THE LAMPARD INQUIRY

BEFORE BARONESS KATE LAMPARD CBE

COMMEMORATIVE AND IMPACT EVIDENCE OF MRS TAMMY SMITH

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1. I am Sophie Alderman's mother. Sophie was the eldest of my three children, she was born on 26 June 1995.

2. Sophie arrived in this world with a burst of energy, nearly two weeks after her due date, weighing an impressive nine pounds and eight and a half ounces. Despite arriving fashionably late, a trait that became a lifelong habit, it felt like Sophie was eager to enter the world, with my labour, from start to finish, lasting just an hour.

3. Upon laying eyes on her for the first time, I was struck by a mix of shock and awe, marvelling at the little human I had nurtured for the last 9 months. I could not stop staring at her in the fish tank like bassinet, gently prodding her every now and again to remind myself she was real, and she was mine.

4. As a toddler, Sophie exuded a mixture of calmness and curiosity. She was the most inquisitive little girl, and it was truly amazing to watch her explore and engage with the world around her. Very particular about her interests, she found contentment in the simple joys of childhood, with a particular love for Winnie the Pooh. I remember having to continuously rewind the movie, as we did in those days, because she loved to watch it over and over again. Even at that young age, Sophie displayed a discerning eye for character, preferring to take a second and observe before fully engaging with others

5. Beneath that laidback exterior, Sophie was prone to overthinking. It was often very evident on her face that she was taking in the situation and wanted to observe before involving herself. She was never wholly committed to being in the thick of it and at birthday parties she would usually be the last person to join in the games.

6. The transition to primary school brought its share of challenges, particularly when we relocated to Winchester. It was right after the summer holidays and Sophie was unable to say a proper goodbye to the friends she had, which was quite difficult for her. Luckily, she found solace in her newfound friendship with Becky who she met at her new school, and the friendship endured all through primary and secondary.

7. Sophie's personality began to develop even more when she was in the junior stage of primary school. She was such a funny person and developed cheeky sarcasms which always kept me on my toes. However it was around this time she began to experience blackouts sporadically, where she would just drop to the floor unconscious.

8. Her battle with mental health intensified as she moved into her adolescence. Blackouts, anxiety and self-harm became increasingly familiar to Sophie, though she never spoke directly to me about her struggles at this stage, and it was through her school I learnt about her self-harming.

9. I understand that Sophie later in life reported to treating professionals that she was raped when she was 12, I know there are also references in her records to her being 15 when this happened. I did not know anything about this at the time and only learnt information from Sophie and others much later in her life. I know at one point it was reported to the police [personal/sensitive] but I do not know what came of this, it was not something that I spoke to her about.

10. Sophie came under the care of the Child and Adolescent Mental Health Service at about the age of 14 and she was with them until she was around 18. Sophie's mental health would improve and decline in 4-6 week increments. When she was feeling good, it was very evident visually. Her makeup and hair would be done and she would make an effort to look her best. So when her mental health deteriorated, that would all go out the window. Her hair and nails would not be done, her clothes would be messy and it was like experiencing a whole different person.

11. Sometimes those peaks and drops coincided with her medication. Sophie would be put on antidepressants for anxiety and medication that worked really well for her and would be absolutely full of life and ambition. She would tell you, 'right I'm doing this or going to this place', just be really social and kind of what you would expect from a teenager, but it was also exhaustingly manic. She would then come off the medication telling me that she is fine and did not need it and then have an episode and spiral back down. At which point she would either be put on a higher dose of the same medication or a new medication altogether. While she was adjusting to that change, things would be really rotten again.

12. There was no predictability on the medication front though. Certain medication made life more manageable for her while others could have the complete opposite effect.

13. Sophie would always put on a brave face for her little sister [personal/ser, and their bond was truly a special one. I remember when [her little sister] was born. . Sophie had gone to stay the night with my best friend, Sara, and she was so excited, asking her every 5 minutes whether her sister had arrived. She was 17 at the time, but the age gap never stopped them from having a close relationship. Sophie absoutely adored [her little sister] and the feeling was definitely reciprocated. They loved being silly together, pulling funny faces at each other and just being daft.

14. That was Sophie to a tee though, she had a wonderful sense of humour. I remember on one occasion I was in the kitchen, and I happened to slip on a grape and fell in the most traditionally comical way. Sophie could not contain her joy that I had done such a perfect slip and never let me live the moment down, always bringing it up and bursting into cries of laughter at the memory. These are the moments that I cherish and will always miss.

15. With her brother, Alfie, Sophie had more of a love hate relationship, as is typical of sisters and their brothers. They would often fight and then in the next second be best friends, asking if the other wanted some sweets from the shops. They loved to get into mischief with each other and were quite good at not saying anything when it came to giving up information. Loyal to a fault, the pair of them.

16. Sophie was the one who taught Alfie how to ride a bike without stabilisers. Completely random and unprompted. She must have been about 7 at the time, while he was just 3 or 4 years old. But she had taken it upon herself to teach him and she did it well.

17. I think the major turning point in Sophie's mental health was in June 2015, when she was 19 years old, about to turn 20. I had been out for the night and Sophie had stayed with Sara. I was later told they had been discussing life and not listening to the voices. She later turned up at Sara's house with a knife at her throat and said something like, "they said I am going to hurt [my sister], they want me to hurt [my sister." [My youngest daughter] was no more than a year old at this point. Sara was pretty confused and asked who they were to which Sophie responded, "the voices". It must have been really distressing for Sophie because she loved [personal/sens so much and we knew she would never do anything to hurt her.

18. We took her to A&E and she was admitted into hospital. I believe Sophie had been hearing these voices for a long time before we knew about them. I think it was around this time that I learnt that the voice was named Shona and this was a real person for Sophie.

19. After Sophie's admission in June 2015 she seemed completely detached from the situation and so she could not understand why she was not allowed home. She was just really cross with me and she thought things would be fine because, as far as she was concerned, it was not really her who had turned up with the knife.

20. That incident was when I made the really difficult decision with Sophie's treating medical team that Sophie could no longer stay at home. Sophie's treating team agreed that Sophie required 24 hour care and so when she was not in hospital, she was discharged to Natalie House for a year between 2015 and 2016. Natalie House was a small residential care home where Sophie could receive 24 hour care.

21. There were a lot of incidents of impulsive and really risky behaviour between 2015 and 2017. In June 2016 Sophie was diagnosed with Emotionally Unstable Personality Disorder (EUPD), which explained some of Sophie's impulsivity. There was a period in which she seemed particularly focused on [a particular bridge], where she was detained and/or removed from on a number of occasions. Despite the struggles she had with her mental health, Sophie never wanted to die. She expressed to me on multiple occasions that she did not want to die but that she just wanted the voices to stop. She would often express regret after incidents of self harm. It is so upsetting for me to think about the pain that she carried with her all through life.

22. Sophie felt deeply uncomfortable by cameras from a very young age. She hated her photograph being taken and would shy away from cameras. At first I understood this to be a response to being body conscious like many young girls but as Sophie got older it became apparent that this was something that triggered acute paranoia. She consistently believed and expressed she was under surveillance by the government. Even when her little sister [personal/sens would try to take photos, Sophie would seem anxious and hide.

23. In late 2016 Sophie developed Neuroleptic Malignant Syndrome (NMS) and she had to be placed in an induced coma. We were told this had been caused by the anti-psychotic medication she was taking. It was a really frightening experience. After this she was discharged into a bedsit but the hospital admissions and incidents of self-harm continued.

24. There was a period between 2018 and 2019 where she did not require any admissions into hospital, but received community support from Southern Health NHS. However she was then admitted and detained in hospital again from June 2019 and the typical cycle of being in and out of hospital resumed throughout 2020 and 2021.

25. During Sophie's early admissions into mental health units in Southampton, one of the first things Sophie would ask is 'where are the cameras?' Back then it was just some CCTV cameras in corridors. There were no cameras in rooms. But Sophie would want to know exactly where they were.

26. Sophie moved to Ipswich on 30 October 2021 and then on to Essex on 28 March 2022, so I understand her last contact, by phone, with Southern Health was in early November 2021. She later came under the care of Essex University Partnership Trust (EPUT) from April 2022 when she was admitted into hospital there.

27. Even though I was not in contact with Sophie in the period before her death she was in touch with my husband, Jason, Simon, her father and [her sister] regularly.

28. Sophie would try her best to mask her mental health problems to [her sister] However Jason, Simon and I were all worried that over the years Sophie's mental health did not seem to be improving and we all felt there was an over-reliance on medication. This was particularly worrying because Sophie's compliance with medication had always been erratic. Whilst Sophie could behave very impulsively I felt there was a predictability to Sophie's behaviour. There were the 4-6 week cycles in which Sophie's mental health would take a dive and Sophie would always struggle around big occasions like birthdays, including her own. She told us and treating medical professionals that self-harm [personal/sensitive] helped her cope with the voices that she heard. Sophie's physical appearance would also dramatically change when things were particularly bad for her. She would neglect self care, stop brushing her hair or showering, and she would also become much more irritable and paranoid.

29. I believe Sophie had a disordered and complicated relationship with food. I perceived it as a very visible form of self-harm that she was doing to herself. In my experience she always ate more when she was in hospital.

30. On 19 August 2022 Simon was informed that Sophie had died that day over the phone by a staff member from Willow Ward. It was someone who introduced themselves as a nurse and told him, "we have lost Sophie". Simon was confused and asked her whether they meant she had escaped, when the nurse responded that Sophie had died, he was shocked and told her that he had to hang up to process what she had told him. He then was unable to call back and find out where Sophie was because he had not taken her name, which added to the confusion and distress. This was a particularly upsetting way to learn of our daughter's death. Simon and I are devastated by the loss of our daughter. Simon had suffered the bereavement of his wife a year before and so he has been particularly struck by the grief of losing Sophie.

31. Sophie is hugely missed by so many of her loved ones. Becky still messages me to say that she is thinking of Sophie and misses her. [Her sister] now 12, tells me daily that she misses Sophie and that she wishes she could come back. I know how much she must miss speaking with her. Sophie made her feel like she was the best little sister in the world and that the world was just the best place with Sophie. And this went both ways. With [her sister] it

felt Sophie could momentarily shut off everything in her mind and just be daft and make silly faces [personal/sensitive] talking about everything under the sun together.

32. My husband, Jason, who spoke to Sophie several times a week, has been hit particularly hard. Though not biologically related, he treated her as if he was her dad and he loved her from the minute they were introduced. Even now, the fact he does not get to talk to her anymore weighs heavily on him. He misses her so much. I am just so thankful they had each other.

33. Sophie was a good person with a massive heart. I feel lucky that she was mine, that she was in my life and even now in the impact of losing her, she has brought massive positivity. She has changed not only my perspective but that of so many others, teaching us that there is nothing you cannot work through because nothing is ever going to be as bad as losing your sister or your daughter.

34. Sophie was a wonderful person and if she loved you, it was like winning the lottery. If she loved you, you were loved and that was it. That's something we all miss.

35. After Sophie died I needed to understand how and why Sophie had died when she was in a hospital where I thought she would be protected. I needed this understanding to be able to properly grieve the loss of Sophie and process her death.

36. In October 2022, I became aware of a new Channel 4 investigative programme, Dispatches, "Hospital Undercover Are they Safe?". I found out that an undercover reporter had been deployed onto Willow Ward at Rochford Community Hospital, where Sophie was a patient. I learnt that the conditions on the ward were heavily criticised by experts interviewed on the programme, particularly in relation to the use of restraint. It was gut wrenching to learn about this. and I was left feeling really anxious about what experience Sophie had had on the ward. Although I could not bring myself to watch the documentary, I knew I needed to find out the truth about Sophie's care and death.

37. Sophie's inquest opened shortly after her death and there was a first preliminary inquest review hearing on 4 November 2022. In that hearing EPUT's lawyers told us that a report from their Patient Safety Incident Investigation, would be provided by 9 January 2023. This was the first time I remember hearing about EPUT conducting an internal investigation. I wanted to learn more about this investigation and provide the investigators with any information that I could because I understood it was supposed to be a process of establishing the truth about Sophie's death and a learning process for the Trust. A draft report was delayed and then delayed again. Eventually I received an electronic draft in late April 2023.

38. Before this report was sent, I had asked EPUT via my lawyer to provide a copy of the terms of reference, and to tell the investigator that I wanted to speak to them. These requests were ignored, and I was emailed a draft report having never spoken to the investigator. I did not feel I had been given any opportunity to provide any input on the terms of reference, or that the Trust valued the contribution I might be able to make to any learning process. The draft report was only sent to me for "factual accuracy checking". I felt like a tick box in their investigation.

39. Worst of all, and compounding my experience of feeling like nothing more than a tick box to EPUT, I was completely unprepared for the information the report contained. As I read

the report, I came to a section which set out in graphic detail the CCTV chronology of Sophie [taking her own life] and her last moments as she lay dying. It was really upsetting to read this information, and because I had not been warned by EPUT in advance about the content, it was a total shock to read . I felt angry that EPUT had given no consideration to who they were sending this information to – to send such graphic detail with no prior warning to a bereaved family felt illustrative of how forgotten we are in this process.

40. More generally, I felt the report was inadequate, and that there had not been a thorough investigation which was quite devastating. I was really upset by the lack of any meaningful areas identified for improvement when, even at that early stage, there seemed to be some really obvious and urgent issues which needed to be addressed. I met with the investigator after reading the draft report, and I provided a lot of feedback. Ultimately, nothing really changed between the draft and final report, leaving me feeling that I had been ignored, and underscoring even more the feeling of being part of a tick box exercise for EPUT.

41. I now know that Sophie had an Oxevision system monitoring her in her room on Willow Ward. She would have experienced it as a camera watching her at all times in her room and she would have hated this. It's really upsetting to know that her medical notes record her complaining of a camera in her room that she believed the government had hacked into, watching her. I hate to think of her in such distress. It is not difficult to imagine this distress having had to sit through partially captured CCTV footage of Sophie, from the hospital corridor, [taking her own life].

42. During the investigation into Sophie's death I learnt about the purpose of the Oxehealth system, an alarm alerts staff when patients are in a high risk area of their room like a bathroom for more than three minutes – they are supposed to then physically check the patient. Sophie was partially in her bathroom when she fatally ligatured, an alarm alerted staff but didn't respond to it. It is difficult for me to comprehend how such an intrusive system which might have worsened Sophie's paranoia and mistrust can be justified when it did not protect her. After Sophie died EPUT also failed to ensure the retention of footage from that Oxevision camera so it hasn't even been of use during investigations into Sophie's death.

43. The inquest jury concluded that Sophie died by misadventure. We know she did not intend to take her life. It was documented in records throughout her care that she used ligaturing as a means to escape auditory and visual hallucinations. We didn't have the opportunity to explore in Sophie's inquest why these hallucinations and paranoia seemed to have got worse over time but I really urge the Inquiry to consider the impact surveillance technologies may have on patients in their rooms, particularly those who suffer with psychosis and paranoia.

44. I also hope the Inquiry will consider the reliance on technology, like Oxevision, to keep patients safe. I met with the author of EPUT's internal investigation report after he sent me the draft report for 'factual accuracy checking'. When I raised my concern that staff had not responded to Sophie's Oxevision alert he was very quick to sympathise with staff, referring to 'alarm fatigue' from his own professional experience in healthcare, essentially several alarms going off regularly on wards means staff become desensitized to them. This was of no reassurance. There was no scrutiny or consideration of how alarm fatigue makes patients unsafe and how this can be prevented. It was a flippant comment, presented as a fact of life, a reality of any mental health ward. Nothing in the EPUT's internal investigation grappled with this.

45. In truth, the entire internal investigation felt like a giant shrug of the shoulders by EPUT in response to Sophie's death.

46. I needed the reassurance of not just feeling my concerns and questions were heard, but that EPUT were genuinely open to learning lessons from Sophie's death. Sadly, in my experience, they seemed to have no capacity for, or interest in, either of these things. My experience of EPUT was characterised by defensiveness, which worsened to obstructiveness during the inquest into Sophie's death, with witnesses being overly defensive when providing their evidence and providing inaccurate information about evidence that was unavailable or had been lost. It made an already unimaginably hard process so much more difficult to get through – practically and emotionally.

47. I say this as a parent, that trusted EPUT to look after my child. I understand that there may be occasions where there are mistakes while caring for our loved ones, but I do not see any indication of an NHS Trust that is willing to learn from its mistakes.

48. Where there have been the most serious errors or actions which have led to the deaths of our loved ones, it is beyond my comprehension that there is no sense of urgency or immediate proactivity to learn lessons to prevent future deaths. Instead, it feels like EPUT are preoccupied with being secretive and self-interested. Throughout the internal investigation and the inquest it felt like EPUT were minimising the events which led to Sophie's death for self-gain.

49. As it stands, I believe Sophie's death was entirely avoidable – a fact that breaks my heart, and makes grieving harder - but there is an opportunity to ensure that Sophie's death is not in vain, and that no family shares this pain. In order for that to happen, lessons must be learnt so that further deaths are prevented.

[personal/sensitive]

Signed:

Tammy Smith

Dated: 03/11/2024