN: And there is a video to play which we'll play

now, please.

(Video played)

THE CHAIR: Thank you.

MR GRIFFIN: Chair, that is all for this morning. Could we reconvene at 2 o'clock?

THE CHAIR: 2 o'clock, everybody. Thank you.

(12.54 pm)

(The short adjournment)

(2.01 pm)

MR GRIFFIN: Good afternoon, Chair. We are hearing now the commemorative statement of Victoria Sebastian. It's about her daughter, Elise Sebastian. It will be read by her legal representative, Nina Ali, and Victoria is here sitting next to her.

Could we put up the photograph, please? Thank you.

MS ALI: Good afternoon, Chair.

Statement by VICTORIA SEBASTIAN (read)

MS ALI: The commemorative statement of Victoria Sebastian in respect of her daughter, Elise Sebastian. Elise's date of birth was 24 May 2004. Her date of death was 19 April 2021.

"Elise was my beautiful baby girl, and despite being mother and daughter, we were like two peas in a pod. She was always very clingy to me and her belongings. She always had a backpack with her, full of her

favourite toys. She would take them everywhere. Elise was always shy as a little girl and found it difficult to be around people she didn't know but she had a fantastic relationship with her brothers and sisters.

"Elise was very close to both of her sisters, Charlie and Kelsey, but in particular with Kelsey. They were always together and loved each other very much. They were like twins with only a 20-month age gap between them and so they didn't know life without each other. Watching Kelsey and Elise grow up together was always such a joy to me. They would go from phase to phase, as children do growing up. I recall Elise and Kelsey going through a Monster High phase to being massive fans of the pop group 'One Direction'. I recall how much we would enjoy going for a drive with me and the girls singing One Direction songs really loudly and probably very badly! We sang our hearts out and we laughed so much.

"Elise was also close with her other siblings, I remember how she would watch the 'Marvel' films with her brother Zachary and he would tell her about the superheroes.

"I loved watching and being part of the extremely close bond my family shared. Life with my family made me so happy. My family means everything to me.

"As a family we went to lots of shows in the West End and we took the children to lots of concerts.

"At school Elise excelled in her schoolwork and wanted to work with animals as she loved them ... Elise was a very caring and loving girl.

"I knew that Elise was different from my other children as she was always socially awkward and often found it difficult to understand other people's behaviour. I mean, she couldn't tell if they were joking or if they meant what they were saying.

"Elise was very sensitive and took everything to heart. When she was at secondary school and she couldn't talk about toys or Harry Potter with her peers she felt lost and ... different.

"I saw how she would sometime take on other people's traits to fit in with the group. She also struggled with her sexuality, her appearance and was a massive over-thinker.

"It was very hard as her mother to watch her struggle. I tried to help her understand other people's behaviour and to help her with her emotions and responses. For example if she felt her best friend was angry at her I would read the messages and then explain that the friend probably hadn't meant it as she had read it. Or when she first had feelings for someone and

she felt she couldn't cope I would explain how powerful feelings could be and how they could make you feel.

When Elise was accepted at Writtle college to do a course in animal management she was so excited but then she became ill.

"When Elise was in hospital I would make sure that no matter how hard my shift at work that day had been or how far away she was to visit her every day to tell her I loved her and to get my cuddle. There was no better feeling than being with my baby girl. I wanted so much for her to be with me and to have my baby back, it was unbelievably difficult to be separated from her as she was my beautiful baby and best friend. When she was alive I spent all my time with her and was always so happy to be with her.

"Losing Elise has shattered my life. My family is shattered. The loss is so heart-breaking and painful that I can't begin to describe it in words.

I had been to see her that day in the unit as always and she had been so happy as always to see me. We chatted for ages and she gave me the most beautiful cuddle. I can't tell you how frightened I was when her dad (Glen) called me to say that my beautiful girl had been rushed into hospital and was unresponsive.

I recall that he was so broken up that he could barely speak. The unit didn't give any information and we didn't even know where she was. It was as though we had entered some kind of nightmare.

"I drove to Colchester hospital blindly hoping that that was where I would find her. I left the car outside A&E and I went in. I recall saying, 'You're going to tell me my baby is dead, aren't you?'. I could not feel my hands and my legs and breathing seemed impossible. The hospital staff seemed to know who I was, and took me to a children's waiting area. A female staff member was there and told me that Elise was on a 'one to one'. A nurse then came out and told me that Elise was having a CT scan and I knew straightaway what that meant. I recall saying to the nurse, 'You're trying to see what damage has been done to her brain'.

"The nurse took the female staff member for a walk and I didn't see her again.

"Glen arrived shaking and crying asking me if Elise was going to be ok. I told him that she was having a CT scan and that I didn't think it sounded good.

"A nurse then came and took us to a children's ward where Elise was laying there with all these tubes and monitors attached to her. I knew as soon as I looked at her that she was gone from me, there was no light in her

eyes. It looked like she was gone. The doctor came and told us that Elise was severely brain damaged as she had been without oxygen for 20 minutes or more. He told us that if she did wake up, she would not be able to do anything anymore. He said they would monitor her brain activity over a few days and that at any time she could go into a cardiac arrest. We sat by her bed holding her hands for days. Her hands were so cold and her eyes were open the whole time. It is an image that is stuck in my head and one that I don't think will ever leave.

"On the Monday after some doctors came into the room and did some tests on her brain activity and told us that nothing had changed. They did this again a few hours later and then told us that nothing more could be done. My already broken heart shattered some more. They then took her off her life support and Elise was gone. I cannot begin to tell you how painful it was to leave my baby on that bed knowing I would never see her beautiful face again. Leaving her felt like I was somehow abandoning her and that is something that haunts me ... every day.

"I struggle to get through the day. I have seen been diagnosed with PTSD and trauma-based ADHD.

"I know that Elise's dad, brother and sisters are

all suffering as much in their own way as Elise was loved so much by us all.

"Her sister Kelsey was at university at the time doing her law degree and never thought that she would have to come home and never see her baby sister again.

"Kelsey told me that she couldn't cope with the loss of Elise and was struggling significantly, and so I went and collected her from university.

"She deferred university for a year and then went back and completed her law degree. Although she seems okay now, I am still really worried about her and very scared, after seeing how badly Elise was let down by the system, that I may lose another child because, if Kelsey struggles in the future, and she may well do, there just isn't a good enough system of care in place to look after her .

"My entire family are still struggling and still finding the pain too much to bear."

Victoria has added some pictures of Elise with her family.

MR GRIFFIN: Could we put up the remaining photographs?

(Images shown)

That's the final photograph.

THE CHAIR: Ms Sebastian, thank you very much for letting us have that statement. Thank you.

MR GRIFFIN: I'll just ask for the table to be re-arranged before the next statement is read.

Chair, the next commemorative statement will be read by Sally Mizon about her partner, Mark Tyler. May I ask that Sally comes to the table? While she does so, may I say this: the Inquiry is aware that Mark's death was part of a longer chain of tragic events affecting his family and the purpose of this hearing is to understand the impact of Mark's death on his family.

Could I ask that the photograph is put up, please?

MS MIZON: Firstly, thank you for including Mark in this Inquiry and, as a family, we would also like to say thank you to Melanie Leahy for being such an absolute warrior and enabling this Inquiry to go ahead.

Statement by SALLY MIZON

MS MIZON: I'm not going to talk to you about Mark Tyler, the person who, as a result of his mental health struggles, shot and killed his mum. I'm going to talk to you about Mark Tyler, the man, a dad, a son, a brother and an uncle.

I met Mark around the end of March 1998. He was a handsome chap with his blonde hair and big muscles. He was quiet, gentlemanly. He wasn't loud and he had nothing to prove to anyone. We went on our first date on 25 April 1998, which had been set up. We sat indoors

in my house drinking black coffee and listening to Oasis, just getting to know each other. I always say that Mark and I didn't date. Instead Mark and I went from zero to 100 in our relationship, as we always would. We were both broken products of our childhoods, but we just got each other, which no one else understood. We were also both very broken people and believed that our chipped edges came together to make us an imperfect whole.

Mark was his mum's third child. He had an older brother and sister and two nephews, who he idolised.

As my relationship with Mark continued, I found out that I was pregnant with our first child. When I told Mark this news, I remember that he went very quiet and barely spoke to me for the rest of the evening. He then got up and went to work the next day and disappeared for a week. We didn't have mobile phones and social media then as it was still only 1998. Anyway, on the Friday evening Mark came home with a bunch of flowers for me, a cheeky smile and I think it was approximately an 18-page letter. I still have this letter.

In this letter, he told me that he was sorry that he'd left the house in a hurry once I'd told him our news and that he was scared. He told me that he had heard voices for most of his life and that he suffered

from uncontrollable rages, and that is why he took to boxing, worked out a lot, went to a gym to keep his mind occupied. Mark also told me that he was scared that our baby would have the same mental health issues and he didn't know what to do and was scared that he may end up hurting me or our children. In his letter Mark also said -- and I'm paraphrasing here -- that he knew that the love he had for us would make sure that he didn't hurt us and we would be safe.

The bond between Mark and all four of our children was a beautiful thing. Our oldest son, Liam, remembers Mark as being a good father, taking on the responsibility of raising my children from a previous relationship as his own. My son says that Mark was who he was; that is to say he remembers fondly that his dad had a good heart and cared for a lot of people. He also remembers that Mark taught him a lot of important life lessons within the short time that he was alive and that he will continue to use those lessons to bring up his own children. Sadly my son had to watch the man he called "Dad" fall apart whilst he was growing up due to him suffering from his mental health issues and Essex Partnership University Trust not taking our concerns as a family seriously enough. Liam also recalls many people felt that, if Mark was supported

correctly with his mental health, then he would have been able to show what we all knew, which was that inside Mark was compassionate and was cared for and loved by many.

Our oldest daughter, Jessie, says that Mark Tyler is the man who she viewed, still views and will forever view as her dad. Jessie knows that if her dad hadn't become so mentally unwell, he would have been in her life for a long time. My daughter adored Mark. She loved everything Mark did and everything he showed her. Jessie loved working out with Mark at the gym and remembers that he taught her how to box, which she has picked back up in recent years. Jessie remembers her and Mark building a white neon BMX bike together. This is a skill that, thanks to Mark, has helped Jessie with the many types of bikes she has since owned.

Mark also taught Jessie important skills. Jessie remembers the moment her BMX bike was built and remembers Mark was zooming around and bunny-hopping off of kerbs. It looked like he was having so much fun. She also remembers that Mark did a spin with a BMX bike off the kerb, which she fondly remembers finding so cool. She remembers the pride on Mark's face every time he saw her excel in sports. Mark was Jessie's coach and biggest supporter, from monkey bars as a kid in the park

to him teaching Jessie how to ride a bike and running laps and laps of a giant field. Jessie remembers Mark being so surprised that she could keep up and do the same amount of laps as he could.

Mark was very protective and cared so much about Jessie and all her siblings. He used to tell Jessie and Liam that he didn't need to adopt them as he viewed them both as his own biological kids. Jessie remembers that Mark would tell others that he did not need to adopt them because they were his kids and a piece of paper wouldn't change that.

Mark was funny, caring, protective and most of all a great dad to Jessie. She is aware that Mark was not a perfect human, but that we all have our flaws and he was a great dad. Jessie also knows that Mark wanted a better life for the family than he had when he was growing up. She has so many memories and so many stories that she could tell people about Mark. Jessie misses Mark a lot and is upset at the fact he is missing out on his life and watching all of his children smashing goals. All the accomplishments, big or small, he has missed with so many and will forever continue to miss so many more. Jessie always says it makes her think what her dad could have accomplished with his life if he had got the right mental health support.

Jessie feels like he was judged because he had encounters with the law and had a history of drug abuse. She also feels that these were partly the reason his mental health wasn't taken seriously enough. But Jessie knows Mark to be her hero.

Our youngest daughter, Tescha, remembers Mark was the strongest man she knew, with strength something she always associated with him. As a child, all Tescha knew of Mark was that he was big, strong, calm and funny. He taught Tescha how to love animals, how to love family and how special being oneself is. Tescha remembers that Mark loved all of his children so loudly and fiercely. He also taught her how important family was and would always be and how sticking together as a team would conquer anything the world may throw at you. Tescha remembers fondly the protectiveness Mark displayed towards her, his calmness, his enthusiasm for life and his affection.

Tescha also remembers that Mark really enjoyed quality time with all of his children, which was of the utmost importance to him for the 12 years she truly had him in her life. She says that she sees it as a blessing that many people do not ever get to experience in a whole lifetime. Tescha remembers that every weekend she got to spend with just Mark was filled

with days in the outdoors, walking the dogs and playing in parks. She also remembers talking with Mark for hours about any and everything, being completely present and having his undivided attention, and memories that she will cherish forever.

Tescha has said that Mark loved his mother and brother and sister and nephews loudly, also that his calm voice and patience are personality traits that not many had and that his enthusiasm for manners and talking kindly to one another pushed her to be the adult that she is today.

Even now Mark has passed, Tescha still acts in the same way he taught her. She remembers that Mark was a mentor to her, her hero and a piece of her heart that has been lost far too early. Mark taught her a lot, but most importantly taught her to be patient, to be yourself and to love like there may not be a tomorrow.

Our youngest son, Dougie, says that Mark was a good man, a family man. He was never angry, always very calm, even when telling them off as children. He'd never shout or even raise his voice. He was very big on manners and enforced this in all aspects of life, eating dinner, making sure your elbows weren't on the table and had the cutlery in the right hands. Walking on the street, no matter who they walked past, Mark taught

Dougie and all the children to say "Good morning". Dougie says that in shops Mark taught the children to always say "Please" and "Thank you" or he wouldn't buy them anything as he always said manners cost nothing.

Dougie remembers that Mark was supportive in every aspect. Dougie and Mark would pretend to be running races through the streets and Dougie would always win. No matter what Dougie wanted to do, Mark would always help. Dougie remembers Mark helping him practise his egg and spoon race before his sports day. If Dougie was good, he would always buy him a Kinder Egg surprise and they would always build it together.

He considered Mark was bonkers, but in a good way. Dougie remembers Mark would always say that he had a pet crocodile. It was a taxidermised baby crocodile that he'd got when in Australia, but it was close enough. At sports day, in the fathers' day [sic] race, Dougie remembers that Mark had done the Forrest Gump run in front of everyone until he realised he was going to lose, and then somehow pulled it out the bag and still won the race.

Dougie knows Mark loved his family, family being so important. He remembers always being around his nan's house, even if it was just for breakfast, to pop in and see her or spend a few days with her. Dougie and Mark

would always do things together. Whether it was bowling, going to the arcades, walking the dogs on one of Mark's unnecessarily long walks, they would always do it together. On all the children's birthdays, Mark would get cards for all of them and he would always do the goofiest smiley face, which was his trademark.

Dougie remembers that Mark always had his troubles, but up until it got really bad he had no idea. He remembers that Mark always put the family first, even when he was unwell, and that he was a very selfless, calm and nurturing man that was never ashamed or scared to show his family how much he loved them. Even up to the end, Dougie never felt unloved.

Mark was quiet and he was an honest man. He was also polite, which was very important to him. Mark would tell the boys that they were never to hurt girls and that they should always protect their sisters and to treat them with respect. Mark's grandad, Bill, lived until he was 106. Mark held the elderly in the highest esteem, understanding what they had gone through and the respect they deserved after listening to his grandad's war stories.

Mark was also an animal lover. We always had dogs. He taught children about nature and environmental impacts. Mark was not this bad man that was portrayed

in the press. He was sadly unwell. Whilst Mark was no angel, to me and my children, for the majority of time we were together, he was just our Mark and we loved him every single day of his life.

People have undeservedly judged Mark on how he was reported and how he lived at the end of his life, and whilst he struggled with drugs, Mark was a man who constantly tried to improve and get better by going to rehab on numerous occasions.

Mark started to behave differently towards the end of his life and he became paranoid, convinced that people were trying to kill him. Mark's deteriorating mental health issues meant that he was also convinced that aliens or God was talking to him. At first as a family we generally laughed this off, but as time progressed his behaviour became more erratic and concerning to us all. For the first time that I had known Mark he became violent towards me. His mental health issues convinced him that I was trying to have him killed.

I have since understood that in and/or around July 2012 Mark had attended Basildon Hospital, saying that he was either going to kill someone or himself. However, again, I understand he was discharged to then go and live with his mother, who was 79 years old at

this time. Mark made several attempts to take his own life prior to him succeeding.

Two weeks before Mark would kill his mother and then himself, I received a call from an unknown number. When I answered the call, it was from Mark. He said, "Sal, it's me ... don't start, I just want to talk". I knew that for him to call me was important. We spent three hours on the phone that day. Mark begged me to let him see the children during the call. I begged him to get help and he told me that he had and that he was fine and it was everybody else that was mad.

For the first time in a very long time I got to speak to my Mark. We talked as we always had before he became unwell. It was beautiful. Sadly that was the last time I ever got to speak to him. I'm glad I didn't put the phone down on him that day.

Mark struggled with substance abuse all his life and had been under drug and alcohol services for years. As a result of this, he had psychosis, which required treatment.

Every single event in my children's lives has now been tainted by the loss of their dad, from simple things like learning to shave or fixing his little girls' broken hearts to the more significant things like teaching the children to drive, finding them their first

car, watching the beautiful transition from child to adult, graduations from college and university. Grandchildren and everything in between and to come is always going to have him missing.

The lack of statutory compliance and institutional neglect towards Mark Tyler has taken away the future my children should have had and instead left us fighting our own individual battles with mental health services to this day. We all deserved for Mark to be given better treatment by EPUT.

To the family, dual diagnosis was and still remains a paper exercise nationwide. Very few practitioners, it appears to me, have the necessary skills or knowledge to make an accurate diagnosis. It is my strong feeling that, due to constant public sector cuts and changes within the availability of effective treatment, multi-disciplinary approaches are rarely effectively implemented. Even if they are, there are challenges to find a pathway that offers treatment that can cope with significant psychiatric and substance issues.

Mark asked for help or made comments that should have at the very least triggered safeguarding protocols on at least 18 occasions. Mark was just 37 years old when he needlessly died.

MR GRIFFIN: Thank you. Would you put up the remaining

photograph, please?

(Image shown)

THE CHAIR: Thank you very much indeed. I found that very thought-provoking. Thank you.

MR GRIFFIN: Chair, it's now time for a break. Can I suggest that we come back at 3.05?

THE CHAIR: 3.05, everybody, yes.

(2.35 pm)

(A short break)

(3.06 pm)

MR GRIFFIN: Chair, we are now hearing from Afka Ray, who will be speaking by videolink about her foster daughter, Ellise Sambora. Can I ask that the photograph is put up, please? Can I ask, Afka, if you can hear us okay?

MS RAY: Yes, I can hear you.

MR GRIFFIN: Please start whenever you feel ready.

MS RAY: Okay, thank you.

Statement by AFKA RAY

MS RAY: Ellise Sambora was born as Ellise Leona Motyer in Cambridge on 7 September 2005 to mother, Lorna Bell, and Lee Motyer. Her mother had changed her name to "Sambora" and Ellise did the same when she was 11 years old to honour her mother's memory and to be closer to her. In 2007 Lee and Lorna split up, at which point Lorna and Ellise moved to Maldon in Essex. I myself

moved to Essex in August 2008 and shortly after became friends with Ellise's mother, Lorna. At the time she had just been given the all clear after having had treatment for breast cancer.

Ellise was three when I first met her as an adorable chatty little girl. I can account for her life and what I know of her from this age.

When Ellise was little, she loved all things princess and Disney and she was a huge fan of Dora the Explorer and wanted to be just like her. Ellise and Lorna had a playful Staffordshire terrier called Ragamuffin. Ellise and Ragga were inseparable. Not long after meeting Lorna, I found out that I was pregnant. Lorna was overjoyed and even threw me a surprise baby shower. Being new to the area, I knew no one and her making such a beautiful gesture at such a scary time for me as a single parent cemented our friendship.

Lorna loved music and enjoyed going out to see live music. In 2009 I was pregnant, so I was happy to stay in with Ellise whilst her mum went out for a bit of me time. Ellise would often say, "You can practise on me being mum", so at weekends I'd look after Ellise until my son was born. We would play games like "The floor is lava" and pretend we were on an adventure with Dora the

Explorer. Ellise of course was Dora. Ragga joined in on the fun. She would often talk to my tummy and ask if the baby would be her new brother. Lorna and I both knew that, because of my age and because of the effects of her chemo, that we would not be having any more children, so we decided that Ellise's idea was perfect. So when my son arrived, Ellise was the first child to meet him. She adored him and we introduced him as her brother from another mother.

As Ellise and my son grew up, I continued to watch Ellise at weekends so Lorna could have a break. My son grew and Lorna began returning the favour and we arranged a deal that I would watch Ellise on Fridays and she would watch my son on Saturdays so the children spent every weekend together as brother and sister.

Ellise did have a fraternal sister who she often spoke about but sadly never met. As time went on, I could see how clever Ellise was. She was an avid reader and read well above her age. Her favourite books were Harry Potter. She had a vivid imagination and was very good at art and loved music. She loved drawing and crafting with her mother and Lorna loved horses and Ellise was no different. They spent a lot of time caring for and riding their horse, Ronnie.

Lorna was a Christian and we all went to church on

a Sunday as a friendship family. Ellise was christened at the church and had two godparents. My impression at this time was that Ellise saw her father, Lee, sporadically.

In 2012, Ellise and her mum moved to Southminster and I continued to see them both. Ellise was excelling in school and had taken up drumming as well as having a keen interest in anything theatre. Ellise's ongoing love for Disney took them to Disneyland.

Lorna was diagnosed with terminal stage 3 cancer in 2013. She was given a year to live. Ellise was there throughout all of her hospital appointments and treatments and often kept mum occupied with song and dance and making her laugh. This is when Lorna recognised Ellise's talent for the arts and she enrolled her in theatre, which was one of Ellise's favourite activities. She went on to be one of the cast in a musical in the Royal Albert Hall. Ellise was so proud of this opportunity.

Lorna had a bucket list, which meant Ellise and her mum went on amazing adventures such as Disneyland again, whale-watching in Scotland and several camping trips and festivals. Ellise was happy and seemed not to be fully aware of what was to come.

Lorna was a fighter and lived one year longer than

expected. In her final year I spent three days a week with them to help look after both of them and walk Ragga, as well as supporting Lorna's mum by giving her a break to do things like shopping and return home to care for her husband, Ellise's grandfather, who was also terminally ill with COPD. In this time I became very close with Ellise's nan.

Early in 2016 I went to pick up Ellise for our usual weekend meet-up to bring her to my home. Lorna was gravely unwell at this point, so I sat down with her and asked her if there was anything she needed me to do for her on this earth when she was no longer here. She answered, "Please look out for Ellise for me, and keep her close", and I promised I would honour this wish. This turned out to be her dying wish. She died the following morning.

Lorna passed away on 17th of the 1st, 2016. Ellise was at my house with me when her nan arrived to tell me the devastating news. Ellise understandably broke down and we all grieved together. She was nine years old at the time. After Lorna's death Ellise's nan was in mourning for her daughter. She was at a very difficult junction and Ellise spent time with me and her godparents whilst they sorted through the funeral arrangements.

Ellise's nan was granted kinship care of Ellise. Ellise moved in with her nan and she had her own room decorated with butterflies and a desk full of art supplies and a stunning princess bed with lots of teddies. Ellise's favourite animal was a duck, so she had a collection of ducks of all kinds. Ellise's nan was a secretary at the Sea Cadets and enrolled her not long after Lorna's passing. Ellise became a core member of this troop.

Ellise settled in well and her nan adored her. Ellise struggled to get on with her grandfather, who often passed judgment and had traditional values. Due to this, Ellise began isolating herself in her room and Ellise spent weekdays with her nan and weekends with my son and me.

I wanted to stay true to my promise to her mum, Lorna, so I continued the arrangement with her nan that we had since she was three. This also gave Ellise's nan and Ellise some respite and time to recover. Throughout this time I continued to have Ellise and she began to see me as her second mum, me often introducing her as my stepdaughter and her introducing me as her stepmum, "step" as in "stepped in" for her mother after her passing.

On weekends we would go to the gym and train

together as a family. We would go roller-skating, swimming and have regular visits to Southend-on-Sea to Adventure Island. Ellise had a core group of friends who sometimes came to visit. At this time she seemed to be very happy. She created lots of TikTok content and danced and did Miranda impersonations, which made us all laugh. She really loved doing impressions and being centre stage. She continued with Theatre Train and Sea Cadets.

Ellise appeared to have settled in quite a bit and was doing a lot of voluntary work with the Sea Cadets and even won an award for most volunteered hours of any young person in Essex. We were all so very proud of her. Ellise enjoyed helping the community and she was working with Theatre Train to improve her acting and stage presence. She was involved in several performances along with my son and their team. She seemed very positive and happy.

Despite this, she began to exhibit some disturbing behaviour throughout 2016 and 2017 and had several visits to A&E to get support for her mental health. She was diagnosed with low mood, panic attacks, anxiety and self-harming behaviour and self-esteem issues. Ellise started at Lower Plume in September 2018 and was doing well at school and enjoyed English and was top set in

maths. She had a school counsellor that she spent most of her time with in her office when she felt anxiety, just chatting about her dreams. Ellise enjoyed working with animals and often spoke about becoming a veterinarian.

Ellise was again admitted to A&E in February 2019. I received a call from Ellise's nan, stating that Ellise could not be released into her care due to her health issues. As a result Ellise moved in with us on the 25th of the 2nd, 2019, full-time. Myself and my son lived in a two-bedroomed home. My son was more than happy to share his room with her. Ellise's mood drastically improved during living with us and all of her school reports reflected this.

Whilst Ellise was staying with me full-time, her father, Lee, began spending more time with us at my home. He had arranged a visit once a week to join in our family dinners. I stayed focused on social care and working to try to become her foster parent while Lee, Ellise's father, focused on attending appointments with her at EWMHS. Sadly things took a turn for the worst in 2019 and Ellise had difficulties with her mental health. As a result and as a last resort, Ellise moved back in with her nan, who was terminally ill at the time.

On the 2nd of the 9th, 2019, I had a call from

Lorna's cousin saying Ellise had died. She had taken her own life the previous evening. Ellise was only 13 years old.

I was destroyed -- that isn't even the word for it. I had tried to honour my best friend's wishes and, due to all of the commotion and lack of support and to-ing and fro-ing with no direction from EWMHS and social care, we were left broken with serious mental health issues ourselves.

I had a breakdown. I became isolated and could not return to my home, my work or my friends in Essex. I never went back home. I couldn't process anything and got to a stage where I was having nightmares at night and feeling nothing during the day. I blocked everything out. I couldn't make sense of any of it. I stayed in Lancashire with my friend and his father, and they supported me and my son during this time. I finally got the strength six months later to go back to Essex and get my things. Now that Ellise had died, I no longer had to stay in Essex, so they arranged the move to Lancashire and that's where I live now.

After her death, no one called, no one did a welfare check on us, no one cared. My son has been broken by Ellise's suicide. He at first had physical symptoms of grief. He was then sent to counselling, initially after

her death. He is suffering from insomnia and he often has nightmares of Ellise. He is in desperate need of support and has been on the waiting list for trauma counselling for almost three years now with CAMHS. I have been diagnosed with complex PTSD and anxiety and panic attacks. I'm getting better, but will never be the same again.

My family and my life has been shattered by our encounter with all of this and we want justice for both myself, my son and Ellise, but also for every person whose life has been destroyed by Essex mental health services and the social care system. Thank you.

MR GRIFFIN: Can you put up the further photograph, please?

(Image shown)

THE CHAIR: Ms Ray, thank you very much indeed for that very affecting statement. Thank you.

MS RAY: Thank you.

MR GRIFFIN: Chair, it will take just a moment to re-arrange things before we have our next account. (Pause)

Chair, we're next hearing the commemorative account of Jamie Peatling. It is provided on behalf of the family of Jack Peatling and indeed it is about Jack, Jamie's son. It's being read by the legal representative, Christina Jose, and Jamie sits next to her. Can we put up the photo? Thank you.

MS JOSE: Afternoon, Chair.

Statement of JAMIE PEATLING (read)

MS JOSE: Commemorative account of Jamie Peatling and family, regarding Jack Peatling, date of birth, 12 December 2002; date of death, 5 June 2023.

"Jack was a sensitive baby and he loved to be close to his mum and dad. He loved being at home and playing in the garden on his swing or in the river.

"Jack loved playgrounds and fairgrounds from an early age and would go on to the fastest rides; he was always desperate to be taller so that height restrictions would not impact on his enjoyment and his access to the adrenalin rush rides.

"Jack did not enjoy school and struggled more after transition to secondary school. He was bullied a great deal, which caused significant anxiety for him and triggered his asthma on many occasions. Despite this, he had some very good friends, and those friends still talk about Jack and his antics in school and out of school.

"Jack's friends were loyal, and they genuinely cared about each other. Those friends supported him through his darkest times and would not allow him to reject them.

"Jack's sister was also a significant support to him

and even when he was not at all communicative, she would visit and sit with him and be with him. That was important to Jack.

"Jack had little confidence in himself and his abilities and was genuinely surprised to have passed his GCSEs (as were his teachers) ...

"Jack loved computers and how they worked and went to college to learn more, however COVID struck, and as he was not an independent learner he did not engage with the course. During that time, he began to excel in computer games and loved Beat Saber, especially the competitions.

"Jack had a magnificent brain and was articulate and funny. He was intentionally annoying and mischievous and had an angelic look that allowed him to get away with anything. He loved scuba diving and sailing with his dad and one of his happy places was being alone on the road with his motorbike.

"Jack loved animals, especially cats, and most specifically, his cat George. George would follow Jack when walking in the village, and Jack would say that it was George that kept him alive. Whenever Jack went out with his friends, he would have cat treats in his pockets in case there was a cat that would like them and that he could pet. He was a sensitive soul who took the

world so seriously. He could not understand the inequality of opportunity and the focus on wealth and greed, which created inequality, marginalisation, and discrimination. He did not want to be part of a world that put wealth before humans and quality of life for all."

Moving on now to the impact on the family:

"Jack was waiting for a hospital bed. Whilst he was at home, he was anxious about his liberty being removed when admitted, and even more worried that he may never get out of hospital because he felt so strongly that this world was not for him and that he wanted to take his life. He was extremely vulnerable.

"On the day Jack died, his friends visited him and his sister spent the afternoon with us. The day was good, and Jack was smiling and laughing with his sister, his friends and his mum. Jack loved a Chinese takeaway and after Jack's friends had left, we decided to order some Chinese food. However, Jack's sister and his mum started to talk about Jack always having a knife with him, especially when he was so vulnerable, and he did not like this conversation and so he went to his room. This is something that Jack often did because his room was a safe place for him. Jack put a crutch under the door handle to stop us going in, but he talked with us

at the door. He would not come out when the food came and when his sister was leaving, he said that he did not want to open the door but said that he loved her. After his sister left, his mum went to talk to him and he chatted but said that he did not want her to go into his room, and that he did not want a cuddle. His mum was used to ... this and so left him after saying that she loved him and that she did want a cuddle. Jack said that he loved her too.

"His mum was downstairs listening to an audible book when she heard Jack shout out. Mum was used to Jack shouting and banging because sometimes he could get angry and punch walls or break things. At those times he was best being left alone for a while to calm down. In that moment his mum had behaved as she would usually, and now she's left with so much guilt for not responding.

"His mum went upstairs about five minutes after she heard Jack shout and bang, and saw that his door was open. Mum peeked through the door and saw that Jack's bed was empty and she thought he was probably in her bed because he came to sleep next to her on her bed when his anxiety overwhelmed him. Mum pushed the door a little wider and felt something resisting so checked around it and saw Jack hanging.

"Mum called 999 and starting CPR. Mum knew what to do as almost a year before she had found Jack in cardiac arrest and had done CPR. This time it was so much harder because his face was so blotched because of the hanging and he was so grey. She did CPR until the police came and then the ambulance and the air ambulance.

"Some of the police responders were those that had attended the year before and they said that Jack's heart had started more quickly than last time ... so he would be okay. Jack was stabilised and taken to Ipswich hospital by air ambulance. Jack's mum and her friend were taken to the hospital by the police.

"When they arrived at the hospital the air ambulance doctor spoke with them and said that Jack's pupils were fixed and dilated and not responding to light. He said that Jack's heart was beating and bloods normal because of the medical intervention. Jack however was not breathing ... at all. The doctor said that he needed a brain scan to see the level of damage. The doctor asked his mum if she understood what he said and his mum said yes. He said that it was likely that Jack's brain stem was dead and that Jack was brain dead and would likely not survive but needed this confirmed by the scan. His mum called me and I went to the hospital.

During the drive, the brain scan results came, and I was told over the phone whilst his mum was with the doctor that Jack was brain dead and his life support would be turned off.

"When I got to the hospital, we stayed with Jack until his breathing and heart stopped. We watched our baby die and turn blue. Our baby, who desperately wanted help but had lost hope in obtaining this and was fearful of any alternative.

"Jack had so much to offer this world, and he had died.

"We do not have the words to describe the loss of Jack on our family.

"Jack completed our world and built on that. He was the most beautiful soul and yet so troubled. The gap and grief and guilt that we feel as a family is indescribable. He was our world and without him the sun has gone down and our hearts are broken. We are left feeling as though we were responsible for not fighting harder for him to get the support he needed and wanted.

"He was so brave.

"The words we read at Jack's funeral and the impact on us.

"'We did not know that there was a gap in our life until you were born, and you filled it.

"'You filled it with your love, your light and your joy.

"'You filled it with your innocence and curiosity.

"'You filled it with your laughter, your humour and your intelligence.

"'You filled it with your kindness, your thoughtfulness and your compassion.

"'You did not have an easy life, and, despite that, we watched you courageously and fiercely battle your way in this world, whilst we wrapped you with love, care, and protection.

"'We could not be prouder of you Jack Peatling. You were perfect and we are better people for having had the privilege of loving you, and being loved by you, for more than 20 years.'

"Alfred Lord Tennyson wrote:

"'T'is better to have loved and lost.

"'Than never to have loved at all.'

"And that is true for us. We've been blessed to have had such a beautiful, intelligent, sensitive and mischievously funny soul in our lives, and our world would not have been so bright without you.

"We will miss you, Jack Peatling.

"We will miss your magnificent mind, and your big blue eyes that sparkled like stars and sunshine with

love, life and laughter.

"We will miss your cheeky grin.

"We will miss holding you close and talking with you.

"We will miss your presence.

"We will miss everything about you.

"We will never forget you and we will always love you.

"Be as mischievous and inquisitive now as you were in life.

"Be free and happy and be at peace.

"Our hearts are broken.

"So much was wrong with Jack's care throughout his dealings with the mental health teams, but we thought a corner had been turned when we were told he needed to be admitted immediately, and Jack agreed. At last, there was hope that he might get the help he needed before he killed himself. The following days, with daily visits, were unbearable. Every day, Jack became more anxious, every day Jack would say that he was struggling more with increased anxiety, every day Jack would say that he would likely kill himself, and every day being told that there was no bed available.

"We were told that Jack was high priority, and despite this high priority, nothing changed. The mental

health team agreed he needed to be admitted immediately, noting that his impulsive behaviour increased his risk, but there were no beds, and he was not admitted. When we asked for ... help in the interim we were told whilst he was waiting for a bed, he could not access other services, and that there was a waiting list for psychological assessments within the community.

"We want to know why he wasn't allocated a bed. Were there no other beds anywhere ... in the area or another area? Were others prioritised over Jack because Jack was at home, or was the prioritisation because others were more at risk? How did the Mental Health Services prioritise the allocation of this resource?"

MR GRIFFIN: Thank you. Can you put up the photographs, please?

(Images shown)

That is the final photograph.

THE CHAIR: Mr Peatling, thank you very much to you and to all your family for that very touching tribute to your son, Jack.

MR PEATLING: Thank you.

MR GRIFFIN: Chair, that is the last account today and indeed for this week, so we reconvene on Monday at 10 o'clock.

THE CHAIR: Thank you, and as we've finished for the day,

I just want to reiterate my thanks to everybody who has contributed these extremely moving tributes and commemorative statements about their family members. They are of course essential to our understanding of the work that we're doing and we are very, very grateful for them. Thank you.

(3.14 pm)

(The hearing adjourned until
Monday, 23 September 2024 at 10.00 am)

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