Opening Statement to the Lampard Inquiry

Lydia Fraser-Ward, 22nd August 2024

My name is Lydia Fraser-Ward and my sister, Pippa Whiteward, died in 2016. In the early morning of Saturday 29th October, Pippa crept out of her house as her husband, mother and two young children slept, walked down towards her local train station and 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 [personal/sensitive], in June 2016. Puerperal Psychosis is an uncommon condition, and leads to maternal death very rarely, usually affecting 1 in 1,000 women after birth. In this case, my sister was that 1 person.

Although my sister lived in Essex, the majority of her care took place outside of 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 below; this is to contextualise my questions and requests for further investigation by the Lampard Inquiry.

I would the opportunity like 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 a) the Coroner's Report into my sister's death; b) an account by her husband of her treatment in a letter to his local MP, c) a poem that my sister wrote about her treatment at Broomfield Hospital A&E department after she was sectioned under the Mental Health Act 1983.

Requests for Lampard Inquiry's consideration

Although much of Pippa's treatment was conducted outside of Essex, it is precisely because her care was carried out so far from 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, failing to consider how a contagious illness she was carrying at the time, which she contracted whilst receiving care on their ward, would impact on 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 Baroness Lampard 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 had Pippa not be discharged home that weekend and instead been transferred directly to Broomfield Hospital from Winchester MBU 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:

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?

I would like this Inquiry to investigate what written records are being kept by Essex NHS hospital trusts and what protocols are in place 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?

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?

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?

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?

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 studies suggest can be a known trigger for Puerpertal Psychosis, especially in patients with Bipolar Disorder (see: https://blogs.bmj.com/ebn/2023/01/15/sleep-deprivation-and-its-relationship-with-the-development-of-postpartum-psychosis/ and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10744103/). 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 her Puerperal Psychosis may have even 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 higher risk of Puerperal Psychosis?

B16: How, and to what extent, was an inpatient's privacy and dignity retained?

Having discovered her poem 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?

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?

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 (see: [personal and sensitive]) and the risks this posed to her ongoing recovery should have been assessed by local clinicians whilst she was discharged home between Stafford and Winchester MBU admissions. What provision is in place with regards to community mental health assessments following discharges from MBUs to ensure patient safety is maintained?

B20: How did providers deal with requests for leave (supervised and unsupervised)? What information was considered? Was this appropriate?

I maintain that it was inappropriate for my sister to be permitted to leave Winchester Hospital MBU to come home so soon after a suicide attempt whilst in care. 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?

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?

The Coroner's Report that investigated my sister's death concluded that the risk assessment for her discharge from Winchester Hospital 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 recovering from a vomiting bug that she had contracted on the MBU ward, and consequently all her family fell extremely ill with this same bug when she was brought home. It was whilst they were all 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?

B27: What consideration was given to the Deprivation of Liberty Safeguards for those who lacked capacity?

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 their needs are met?

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?

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; and what explanations are being provided to family members for why physical restraints are used, instead of alternative methods to keep them safe?

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?

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?

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?

As previously stated, it is my belief that my sister should never have been discharged from Winchester Hospital MBU on Friday 29th October 2016. I would like to 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?

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?

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 28th October to check her condition, but these were made by medical staff at the Winchester Hospital MBU responsible for her discharge. 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 readmitted into care. I would like the Lampard Inquiry to investigate what the current protocols and provisions are with regards to home visits within the community following the discharge of high-risk patients. Is there a mandatory requirement to visit these patients in person within their home setting? If so, is there a target for how quickly this is carried out following their discharge?

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?

Although updates and information on my sister's care was 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 also 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 families regularly updated on her progress. 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, 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 Winchester Hospital 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.

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?

To this day I am still unsure of the treatment that my sister received in Broomfield Hospital A&E. Having discovered her poem since her death, and knowing that she lost her phone and all of her contacts during this 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 am 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 lack of mental capacity.

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?

The Coroner's Report into my sister's death concluded that the risk assessment carried out by Winchester Hospital MBU upon my sister's discharge failed to consider how her contagious vomiting bug could be contracted by her family and therefore, in turn, impact on the care that they were able to provide 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.

L93: How, and to what extent, did providers respond to the following in relation to the provision of mental health inpatient care and treatment:
a. Concerns and complaints;
b. Serious Incident, Root-Cause Analysis, and/or Patient Safety Incident Response investigations (or similar);
c. Internal and external audits, particularly when they found shortfalls in compliance and / or unmet targets;
d. Inspections and / or investigations by Commissioners;
e. Inspections and / or investigations by the Care Quality Commission;
f. Investigations by the Health and Safety Executive;
g. Police investigations;
h. Investigations by HM Coroners Service; and
i. Any other investigations or programmes undertaken or commissioned by the provider relating to the death of an inpatient or delivery of mental health inpatient care and treatment.

M100: How did providers in Essex interact with external bodies, including (but not limited to): a. NHS England;
b. Special Health Authorities;
c. Other NHS Trusts;
d. Department of Health and Social Care;

e. Commissioners;

f. Integrated Care Boards;

g. Provider Collaboratives;

h. Local Authorities;

i. The Health and Safety Executive;

j. The Care Quality Commission;

k. Other professional regulators;

l. Complaints bodies;

m. The police;

n. National rail;

o. HMPPS; and

p. HM Coroners Service.

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 contributing appropriate information to investigations by HM Coroner's Service.

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?

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 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 recommendations?

Final Disclaimer

Although it has been several years since my sister's medical treatment and death in 2016, I have attempted to provide information in this Opening Statement which is accurate to the best of my knowledge. Information has been sourced from:

- Coroner's Investigation Report, commissioned by North West Area Manager, Southern Health NHS Foundation Trust (date not provided)
- Letter 'My wife killed herself. We need more beds in more Mother & Baby Units' addressed to Rt Hon John Whittingdale OBE MP, from Gary Whiteward (3 May 2017)
- 'Ode to Broomfield Hospital', poem written by Pippa Whiteward (date unknown)

If there are inaccuracies in the information that I have provided in this statement, it is purely accidental.