Name of witness: Alan Oxton
Statement No:1
Exhibits:0
Date:24th May 2025

LAMPARD INQUIRY

WITNESS STATEMENT OF MR ALAN OXTON

I, **MR ALAN OXTON**, date of birth [I/S] of [I/S], [I/S], will say as follows:

1. I make this statement further to a Rule 9 request from the Lampard Inquiry in relation to treatment provided to my late father, Stephen Alan Oxton, while under the care of North Essex Partnership University NHS Foundation Trust. I make this statement from my own memory of events, knowledge and belief. I have also had sight of various documents and reports which have assisted me. where names have been abbreviated, these are abbreviations/redactions used in the documents I have seen.

2. My father, Stephen Alan Oxton, suffered with his mental health since the murder of his own father in January 1998. My father had been struggling with flashbacks which stemmed from identifying his father's body and suffered from panic attacks and uncontrolled anger for around two years before he sought help from his GP on 26th January 2000.

3. This initial referral was not accepted, and instead he was simply signposted towards counselling agencies.

4. The GP re-referred my dad on 14th February 2000 which resulted in an assessment on 2nd March by CP Community Psychiatric Nurse (CPN). My dad was diagnosed with post-traumatic stress disorder (PTSD) and accepted cognitive behavioural therapy (CBT) and four sessions of eye movement desensitisation and restricting.

5. My dad was subsequently seen as an outpatient until his discharge in October 2009.

6. Following a deterioration in his mental health, my dad was seen by his GP who referred him to the community mental health team (CMHT) on 5th February 2010, where he was assessed by a CPN and a clinical psychologist who agreed to provide 'top up' support. He was seen by [I/S] on the 4th May 2010 and subsequently discharged back to the GP.

7. On 8th July 2010, the GP re-referred my dad, however no re-assessment was offered and instead he was advised to continue with Support After Murder and Manslaughter (SAMM) and given North Essex Resource and Information Line's (N.E.R.I.L) contact details.

8. On 28th July 2010, the GP re-referred my dad once again to the consultant psychiatrist [I/S] who advised there was no benefit to CMHT and recommended a change in medication.

9. My dad attempted an overdose on the 19th February 2011 and was subsequently assessed by the duty team, I think this was at Colchester Hospital. He was re-assessed on 23rd February 2011 following contact by ReThink and later referred to a consultant psychiatrist [I/S] who, on the 16th March 2011, issued a letter advising that an outpatient appointment was not appropriate.

10. My dad subsequently met with [I/S], CMHT manager, and [I/S] the clinical manager on 1st April 2011 to discuss his concerns about the services he had received.

11. On 27th April 2011, my dad overdosed on medication and alcohol for the second time and was taken to Broomfield A&E, under section 136 of Mental Health Act. He stayed at Galleywood ward at the Linden Centre from 28th April 2011 to 5th May 2011 under section 2 of Mental Health Act.

12. On 15th May 2011, my dad made a written complaint regarding his lack of care/treatment. In addition to this, I also wrote a complaint to the CMHT.

13. On 26th May 2011, my dad attended a psychological assessment and specialist psychometric testing with [I/S] who concluded he was suffering from complex trauma, with elements of PTSD and personality difficulties.

14. On 1st July, there was a CPA review which I attended with my dad, and it concluded that my dad should continue with the outpatient clinic held by the community psychiatric nurse and be added to the waiting list for PTSD therapy from the North Essex Partnership NHS Foundation Trust department.

15. My dad commenced cognitive analytical therapy on 21st October 2011, however on the 25th October he took an overdose (for the third time) whilst attending the inquest into the death of my grandfather and was subsequently referred back to the care of [I/S], the community psychiatric nurse.

16. My dad attended multiple outpatient appointments with the consultant psychiatrist [I/S] and clinical psychiatric nurse [I/S] throughout November 2011 to January 2012, however on 7th March 2012, my dad took an overdose (for the fourth time) and was referred to crisis resolution and home treatment (CRHT) by the intensive care unit at Broomfield Hospital. He was assessed by [I/S] on 8th March 2012 as not detainable and therefore accepted home treatment with the crisis resolution and home treatment team for seven days. He was subsequently discharge from crisis resolution and home treatment on 19th March 2012 and was to continue with [I/S] and psychology support.

17. On 31st March 2012, my dad phoned crisis resolution and home treatment and requested to be sectioned. The police were informed, and he was subsequently found on the railway line and taken to Shannon House, Harlow as the Linden Centre in Whitham had been closed from 16th March to 5th April for cleaning due to Police using CFC gas.

18. Upon arrival at Shannon House, my dad was seen by several members of staff who all recalled conflicting versions of events when later questioned. Support worker [I/S] reported my dad was searched in the presence of police, with items being removed and placed in a property box. The support worker stated these items included a belt (although they were unable to recall the colour or design of the belt), however this was not included on the property sheet as this only contained a list of valuables. Staff nurse [I/S] who was also present upon my dad's arrival at Shannon House was unable to recall if he was even searched on arrival or whether he was wearing a belt. Staff nurse [I/S] (who was in charge of the unit on the day my dad was admitted), stated that my dad was searched in line with

policy and was certain that in this instance the belt had been removed, however was unable to confirm having actually seen a belt. Support worker [I/S] spent 3 hours observing my dad (under level 3 observations) and was unable to confirm seeing a belt during this time.

19. My dad was subject to level 3 observations at Shannon House which was undertaken from behind a glass panel within an office (contrary to the inpatient observation and engagement policy).

20. Shannon House only had access to limited medical records and therefore my dad was transferred by ambulance to the Lakes in Colchester where he was previously seen as an outpatient.

21. The Approved Mental Health Professional (AMHP) [I/S] did not escort my dad to the Lakes, but delegated responsibility for conveyance to the ambulance staff. [I/S] had stated the reason for this was because they had to attend another assessment, however this was later confirmed not to have been the case by [I/S]

22. Upon arrival at the Lakes, staff indicated that his property was searched but nothing was removed from his person, however a wallet and mobile phone was later handed in.

23. My dad was not seen by a Dr for five and a half hours at which point he was too tired to engage. He was downgraded to level 2 observations without an assessment being performed.

24. As my dad's previous suicide attempts had been by overdose, accessing the train tracks and expressing the desire to crash his car, staff at the Lakes stated they were not concerned about other forms of suicide such as by ligature. They repeatedly assured me he was in a place of safety.

25. Unaware of any care plan, my dad used the window as a ligature point in order to take his own life using his own belt. In addition to this he managed to move furniture within his room to barricade himself in, without being noticed.

26. I was informed of my father's death by his girlfriend who had been notified. The ward provided very limited details and would not engage or answer any of my

questions. They offered no explanation as to how he was in possession of his belt and why his level of observation had been dropped from level 3 to 2 without an assessment taking place.

27. I was offered no support and instead faced a wall of silence. I subsequently liaised with the police to re-investigate and the trust only engaged with me after a formal complaint was made. Even then there was no apology or acceptance that it was their fault or mistakes until after the narrative verdict was given at the coroner's court holding them responsible.

28. The narrative verdict on my father's death certificate stated '*Mr Oxton's risk of self-harm was correctly assessed, but there was an incomplete transfer of the risk assessment, resulting in a lower level of observations being applied. Mr Oxton was left in possession of his belt and the bedroom environment provided an opportunity to barricade the door and provided a point to achieve suspension*'.

29. While I think the inquest came to the correct conclusion in that the state was responsible, they didn't give me the answers I was seeking in order to finally achieve some sense of closure. I believe the inquest should have established the facts of the case and identified who was lying in the conflicting reports in order to hold staff accountable.

30. My father's girlfriend subsequently attended the Lakes and was told by staff that had he not used his belt, he would have found an alternative method **[I/S]** **[I/S]**

31. Following my father's death, I contacted The Lakes and spoke to **a staff member** to request my father's medical records. **[I/S]** refused to provide any medical records, was unhelpful, uncooperative and rude. **[I/S]** showed no empathy when speaking to someone who had lost their father the day before. When asking for answers as to how this happened, **[I/S]** responded with a list of policies and procedures as a means of avoiding answering the question.

32. Both my father and I complained about his lack of treatment and repeated rejection for support as an outpatient. He was only taken seriously when he attempted to take his own life in April 2011. By then he was already on a

downward spiral with his mental health as evidenced by his medical record and multiple suicide attempts.

33. I believe my father should have been seen sooner as an outpatient and re-admitted back to the community mental health team when originally referred by his GP and not rejected and repeatedly told there was nothing that could be done.

34. Following my complaint, a serious incident investigation was conducted by [I/S], [I/S], [I/S] and [I/S] who met with myself on 3rd July 2012. The panel interviewed staff members between 3rd July to 16th November 2012, with six having second interviews.

35. The investigated noted the following summary of findings:

- The panel were satisfied after interviewing all relevant Community Mental Health Team members and Psychologists involved in Mr Oxton's care pathway, that North Essex Partnership NHS Foundation Trust had the appropriate skills and services to meet Mr Oxton's identified care needs. The Panel were further satisfied that Mr Oxton and his family had been involved in the formulation of his care pathway.

- There appeared to be no clearly defined and universally understood clinical responsibility for clients admitted to the 136 Suite at Shannon House, Harlow.

- There appeared to be no clear clinical responsibility for implementing an appropriate risk management plan within the 136 Suite at Shannon House, Harlow other than the implementation of level 3 observations as standard practice.

- There appeared to be no clear line of accountability and reporting of clinical information for staff undertaking observations within the 136 Suite at Shannon House, Harlow.

- There remains a difficulty for the Derwent Centre bleep holder to be actively involved in the clinical management and decision making for clients admitted to the 136 Suite whilst not in a supernumerary role.

- There remained an inconsistency regarding the information given to the panel relating to the implementation of a search policy within the 136 Suite.

- There remained a lack of absolute clarity from all staff concerned regarding the search and removal of the belt from Mr Oxton. The panel were also unable to gain absolute clarity with regard to Mr Oxton's medication given that [V/S] documented within the observations records that she gave the medication that he came in with to his social worker. It is also documented in the E.C.C. 535 report that medication accompanied Mr Oxton on admission to the 136 Suite. Furthermore, it is documented within the ambulance patient care records that Mr Oxton left Harlow with his medication. The panel were unable to ascertain what happened to this medication on his arrival at the Lakes.

- Level 3 observations in the 136 Suite at Shannon House were frequently implemented from behind a glass panel within an office, contrary to the guidelines from the Inpatient Observation and engagement Policy.

- There was no clearly documented discussion between the Mental Health Act assessing team including the AMHP with the nursing staff with regard to the observed presentation and risk following Mr Oxton's arrival in the 136 Suite and the commencement of the Mental Health Act assessment.

- There was no evidence of a discussion between the Mental Health Act assessing team and the Unit bleep holder or nursing staff regarding the ongoing risk management of Mr Oxton, including safe transportation to the in-patient unit and any possible requirement for escort.

- There was no evidence of a process of risk assessment being implemented prior to property being returned to clients departing from the 136 Suite.

- There was no communication between the assessing team and the accepting in-patient doctor.

- The AMHP did not escort Mr Oxton to the Lakes, but delegated responsibility for conveyance to the ambulance staff.

- The 535 Social Circumstances Report was not available to staff at The Lakes until the night staff had commenced duty.

- There was a lack of clarity regarding the process to implement search policies and procedures at The Lakes.

- There was a delay in the duty doctor admission assessment being instigated at the Lakes from 18:30 when Mr S Oxton arrived on the unit, until 22:00 which may have represented a missed opportunity for further engagement, assessment and review of appropriate treatment and care.

- Staff clarified that the rationale for level 2 observation on admission to the Lakes was because of the risk of suicide related to overdose or absconsion and crashing of a vehicle rather than the use of a ligature.

- There was a delay in undertaking a medical assessment from 18:30 when Mr Oxton arrived at The Lakes, until 22:00 when Mr Oxton was seen by [I/S] [I/S], and that this delay represented a missed opportunity for further engagement, assessment and review.

- All staff at The Lakes who responded to the alarm at 08:10 on 1st April 2012 did so in an extremely professional, appropriate and timely manner, additionally the ambulance who were called to the Lakes commended the nursing staff on duty for their CPR practice.

- An updated risks management plan was completed by **[I/S]** at 21:00hrs on 31/3/12. Risk assessment information was included under the inpatient events notes tab on Carebase at 19:06 on 31 March 2012 completed by **[I/S]**.

- There was minimal recorded active engagement with Mr Oxton during his time both in Shannon House 136 Suite and The Lakes. Specifically, whilst in the Lakes Mr Oxton was maintained on level 2 observation and it was reported to the Panel that he was unwilling to engage with the staff.

- There was no evidence that the nurse in charge of Ardleigh Ward was informed of Mr Oxton's presentation as observed at 07:55 on 1st April 2012.

- The Trust undertake annual ligature and risk management audits within all in-patient environments, which since 2011 have involved clinical ward staff.

32 The investigation failed to establish the truth as to how my dad remained in possession of his belt. Staff at The Lakes provided conflicting accounts in regard to this and it was not investigated further. I also do not feel the report truly held to account how the risk assessment was incorrectly transferred from Shannon House to The Lakes.

33 Essex Police investigated my dad's death at the time and then I requested them to re-investigate his death, both of which resulted in no further action.

34 I initiated legal proceedings against the trust through Glynn's Solicitors Limited from 2012 to 2015, resulting in a settlement out of court. An expert witness Dr [I/S], a Consultant Psychiatrist, was of the view that the treatment, or lack of it, that my father received in 2010 up to May 2011 did fall below an acceptable standard of care (i.e. this would constitute a breach of duty). Dr [I/S] was of the opinion that the fact my father was allowed to keep his belt and that there was no evidence of a risk management plan with regard to this probably fell below an acceptable standard of care.

35 I then took part in Essex Police Operation Ludlow, which investigated corporate manslaughter against the trust from 2020 to 2021 and then the Health and Safety Executive prosecution against the trust in 2021. It was not possible to proceed with charges due to the high threshold of evidence required. I felt let

down by the investigation as I feel like a criminal conviction would be the only way true justice is served against the trust.

36 Over the years and numerous investigations, I am yet to find the answers as to what happened on the day my dad died and the conflicting accounts provided by staff have weighed heavily on me over the years, making it extremely hard to move on.

37 Therefore, I hope the Inquiry's investigations seeks to clarify the below points:

- Why were the referrals from my dad's GP not accepted?

- Staff members provided differing accounts regarding whether my dad was searched on arrival at Shannon House and if a belt had been removed from his possession or not. I would like clarity on how my dad had access to his belt? Was he searched on arrival at Shannon House? Was the belt removed from his possession and if so, how did he come back into possession of the belt? Why was he not searched on arrival at The Lakes?

- The AMHP reported she was unable to accompany my dad on the transfer from Shannon House to The Lakes as she had to attend another assessment, however this was later confirmed to not be the case by [I/S] If the AMHP did not have to attend another assessment as she had stated, then why did she not accompany my dad on his transfer?

- On arrival at The Lakes, my father was downgraded from level 3 observations (which he was under at Shannon House) to level 2 observations with no assessment being made. Who made this decision and what was the rationale?

- Why did it take 5 hours for a Dr to finally arrive to assess my dad on arrival at The Lakes?

- My father had been able to barricade himself in his room using the bedroom furniture. Was this MO previously featured in any investigations and recommendations failed to be implemented prior to my dad's death? Were

changes made to prevent this happening again following my dad's death or did this continue to feature in future incidents?

- Had the window previously been highlighted as a cause for concern prior to my dad's death? Did this feature in any prior investigations? I believe the windows were changed following my dad's death; can this be confirmed?

- What happened to the staff members involved? Were there any internal investigations/disciplinaries and what were the outcomes?

36. I believe the following changes need to be made to prevent the tragic deaths of those suffering from ill mental health in the future:

- Easier Access to mental health services and a decrease in waiting times is required to allow earlier intervention.

- Wider variety of talking therapies (other than just CBT) should be available including increased access to high quality psychological therapies and specialist trauma treatment.

- Ensure seamless transitions between primary care (GP) and specialist mental health services, allowing for earlier intervention and better coordination of care.

- Crisis Resolution, Home Treatment teams and community mental health teams all need to be properly resourced so they can provide the level of care that is required.

- Invest in mental health research to improve our understanding of mental illness and develop more effective treatments and interventions.

- Increased transparency between families and the trust with regards to concerns about the quality of care provided.

- In the event of a death, the NHS need to keep families informed as to any internal investigations conducted and the outcome of these e.g. have specific staff members been found to be negligent and what were the consequences?

- Provide accessible support for family and carers who provide a vital role for supporting individuals with mental ill health.

- Increased accountability for staff; psychiatric negligence should be a criminal offence and those found negligible should be prosecuted.

Statement of Truth

I believe the content of this statement to be true.

SIGNED Alan James Oxton

Mr Alan Oxton

DATED 24th May 2025