Thursday, 10 July 2025

(10.06 am)

THE CHAIR: Ms Troup.

MS TROUP: Good morning, Chair. We are ready for our first witness.

EMMA SORRELL (affirmed)

Questioned by MS TROUP

MS TROUP: Thank you. Could you first state your full name for the record, please?

A. Yes, it's Emma Louise Sorrell.

Q. Thank you. Emma, you are the daughter of Frederick James Peck, who died on 4 December 2004, when he was 54 years old?

A. That's right.

Q. At the time of his death, your father, who we are going to refer to as Fred, I understand --

A. Mm-hm.

Q. -- was an inpatient at The Lakes Unit in Colchester?

A. Correct.

Q. You have with you today your husband Dave, sitting with you for support --

A. Yes.

Q. -- and I understand that you have in front of you a copy of your witness statement that was sent in response to this Inquiry's Rule 9 request?

A. Correct.
Q. Emma, your statement is 69 pages long and, if you turn just very briefly to the final page, we can see that it is dated 6 June of this year --
A. Correct.
Q. -- and that you have signed and given a statement of truth?
A. Correct.
Q. Have you had a chance to look through your statement recently?
A. Yes, I have, thank you.
Q. Are you happy that its contents are true and accurate?
A. Yes.
Q. Thank you. Emma, as has been explained to you, that witness statement therefore stands as your evidence?
A. Yes.
Q. For that reason, I don't intend to take you through it line by line in your oral evidence. We will go through it together and I want to start by talking a little bit about the background to the development of your father's mental ill health.

As we go through, so that you can follow but you don't need to, I'll talk you through what page numbers and paragraph numbers I am up to.

A. Thank you.

Q. Emma, I understand that you first noticed that your father was low in mood in around December 2003?
A. Correct.
Q. Then in about March 2004, you had your first indication that he might in fact be suffering from depression?
A. That's right.
Q. I think this was around about the time of your own 27th birthday?
A. That's right, it was mid-march. Yes, he came round and pointed out that his hair was falling out again. He had suffered from alopecia prior to my birth --
Q. Yes.
A. -- in 1977, it had grown back a little bit and his mental health had improved greatly over that period of time. He hadn't suffered from depression prior to that. And, yes, his hair was falling out again and that caused him a lot of trauma.
Q. Yes. I understand that, at that time, that was the first time your father had ever cried in front of you?
A. That's correct.
Q. And it's your belief that the alopecia triggered, in some way, a spiral of depressive or very negative thoughts?
A. Yes, that was absolutely the trigger, as far as I'm concerned.

Q. I understand that it took him back to a time when he had split from your mother?
A. Yes, in 1989/90, yes.
Q. My understanding, from what you have told us and from your witness statement, is that, to put it mildly, that was not an amicable divorce?
A. Correct. It caused him a lot of trauma at the time.
Q. After that incident in your garden in mid-March 2004, you -- and we understand, I understand, from your witness statement you were very close with your father?
A. Yes.
Q. So you talked frequently on the phone?
A. Correct, yes.
Q. You were in contact with him very regularly and he put on a brave face in those months?
A. Very much so. He tried to muddle through the best way he could but I could see that his mental health was beginning to spiral.
Q. Yes.
A. It was just a general low mood to begin with.
Q. Yes.
A. It wasn't until May, the end of May 2004, that he recognised that his mental health was really not very good at that point --
Q. Yes.

A. -- and that he of may have been suffering from depression.
Q. Yes.
A. It was 28 May that he actually admitted himself privately to the Priory hospital in Chelmsford --
Q. Yes.
A. -- where he stayed for a week but, due to financial constraints, because obviously it is very expensive, private mental health care --
Q. Yes.
A. -- he discharged himself on 4 June.
Q. So he was there between 28 May and 4 June and then came home?
A. Yes.
Q. I understand that, in the period then -- because we know that your father was sectioned on 20 July --
A. Mmm.
Q. -- so between him coming out of the Priory on 4 June 2004 and his admission to The Lakes on 20 July, you saw quite a marked deterioration in his mental health?
A. It was rapid and I think this is something I really want to stress, the importance of mental health and people recognising how rapidly these can progress --
Q. Yes.
A. -- and that health mental health can decline at such

a fast rate because, between 4 June and 20 July when I had him sectioned, he became a completely different person.

Q. Yes.

A. I wasn't aware of psychotic depression or anything back in those days, that terminology wasn't familiar to us back in those days.

So -- but he was, he was very much talking about -- he was reliving the trauma of the divorce in 1989/90.

Q. Yes, yes.

A. But he was speaking in terms of everything was in the present, so he was going to lose his house, he was going to lose his business, that his world was basically falling apart.

Q. Yes, I understand.

A. And I could see that his grip on reality had been lost at some point during those months of progression of his mental health decline.

Q. I understand. You make reference to him pacing up and down relentlessly, being unable to sleep, talking about running out of time --

A. Correct.

Q. -- chain smoking --

A. Yes.

Q. -- very, very agitated throughout?

A. Yes. He continued to go to work for quite a period of months during this time.
Q. Yes.
A. I cannot remember exactly when he stopped going to work because he was a business owner, so obviously he needed to work to keep the business going.
Q. Yes.
A. But, at some point, he stopped going to work and, by 15 July, he had got to the stage where he was -- he had given up completely, he had stopped eating --
Q. Yes.
A. -- he had stopped drinking --
Q. I understand that by --
A. -- he stopped --
Q. Sorry, no, you go ahead.
A. -- he stopped sleeping.
Q. Yes.
A. And the repeated pacing and talking about running out of time --
Q. Yes.
A. -- and expressing wishes to end his own life --
Q. Yes.
A. -- was a 24-hour, 24/7 occurrence.
Q. I think --
A. So between -- sorry.

Q. No, go ahead.
A. Between 15 and 20 July, his partner and I found ourselves on 24/7 suicide watch --
Q. Yes.
A. -- which was obviously very concerning.
Q. Of course. You have expressed in your witness statement how traumatic that time obviously was, this period where you and his partner were effectively on suicide watch 24 hours a day. You had had police remove his guns from him.
A. That's right.
Q. You removed sharp objects from the home and, effectively, his response in expressing how strongly -- or in expressing strongly his own wish to die was to stop eating and to stop sleeping, and so on?
A. Yes, that's correct, Rachel. So we had what I called social workers back then, in the day --
Q. Yes.
A. -- which I now probably -- I understand were the social care or were the crisis team -- came and assessed him --
Q. Yes.
A. -- during that final week of his rapid decline. And it was when he stopped drinking, that's when it became a real concern because he started to go yellow, obviously, because he was suffering from jaundice

because he wasn't drinking enough.

Q. Yes.

A. So that was at the point where his physical health was --

Q. Being very severely affected?

A. Absolutely.

Q. I think it was at that point, is this right, that one of those either crisis team members or social workers expressed to you and to his partner that he needed to go immediately to hospital?

A. That's right, on 20 July.

Q. Yes.

A. They came to the house. They assessed him and that was at the point where they said he needs to go to The Lakes Hospital in Colchester. I cannot recall because obviously it was a very traumatic event in my life, I cannot actually recall how he got there, whether I drove him there or whether they drove him there. I know that, if I didn't drive him there, I followed.

Q. Yes.

A. And at that point, we were not aware of what was actually the process was going -- what was involved with the process.

Q. Yes.

A. Once we arrived at The Lakes hospital, this is all

an unfamiliar landscape to us obviously --

Q. Yes.

A. -- and he was assessed there and then --

Q. Yes.

A. -- and it was decided that he needed to be sectioned under the Mental Health Act --

Q. I understand.

A. -- at that point.

And it shows how unprepared we were, where we didn't even take an overnight bag.

Q. No.

A. We didn't -- we were not aware at that point that sectioning was on the cards.

Q. I understand. It was all completely alien to you?

A. Absolutely, yes.

Q. I think you also say, in what is likely related to the trauma of the period that had preceded it and day, that you have something of a mental block about the events of 20 July?

A. Absolutely, although it is strange because once we got to the hospital, I can accurately remember everything.

Q. Yes.

A. But I think because we had been on 24/7 suicide watch for five days --

Q. Yes.

A. -- we were exhausted --
Q. Of course.
A. -- we were traumatised. The period of getting him to the hospital is the part that I cannot remember.
Q. That's all right.
A. So once he's at the hospital, I can remember very vividly --
Q. Yes.
A. -- because, due to personal circumstances, I had to request that he was immediately transferred to the Peter Bruff unit in Clacton.
Q. Yes, so he wasn't -- so the assessment took place?
A. Yes.
Q. A decision was made that the situation, the crisis, was severe enough that your father needed to be detained under the Mental Health Act, and there was then an immediate transfer from The Lakes to Peter Bruff at Clacton?
A. Correct, yes.
Q. One of the other things I wanted to ask you about, and we will come back to this, is about any diagnosis that your father received. I am looking now, Emma, at page 6 of your witness statement and it is at paragraph 7?
A. Mm-hm.
Q. I think the answer is, in terms of any definitive

diagnosis, you were not aware of one until the time of your father's inquest, does that sum it up?

A. Absolutely. It absolutely does, Rachel. The only mention of any form of diagnosis was a breakdown of some kind.

Q. Yes.

A. It was just breakdown or mental breakdown. There wasn't a proper diagnosis, I didn't receive any official diagnosis throughout the five months --

Q. Yes.

A. -- five month period of time that he was detained.

Q. Yes.

A. It wasn't until the inquest that -- and the verdict was read --

Q. Yes.

A. -- and that was at the point where they said he killed himself while suffering from psychotic depression. That was the first time that I had heard the phrase or the terminology "psychotic depression", at which I had to go home and research because --

Q. Yes.

A. -- I hadn't been aware of the term up until that point.

Q. Yes.

A. But it does make sense because of his psychosis because of what I have said previously?

Q. Yes, and what you have described about what almost appear, in your description of them, to have been delusional beliefs at the time and something that had triggered him to be believing things that were not objectively true, and so on.
A. That's right.
Q. I think one of the other things you say, and we are going to come on to this, but that you had very limited engagement from staff at both The Lakes and less so at Peter Bruff during the time that your father was an inpatient but that the only real reference to any diagnosis you ever heard was fairly informal conversation with staff talking about a breakdown?
A. Mmm.
Q. And I think one member of staff in particular, in around October 2004, saying to you that it was one of the most severe breakdowns they had ever seen?
A. Correct. So when he was in Peter Bruff --
Q. Yes.
A. -- in the initial, I would say, first month, I had a good relationship with one of the nurses, which was his nurse that was basically observing him most of the time --
Q. Yes.
A. -- and the nurse in charge of him.

Q. Yes.
A. They were great at actually talking to me and telling me what was going on, as much as they could.
Q. This was at Peter Bruff?
A. At Peter Bruff.
Q. Yes.
A. And during that first month, the prognosis was good.
Q. Yes.
A. You know, they said within the first week, "Well, he won't be here very long".
Q. Yes.
A. You know, "This isn't -- this -- I wouldn't worry yourself too much, he is in a safe place but we are going to get him better and, you know, it is just a little breakdown, it's just a breakdown".
Q. Yes.
A. It wasn't until October, like -- as you have mentioned, that someone actually said to me that they hadn't seen such a severe breakdown for such a long time.
Q. I understand. I think it might be helpful to set matters in context and so that all happened is understood. I am going to take you through the timeline. If you look, please, Emma, at page 10 and it is actually a section entitled "Admission", but just to take you through the dates and you must tell me if

I have any of this wrong.

A. Mm-hm.

Q. As we have heard, the assessment took place at The Lakes on 20 July and there was then an immediate transfer to Peter Bruff?

A. Correct.

Q. Your father was discharged from Peter Bruff on 18 September 2004?

A. Correct.

Q. He was readmitted two days later on 20 September 2004, having made a number of threats to take his own life?

A. Correct.

Q. He remained on Peter Bruff then until another discharge on 17 October 2004.

A. Correct.

Q. Then on 22 October 2004, whilst at home, he made a serious attempt to end his life and was taken to Colchester General for treatment?

A. That's correct. He nearly died.

Q. Yes.

A. He had to be cut down and a neighbour had to resuscitate him while they waited for the ambulance.

Q. Yes, yes.

A. Yes, so that's correct.

Q. From Colchester General --

A. Yes.
Q. -- he was then admitted to The Lakes on 24 October 2004 --
A. Correct.
Q. -- and there he remained?
A. Correct. And I was not informed or asked whether The Lakes was a -- was the best place for him. He was just transferred there.
Q. Yes.
A. And, obviously, because of the personal circumstances during the sectioning when I viewed my concerns with regard to Dad being in The Lakes Hospital --
Q. Yes.
A. -- I found it quite odd that he was then admitted to The Lakes Hospital following this incident and was not transferred back to Peter Bruff, where I knew that he had been relatively -- as happy as he -- or more comfortable.
Q. Comfortable.
A. Mmm.
Q. Yes, yes, we will come on to that because you go on to give us a very clear description of what is a stark contrast between those two units, The Lakes and Peter Bruff.
A. Yes.

Q. You were not involved in the decision to admit him to The Lakes or not consulted about it?
A. No.
Q. In fact, taking it in the round, I think it's right to say that you were not involved at any stage or in almost any aspect of decisions about your father's care and treatment, save for one meeting on 29 November 2004?
A. That is correct Rachel, I -- yes.
Q. Well, that only came about because you took very proactive action and wrote a detailed letter to his treating doctor; is that right?
A. Absolutely, that is correct. I had tried contacting his psychiatrist on a number of occasions, I had repeatedly requested to be involved in any meetings to discuss anything: discharges, transfers, anything. I was deemed important enough to sign the papers to have him sectioned.
Q. Yes.
A. It felt to me that, following the sectioning, I was brushed under the carpet.
Q. I understand.
A. And it wasn't until October -- I was so desperate, Rachel, at this point -- that I did, I wrote an email and a letter. Within the letter I was explaining what I believed his feelings were --

Q. Yes.
A. -- because we had a very close relationship.
Q. Yes.
A. And I did this because a man of a certain age and era, and he was very poorly, I thought that perhaps he wasn't opening up as he should.
Q. Yes.
A. And I thought that I could perhaps shed any light -- anything could help, any information could help at this point. And he had repeatedly -- he had been repeating certain key sentences over and over again, so I included those.
Q. You set those out, yes?
A. I included all of the key triggers, the things that I thought may have caused his depression.
Q. Yes.
A. I am not a psychiatrist but I was desperate and that was at the point where I was trying to get them to actually involve me at all.
Q. Yes.
THE CHAIR: Was that a letter of complaint or was it a letter that actually just pointed out what you wanted to say about him, or was it a bit of both?
A. It was -- it was a letter just explaining, clarity -- trying to help I think, Chair, more than anything. But

the email was also trying to put it in the most formal way that I thought I could --

MS TROUP: Yes.

A. -- that I needed to be involved and I wanted to be involved.

Q. Yes.

A. Because I was being -- I had been ignored up until that point and we were four months in, at this point, and he wasn't getting any better and that was my concern.

Q. Yes, I understand. It is right, I think, that you received no response to that letter --

A. I didn't, no.

Q. -- and that your overall feeling thereafter, because communications did not improve --

A. Mmm.

Q. -- you were not after that letter asked for your input?

A. No. Apart from -- sorry, Rachel.

Q. No, go ahead.

A. Just to clarify that I was invited to the meeting on the 29th.

Q. Yes.

A. And that's result of it --

Q. Yes.

A. -- was that I was actually involved in that meeting but that was the one meeting that I was involved with --

Q. Yes.
A. -- because, sadly, he passed away not long afterwards.
Q. A number of days later. Yes, I understand. So you did attend that meeting?
A. Yes.
Q. But there was no response, and my very strong sense, Emma, is that you were desperately trying to provide input and background and give his treating clinicians a sense of who this man was, what might be troubling him and how they could help him?
A. Oh, absolutely. Absolutely.
Q. Yes.
A. Anything that I could do to help because, as I say, he was not improving at all.
Q. Yes.
A. And I could see that, especially once he was in The Lakes Hospital, he withdrew further into himself.
Q. Yes.
A. And that's to say that, not only was he not communicating with the staff, so I was suspecting that he wasn't communicating with his psychiatrist --
Q. Yes.
A. -- but he was also withdrawing within himself, with regards to even speaking to visitors.
Q. Yes.

A. It was like he had given up --
Q. Yes.
A. -- and he was just biding his time until he got the next opportunity.
Q. So, in a way, this was your effort to be his voice because, by that point, he was unable?
A. Absolutely.
Q. I understand.
A. Yes.
Q. What you say in your witness statement is that the fact that there came no response and, other than your attendance at that one meeting, no improvement in communication, left you feeling belittled?
A. I felt very belittled and I felt that I didn't matter.
Q. Yes.
A. I felt that I was insignificant. It's actually damaged me to this day, to be honest, because the treatment from start to finish --
Q. Yes.
A. -- it was like I wasn't important enough, I wasn't significant enough and, actually, I think -- I believe I stated within the substantive evidence -- that I still believe -- I was questioning whether I was significant enough to complete this Rule 9 request because that was the way that it left me.

Q. I understand.
A. It left me feeling like I was nothing.
Q. Yes. I am so sorry.
A. That's ...
Q. Let's go to -- no, in fact, just to -- if we can, just going back to the sort of timeline of what occurred. You attended that meeting on the 29 November.
A. Mm-hm.
Q. At that stage, a possible discharge before Christmas was discussed?
A. Correct. It was decided during that meeting that he was not ready to be discharged.
Q. Yes.
A. His psychiatrist was in agreement with me that he had -- he was still presenting in the same way that he had during the meeting prior to his discharge in October --
Q. Yes.
A. -- and that subsequently he had nearly succeeded in taking his own life. So the decision was that he was not going to be discharged and that a follow-up meeting would be held on 6 December.
Q. Yes.
A. But, unfortunately, Dad didn't make it to the 6th.
Q. Indeed. I think if we turn, please -- if you and I turn to page 14 of your witness statement, and to

paragraph 18?

A. Mm-hm.

Q. One of the things you have been asked about there is what the effect on your father was of being admitted under section. One of the things that you have noted throughout your witness statement is that, taking ourselves back in time, in 2004, it was simply not the case that mental health and mental health difficulties were discussed in quite the open way that they are now?

A. Oh, absolutely. We have come a long way --

Q. Yes.

A. -- and I am glad that we have come a long way in acknowledging mental health. Do you mind if I read -- may I read?

Q. Go ahead, you wanted to read a particular section, I think, at the top of page 15?

A. Yes, thank you:

"He had worked hard for over 30 years to build himself a respectful reputation. He was a proud, independent and dignified man, so to strip him of his freedom and for him to be 'sectioned' and grouped together with 'mentally unstable' people of varying degrees and illnesses, was devastating for him. For a man of a certain age and era, if he was sectioned, he believed that there was no going back into society and

facing people after something like that, even if he did get better."

And this was something, one the key phrases that he repeated while he was under section, that is it all over the press, is everyone talking about me, how can I face people again?

Q. Yes.

A. Can I continue?

Q. Go ahead, please go on.

A. "I think that we all felt overwhelmed and like it had all happened very suddenly. I understood the severity of the situation but my dad was not in the right frame of mind at that time to make such decisions. We were not aware that he was going to be sectioned until the moment that it happened. We were not at all prepared. Dad was assessed during that meeting at The Lakes Hospital and they made the decision. I agreed of course because they were the professionals and I was exhausted, traumatised and desperate."

Q. Yes.

A. "Having to watch his daughter sign the papers to have him sectioned was, I am sure, a very demoralising and distressing experience for him. He had prided himself on being a strong, stable, dependable man to all. He was used of to having control of his life and being the

support figure for so many family members and friends."
Q. Thank you. Emma, one of the other things you note is that, apart from the process being completely alien to you, the whole environment was completely alien to him. Here was a man who liked to be at home and, suddenly, he was in this strange environment, surrounded by people with varying degrees of mental illness?
A. Yes, absolutely, Rachel. He was a man who had a close knit group of friends and family, he was a homebody. He hardly ever went out.
Q. Yes.
A. He hardly ever went on holiday.
THE CHAIR: Do you think, if he hadn't been sectioned, he would have been prepared to be in hospital on a voluntary basis. Do you think he would have --
A. I think he would have rather that. I think he would have been able to retain his dignity, I think, in his mind.
THE CHAIR: And he did know he was very unwell because he put himself in The Priory, hadn't he?
A. Indeed, yes, and he wanted to get better. I think that's something worth noting.
THE CHAIR: Yes.
A. And that will be -- because when we come on to it, it was made apparent that they had kind of given up on him

but he hadn't given up on him at that point and neither had I.

MS TROUP: Yes, of course.

I understand that, save obviously for the periods where your father was discharged, it is the case that between the date of his section on 20 July 2004 and date of his death on 4 December 2004, you visited him if not every day close to?

A. As much as I could, yes. I visited him every day for weeks --

Q. Yes.

A. -- probably about six weeks. But I was working full time at that time --

Q. Yes.

A. -- long hours, 12/13 hours. I was having to pick up, then drive from where I worked to pick up his partner to take his partner to the hospital.

Q. Yes.

A. We would spend three or four hours there, then I would take her home, then I would have to go home. I would get about three or four hours sleep --

Q. And do it all again?

A. -- and do it all again.

Q. Yes.

A. So, by that stage, I had to reduce my visitations to

three to four times a week --

Q. Yes.

A. -- for my own health because I'd lost so much weight as well and I was exhausted.

Q. To protect yourself, yes.

We know that your father had these two distinct periods as an inpatient, first at Peter Bruff and then at The Lakes, and, Emma, if we can talk now a little about the ward environment and the contrast that I have referred to already. If you can go to page 18 of your witness statement, please --

A. Yes.

Q. -- and to question 24, where you were asked about your impressions of any ward that your father was on as a whole?

A. Mm.

Q. What you tell us there, and I think this sums up the stark contrast --

A. Yes.

Q. -- you describe Peter Bruff, which is at Clacton, as more of a warm, calming, nurturing environment, both physically and therapeutically, and you described The Lakes as feeling more like a prison than a hospital --

A. (Witness nodded)

Q. -- and that patients appeared to be treated like

inmates.

A. Absolutely. I didn't like leaving him there. I really, I didn't like spending time there and I really didn't like leaving him there and that, I think, is why withdrew into himself.

Q. Yes.

A. Because he -- the entire environment was sparse.

Q. Yes.

A. There was nothing to do. I think they did have a few activities but perhaps most of them were not applicable to someone of his age.

Q. I think you mention manicures and pedicures --

A. Indeed.

Q. -- or cookery, just unsuitable?

A. Yes, absolutely. All there was to do was watch the television --

Q. Yes.

A. -- and I cannot recall one incident where he went out into the garden during the five-week stay at The Lakes either. And he was an outside kind of person.

Q. Yes.

A. So he spent a lot more time in his room. So the times when I would arrive, I cannot remember many times, I can't actually remember one time when he was actually out in the social area. They had to go and get him from

his bedroom.

Q. Yes, this is what you describe about him beginning to withdraw into himself at The Lakes?

A. Yes, yes.

Q. In contrast, you describe Peter Bruff as a more warm environment with things to do --

A. Yes.

Q. -- and a social area, a kitchen for him to make refreshments?

A. Yes.

Q. You describe him forming good relationships with the nurse who was observing him most of the time --

A. Yes.

Q. -- and just being more social, as well as being able to be outside?

A. Yes. Absolutely. Obviously, he wasn't happy to be there --

Q. No.

A. -- but he was still engaging.

Q. Yes.

A. He was still engaging with people and he would actually have a laugh with his nurse.

Q. Yes.

A. They had a very close bond.

Q. Yes.

A. And there was just, there were more -- they were small things.
Q. Yes.
A. They didn't have to be big things. He loved doing puzzles, all of a sudden. At least it kept his mind occupied and it was something that he could do with other people.
Q. Yes.
A. There was a tennis table --
Q. Yes.
A. -- there and, like you said, the garden, and he could make himself a cup of tea.
Q. Yes.
A. It was all those little creature comforts and things to keep his mind occupied, which I think helped him --
Q. Yes.
A. -- which were missing from The Lakes Hospital. I think there was a tennis table but that was in a separate room, a small room.
Q. Yes.
A. And --
Q. It just didn't work?
A. It just didn't work. Really, the whole environment didn't work.
Q. I understand. The other thing you tell us in the same

vein, is that staff at Peter Bruff were very much more engaged with you --

A. Oh, absolutely.

Q. -- and talked to you about how he was getting on, set expectations --

A. Yes.

Q. -- and helped you to understand and have an insight into the care and treatment that he was receiving?

A. Absolutely. It wasn't so much the care and treatment because, obviously, I was naive to all of that, Rachel.

Q. I understand.

A. This is all new to me since the beginning the Lampard Inquiry but, at the time, at least they could tell me how his day had been.

Q. Yes.

A. How he was feeling, how he was presenting within himself. That was really helpful and comforting for me to know that they were at least doing that and keeping an eye on him.

Q. Yes.

A. I cannot recall one member of staff ever speaking to me at The Lakes Hospital and I didn't feel that I could approach them either, and I didn't actually know any of them.

Q. Yes.

A. One thing I have noted, I have actually found the courage to start reading some notes from the hospital that I found.

They didn't actually -- it's not actually mentioned that I visited for pages in. Now, I haven't read the whole lot because it's too emotional for me to read but we are talking about days and I haven't visited and I know I visited, so either they didn't note down that I visited --

Q. Yes.

A. -- or they actually didn't know that I was his daughter --

Q. Yes.

A. -- because that was how impersonal the whole environment was.

Q. But either way, it's not --

A. No.

Q. It's not good. You also tell us that, in contrast to Peter Bruff, there was such a diverse range of patients at The Lakes and such little interaction or sort of visibility of staff that, in fact, the environment was particularly difficult for your father who was a quiet man, who liked to be at home, who, as you have described him, was a man of a certain age. He was being approached by the patients and asked intrusive and

difficult questions, and the picture that you paint in your description, you must tell me if this is fair, is of some chaos?

A. Oh, absolutely. The diverse range of illnesses was extraordinary --

Q. Yes.

A. -- and it was the invasive way -- because the staff were not around and were not supporting and not interacting with either my father or any of the other patients, the patients, some of them, they had -- they didn't have that sense of personal space, and I understand that they had their own issues, but, for dad and for myself, that was -- we are not used to that.

Q. No.

A. It was very intimidating, in fact --

Q. Yes, yes.

A. -- which is -- that was probably a spent a lot of time in his room.

Q. Yes. Thank you. Talking about staff and, Emma, I am looking now, forgive me, I am looking now at --

THE CHAIR: 20?

MS TROUP: Thank you, page 20.

One of the things you say is that there never seemed to be many staff present on the ward at The Lakes.

A. No.

Q. You go on, and we will come on to this, but you were asked about the inquest and you have dealt with that later in your statement, and one of the things you learned at the inquest was that that ward at The Lakes was severely understaffed at the time of your father's death?

A. It was, yes.

Q. You describe that, looking now at page 21, as a matter that was one of outrage to you?

A. It was. Would you mind if I read it?

Q. Please go ahead.

A. I think it is just because I have put it so --

Q. You have put it so well.

A. -- concisely:

"I was absolutely outraged when I discovered the reasons for the multiple failings was due to a lack of staff. If this was the case and they could not provide the adequate care that my dad and the other patients on the ward required, we should have been informed. We were in no way informed that he was not receiving the required care that he so desperately needed. Had I known, although I should not have had to, I would have paid for him to receive private care once again.

"If the hospital could not provide the care needed, why were they allowed to continue functioning at all?

If it was a hospital managing physical ailments, would there not have been protocols in place to ensure that patients were cared for adequately? If someone were to die because their drip or ventilation system was not managed due to staff shortages, would there not be utter outrage? Why should mental health patients be treated with any less respect and responsibility? To whom did the responsibility lie and why was this not escalated and managed? I am still furious about this.

"It wasn't just the observations that were compromised due to understaffing; he didn't receive any psychiatric care. How on earth was he supposed to improve if he didn't receive any treatment? An analogy would be me arriving at A&E with my arm hanging off and the nurses stemming the bleeding but leaving the arm hanging to rot for five months."

Did you want me to continue?

Q. You go -- you are very welcome to.

A. Yes.

Q. You go on to say that, effectively, he was imprisoned, in your view, in an inhospitable environment --

A. Correct.

Q. -- where there were not sufficient staff to take care of him?

A. Absolutely.

Q. You say in that last paragraph that the culmination of that hostile environment, the lack of therapeutic care and psychiatric treatment massively contributed towards the rapid deterioration of your father's mental health and, in your view, resulted in his ultimate demise?
A. Absolutely, because he gave up because they gave up, or that's the way he perceived it because no one was doing anything to help him or getting him better.
Q. Yes.
A. He was just stuck there, left there to rot, and that was what he expressed to me, Rachel, repeatedly, "I have just been left here to rot".
Q. Thank you.
A. Sorry, I shout when I get a bit angry.
Q. There is nothing to apologise for: shout away.

I am turning now, Emma, to talk a little with you about the treatment your father did receive and I am looking at page 24, paragraph 38. You have explained in very clear terms how little communication there was with you at all, never mind about the details of your father's care and treatment, and we will come on to this, but you later discovered that there were no therapeutic services available at all?
A. Yes.
Q. On the ward?

A. That's right.
Q. Again, to be clear, we are talking about The Lakes --
A. Mmm management.
Q. -- so the second part of your father's inpatient stay.
You are aware, though, that he received ECT?
A. That's right, yes. He received the maximum number of treatments, and it was in October that he had received the maximum number of ECT treatments and that he needed a four-week break.
Q. Break.
A. But it was during this time that I noticed that he was actually getting worse not better.
Q. Yes.
A. And that I expressed my concerns to one of the nurses or one of the members of staff that he was actually getting worse.
Q. Yes.
A. And they said that that was a side-effect of the treatment, and I presumed that it was a side-effect that was temporary and that, hopefully, it would have got him better but it didn't.
Q. I think, as well as being told that it was a side-effect, you were effectively told, when you raised that concern that he appeared to be getting worse, that that was a normal reaction to the maximum

amount of ECT treatment?

A. Yes, absolutely.

Q. The other thing you tell us is that, bearing in mind all that you have told us thus far about your father and his background and his sense of pride and his integrity, those ECT treatments left him feeling particularly bereft?

A. They did, absolutely, Rachel. It was incredibly distressing. He had hit rock bottom already.

Q. Yes.

A. But the ECT treatment, I don't know if I should go into the details of what happened when he received the ECT treatment --

Q. You are absolutely welcome to do that.

A. -- but he would soil himself, he would wet himself --

Q. Yes.

A. -- and that was incredibly distressing to my father.

Q. Yes.

A. He was very proud.

Q. Of course. He was such a polite man?

A. Oh, he was incredibly polite and he would not have complained but he did complain about that.

Q. Yes, I think that was the only thing, wasn't it?

A. That was the only thing he complained about.

Q. Yes. You discovered -- and I think if I summarise -- in

fact it is the case that it's your understanding that your father received no psychological or therapeutic care at all from the date of his sectioning on 20 July to the date of his death on 4 December?

A. That is my understanding from the admissions during the inquest from the witnesses.

Q. Yes. That, obviously, was something that you were incredibly shocked to learn?

A. Oh, it was, yes. Absolutely.

Q. But, in particular, and we will come back to this, it was something of a shock to you to see, in the executive summary of the Serious Untoward Incident report that has been provided to you, a comment to the effect that he declined psychological treatment or refused to engage with it?

A. Absolutely. I think we come onto it in detail further on, Rachel --

Q. We do.

A. -- but, yes, you are absolutely right. It was said that he had declined psychological treatment. He was poorly, and he was a man of a certain age and era, I hate to repeat it, but it was difficult for -- men are only just starting to learn how to talk about their mental illness and to talk about their mental welfare.

Q. Yes.

A. That would have been very difficult for him to open up in the first place.
Q. Yes.
A. But that's their job, surely, to find a way?
Q. To facilitate that.
A. To engage, to facilitate, to find a way to get him to engage.
Q. Yes.
A. However minimally, that's the job.
Q. Yes. You also learned at the inquest into your father's death that, quite apart from having received no psychological care, his psychiatrist giving evidence stated that that could have assisted him?
A. Yes. She actually said that, had resources been available to provide psychological care, that that could have helped him --
Q. Yes.
A. -- but because of a lack of resources, it was not offered.
Q. Yes.
A. So how on earth was he supposed to be getting better if they couldn't even provide psychological care in a mental health hospital?
Q. Yes. Could I ask you then, Emma, if you look at the bottom of page 26 --

A. Mm-hm.
Q. -- and the paragraph, the last paragraph there, I think that's one that you wanted to read?
A. May I?
Q. Yes.
A. Thank you:

"I am utterly disgusted that during a five-month period of admission, my dad did not receive any psychological care. If a patient is admitted to a physical ward with an illness, they would be assessed, diagnosed and they would receive the appropriate treatment. I recognise the complexities surrounding the diagnosis of mental illness, but this is also true of physical illness. In a physical health environment, treatment and results would have been regularly assessed and adapted until a diagnosis and possible treatment plan could be agreed. My perception was that [his psychiatrist] did not understand why he had depreciated so rapidly under her care and she did not seem to know how to treat him. It is now obvious to me -- he hadn't received any care! The situation and environment just exacerbated his illness."

Q. Thank you. You went on to learn from the executive summary to the SUI report that I have just referred to, and I am quoting from it, this is in the middle of

page 27 of your witness statement:

"The panel acknowledged that there is no clinical psychologist or psychotherapist based at the inpatient unit or allocated to the ward."

A. Correct, correct. I think we covered that a little bit later as well.

Q. Yes. I want to go on, please, Emma, if you can turn to page 31, to talk a little about the observations your father was under, particularly in the latter half of his time as an inpatient, so from late October onwards?

A. Mm-hm. I'm sorry I do not have all of the details, all of the reductions and increases on his observations but this is over 20 years ago.

Q. Of course.

A. And I didn't expect myself to find -- I didn't expect it find myself in this situation, in the first place. So ...

Q. Of course.

A. But the ones that I have recorded are here.

Q. Of course, and we will run through those. You know, I hope, that there is nothing to apologise for. You tell us, and I will run you through it, that when your father was first admitted to The Lakes in October 2004, he was placed under 24-hour observation?

A. Correct.

Q. By 29 November and the meeting that we have discussed that you were able to attend because of your letter, this had been reduced to 15-minute observations --
A. Correct.
Q. -- despite it being noted at that meeting that day, on the 29th, that he wasn't much improved?
A. Correct.
Q. When your father died on the ward, on 4 December, he was still subject to 15-minute observations --
A. Correct.
Q. -- although -- and we will come back to this -- there is no evidence that those observations every 15 minutes were, in fact, being carried out?
A. There wasn't.
Q. From the records you have seen and the evidence you heard at inquest, staff admitted that they did not always have time to carry out those observations?
A. Correct.
Q. On 4 December 2004, when it was noticed that your father was missing, that was only because he hadn't attended to take his morning medication?
A. That's right.
Q. It was well outside of a 15-minute timeframe?
A. Absolutely. I think I've summarised the findings of -- during the inquest of the inconsistent statements

received by the key witnesses --

Q. Yes.

A. -- from The Lakes Hospital.

Q. Yes.

A. So during -- so -- and by the PCs attending the scene --

Q. Yes.

A. -- and the coroner's officer. So the statement provided by a PC who attended the scene, him and his colleague were informed he was determined dead at 1010 hours by a doctor.

Q. Yes.

A. The coroner's officer stated during the inquest he was confirmed dead at 9.15.

Q. Yes.

A. But a nurse stated during the inquest that she had let him into the bathroom at 9.15 and that, at approximately -- approximately -- 9.30, he had not responded to a knock on the door.

Q. Yes.

A. Another witness stated at the inquest that they noticed that he was missing when he did not turn up for his morning medications, as you said, Rachel.

Q. Yes.

A. But then the final verdict was that, at about 9.30 am, he was found hanging in the bathroom.

Q. Yes.
A. So you can see my problem with the inconsistencies --
Q. Of course.
A. -- between the statements.
Q. In fact, so you heard all this conflicting and contradictory evidence at inquest, and I think one of the things you tell us, and we will come to it, is that in many ways you came away from that inquest with more questions than you had going into it?
A. Indeed, I did. And I unfortunately believe I will never get answers to those questions.
Q. Yes. One of the things, just looking briefly, please, at the bottom of page 33 of your witness statement, one of the things that we know is that your father died by ligature, using his shoelaces?
A. Correct.
Q. One of the questions, understandably, that you ask is why he had those in his possession in the first place?
A. Absolutely. And they said a PC had mentioned had -- no, a member of staff had informed a PC, one of the PCs that attended the scene, that belts and shoelaces were only removed on a seclusion due to their human rights.
Q. Yes.
A. Now, I found this very difficult to understand because my dad was not on seclusion, so, yes, I can understand

why his shoelaces were not removed.

Q. Yes.

A. But they had removed his -- if I can remember from memory -- sorry, his dressing gown belt --

Q. Yes.

A. -- his trouser belt and his mobile phone lead.

Q. Yes.

A. So where -- is it selective human rights that we are adhering to here?

Q. Yes.

A. Or -- it just it didn't make sense to me, Rachel.

Q. And doesn't now, presumably?

A. No.

Q. I understand, thank you. Also, apart from the contradictory evidence you heard at inquest about timing and when it was that it was noticed that your father was missing, and what was happening with the observations, there was also a great deal of contradictory evidence about whether or not the bathroom in which your father died was locked --

A. Absolutely.

Q. -- and how it was opened.

A. Yes, that is absolutely right. One of the witnesses said that they had to find the nurse in charge of observations in order to unlock the door.

Q. Yes.
A. But then I found, during one of the statements during the inquest -- sorry, I have lost my place now.
Q. That's all right, if you look at page 33, I think.
A. 33.
Q. Yes, towards the bottom of that page.
A. That's -- yes. It was stated the keys had to be found.
Q. Yes.
A. I am just getting my bearings.
Q. No, that's all right. I think, if I can help --
A. And they had actually stated that all staff carried keys.
Q. Yes.
A. Well, if all staff carried keys, why did --
Q. Someone else have to be found?
A. -- someone else have to be found?
And then, I believe, during one of the PC witness statements, that they had mentioned that there was a locking system that -- whereby they could unlock it without the key from the outside.
Q. Yes.
A. So they are contradictory statements, once again.
Q. Yes. And again, for you, left struggling to understand what happened to your father, raising more questions than these statements answered?

A. Absolutely, and no closure, may I add.
Q. I am so sorry: no closure?
A. No closure.
Q. I would like to talk briefly about periods of leave from the ward. I know that there is more to say about the decisions to discharge him and your feelings about those being demonstrably wrong.
A. Mmm.
Q. If you look, please, Emma, at page 36 and at paragraph 66, as I understand it, when he -- when your father was away from the ward on leave, generally that was with you?
A. Yes, that's right.
Q. You were given no information whatsoever about how to support him?
A. No, I wasn't. I was just -- I was informed by his partner that he had -- he had been given leave --
Q. Yes.
A. -- and that I was to collect him at a certain time and bring him back at a certain time, and that was all of the information that I received.
Q. Yes.
A. I had no idea of the risk factors, although I knew that he hadn't got any better.
Q. Yes.

A. But, by this stage, it seemed that the opinion of the psychiatrist was that, "Well, he's not getting any better in hospital, so let's see, let's chuck him out there for a few hours and see how he gets on".
Q. Let's see what happens?
A. And hope for the best.
Q. Yes, I see.
A. I am not aware of any risk assessments, I am not aware of -- I was not informed of what to look out for or -- obviously, I knew the obvious things but, you know, how, how to manage him while he was out.
Q. Yes, what risks to look out for?
A. Indeed, or the process or protocols of getting him back because sometimes it was incredibly difficult to actually get him back in the car to take him back because obviously his reticence to actually --
Q. Be there?
A. -- be there.
Q. Yes.
A. And sometimes he would actually kick the car out of gear while I was driving him back to the hospital.
Q. Yes.
A. And he would be repeatedly begging me not to take him back. So I had no idea of what the protocols would have been had I not been able to actually succeed in getting

him back to the hospital. Thankfully, I did --

Q. Yes.

A. -- on each occasion.

Q. You describe, unsurprisingly, those periods of having your father away from the ward on leave as terrifying for you, for those reasons?

A. Oh, absolutely, Rachel. I couldn't rest, I couldn't -- I couldn't relax while he was out. I was absolutely terrified from start to finish.

Q. Yes.

A. And he came to our home quite a few times.

Q. Yes.

A. And he was so drugged up on medication that he could hardly function at all.

Q. Yes.

A. So my fear -- I just couldn't keep him -- I couldn't let him out of my sight for five minutes --

Q. Yes.

A. -- during those periods. They were terrifying, quite frankly.

Q. Thank you. In the same way, talking about those periods when your father was discharged, both from -- well, from Peter Bruff in fact on 18 September, and again on 17 October --

A. Mmm.

Q. -- and if you want to follow it I am looking now at page 39 -- you were not involved in any decisions to discharge him?
A. No.
Q. On both of those occasions, I think it's your evidence that, had you been, you would have strongly advised against it?
A. Oh, absolutely. Absolutely. He hadn't got any better.
Q. Yes.
A. In fact, he was just getting worse.
Q. As you say, that wasn't simply your view. There was a general acknowledgement that he had not improved but, as far as it seemed to you, the attitude was, well, let's give it a go and let's see what happens?
A. Absolutely, it was the same attitude, Rachel, as the leaves.
Q. Yes.
A. The discharges were, "Well, he's not getting any better, let's just keep our fingers crossed and hope that this helps and this goes well".
Q. Yes. On neither of those occasions, following discharge, as far as you are aware, was there any plan for follow up or any kind of care or treatment in the community?
A. No, that's correct. I wasn't actually aware of any of

these things --

Q. No.

A. -- until obviously this Inquiry. No.

Q. You have found reference in your own emails, certainly to the period just prior to your father's discharge on 18 September, that at that very time he was continually expressing a wish to die?

A. He was. Yes, he was.

Q. To you, I think, it therefore was plainly at best a questionable decision to discharge him?

A. That's putting it very politely.

Q. Too mildly?

A. Very kindly.

Q. You put it in your words, please?

A. I think it was disgusting, disgraceful and quite frankly irresponsible and unprofessional --

Q. Thank you.

A. -- and it put him at risk.

Q. Yes.

A. And obviously it did put him at risk because he nearly succeeded the first time.

Q. Yes.

A. Had he actually succeeded, which he nearly did, I wonder what the accountability would have been, and I guess it would have been nothing --

Q. I understand.
A. -- as it was on 4 December.
Q. Thank you. We have talked about how little engagement there was from treating clinicians, ward staff and Trust staff. You have described in very vivid terms the effect that's had on you.

I think this is right, isn't it, that at the time and throughout your father's inpatient stays at both of these units, you would have been done anything to be able to input into his care and to engage with staff?
A. Absolutely. I mean, I think you are getting an impression of the kind of person that I am by now. My only concern was for my dad's mental health -- was for my dad's safety and for him to get better --
Q. Yes.
A. -- and any way that I could have helped, I would have done.
Q. Yes.
A. And I -- my opinion is that it was an easier option to ignore me because I was asking difficult questions that they couldn't answer because they were understaffed and were not providing the care.
Q. Yes.
A. So avoiding -- avoidance was the easy option.
Q. I understand, because you were potentially presenting

challenges and asking questions?
A. Yes, indeed.
Q. Any requests you made, other than the one we have discussed which led to you attending the meeting on 29 November, any requests you made to speak to his psychiatrists were ignored?
A. Ignored. Absolutely. And, actually, a meeting did occur, I think we come on to it, but a meeting did occur following the 29th --
Q. Yes.
A. -- and I was not invited to that one.
Q. Thank you.
A. And that's when Dad petitioned to have his section lifted.
Q. Yes, that was on 3 December.
A. It was.
Q. He appealed against his section?
A. That's right.
Q. Did you even know that that meeting was taking place?
A. No, I didn't find out until the inquest.
Q. Indeed.
A. And that's when I found out that he had actually been granted eight hours' leave on 4 December, rather than the three that my sister and I believed he was on.
Q. So to make --

A. Had we known that, we would have picked him up first thing that morning.
Q. I understand. So to make that clear, for those listening, you had understood, before 4 December, that he had been granted just three hours' leave?
A. Correct.
Q. Unbeknownst to you on the 3rd, despite the fact that his condition had not improved --
A. Mmm.
Q. -- and that that appears to have been widely known and acknowledged --
A. Mmm.
Q. -- a decision was taken that, in fact, that period of leave would be extended to eight hours?
A. Correct.
Q. Neither you nor your sister were informed of that fact --
A. No.
Q. -- and, therefore, didn't arrive to pick him up and that is, in fact, the date on which your father died?
A. Indeed. And we -- it questions why we were not informed, as we were the ones that were taking care of him that day.
Q. Of course. Thank you.
THE CHAIR: If you had been invited to that meeting, what

would you have said?

A. Eight hours is too long, quite frankly. At that point, Chair, he wasn't presenting well enough. I think three hours was safe -- that was still risky enough. Eight hours would have been too much.

MS TROUP: Thank you. Emma, if you are content, what I would like to do is take a short break now, perhaps of about 10 or 15 minutes and as long as the Chair is content, and then we will come back to this.

A. Mm-hm.

THE CHAIR: 10 minutes.

MS TROUP: Thank you.

(11.11 am)

(A short break)

(11.27 am)

MS TROUP: Chair, thank you. Thank you.

Emma, I would like to move on to some of the events after your father's death and the first thing I want to note is that you tell us in your witness statement that, as far as you are aware, at no time during any stage of his treatment were you informed how to raise a concern or a complaint of any kind?

A. No. No. And by this stage, I didn't think that I was valuable enough to actually do that anyway because I had been so blatantly ignored.

Q. Yes. In the same vein, after your father's death, you received no information about the processes that might take place or investigations that might be carried out?
A. No, that's correct. The only information that I received was when I employed a solicitor and my solicitor informed me and tried to reassure me that there would be a police investigation --
Q. Yes.
A. -- and that there would be an investigation by the coroner.
Q. Yes.
A. And that my answers -- my questions would be answered during the inquest.
Q. At that stage?
A. Yes.
Q. In terms of the Trust, no support was offered?
A. No.
Q. There was no communication whatsoever?
A. No, absolutely none. No, absolutely none. I didn't hear anything following my dad's passing from the Trust. The only time that I ever saw them or heard from them again was during the inquest -- during the inquest.
Q. Yes. You understand now that the circumstances of your father's death were included in the Health and Safety Executive's prosecution of the Trust --

A. Yes.
Q. -- in 2020 and 2021. When is the first time you came to learn that that was the case?
A. When you informed me of it, Rachel, in April this year.
Q. From this Inquiry?
A. Indeed that was the first -- it was a big shock to me, to be honest.
Q. Yes.
A. Yes, I wasn't aware of that. I was aware that there had been an internal investigation --
Q. Yes.
A. -- because, during the preparation for the inquest, after what I should add was many months, over a year of requesting information from the Trust in preparation for the inquest --
Q. Yes.
A. -- an hour before the inquest was due to start, I was provided with the SUI executive summary, which is three pages --
Q. Yes.
A. -- which is all -- so I would like to point out that this evidence today, as it stands right now --
Q. Yes.
A. -- is only based upon --
Q. That document?

A. -- that document and the emails and information that I had --

Q. Yes.

A. -- retained over the years between -- the correspondence between myself and my solicitor --

Q. Yes.

A. -- and barrister.

Q. Let's turn to that executive summary, Emma. If you can look please at page 49 of your witness statement.

A. Mm-hm.

Q. There are a number of parts of that that it's crucial that you highlight, or that you feel very important to highlight are.

If we go to the first bullet point there. There are two statements you find in that executive summary. The first, I don't know whether you want to read it or you would like me to do that?

A. May I read them both?

Q. Of course, of course, read them both.

A. Thank you, Rachel. This is within the SUI, a summary report because this is the only information that I received. It stated in one point:

"... Mr Frederick Peck demonstrated a sustained level of risk of suicide throughout his involvement with the Trust's services."

Another point within the SUI executive summary report states:

"At the time of the incident the clinical team were sufficiently optimistic about Mr Peck's progress that they granted him up to eight hours accompanied leave with family members. The Panel felt this to be technically appropriate."

Q. Yes.

A. To me, the two statements are utterly contradictory.

Q. That is because, you must tell me if I am wrong, the level of risk remained unchanged --

A. Indeed.

Q. -- progress did not appear to have been made --

A. Indeed.

Q. -- and, yet, in the second point that you have read to us, progress was apparently deemed sufficient for him to have that longer period of leave that we were discussing before the break?

A. Indeed. And we have to bear in mind that this is the SUI executive summary report, so this is in retrospect.

Q. Yes.

A. So the first statement was obviously what they believed to be the case at the point where my father took his own life.

Q. Yes.

A. And the second statement was, because they are both respective.

Q. Yes. If we go on, please, to the next section that starts "The panel concludes", this is the second, really, key statement from within that executive summary that you wanted to highlight, and that reads as follows:

"The panel concludes that no omission or action contributed to the incident."

The incident, to be clear, being your father's death?

A. Yes, that's correct.

So the two statements below this within my substantive evidence completely contradict this statement. The first point was that:

"The panel acknowledged that there is no clinical psychologist or psychotherapist based at the inpatient unit or allocated to the ward. It remains an open question whether easy access to psychological treatments on the ward would have helped Mr Peck to enter into a trustful therapeutic relationship, that might have enabled him to address his difficulties and relationships and his traumatic past experiences."

Q. Yes.

A. That's surely an admission --

Q. Yes.

A. -- would you not agree?

It's also worth stating that, nowhere within the SUI report does it state that there was a staffing issue --

Q. No.

A. -- that the ward was understaffed.

Q. Yes.

A. And that is, in my humble opinion, one of the contributing factors --

Q. Yes.

A. -- contributing factors to what actually happened on 4 December.

Q. Yes. At the second bullet point, the very end of page 49, if you want to go on to that -- have I lost you I'm sorry?

A. No, that's fine?

Q. The final bullet point on page 49.

A. Sorry, Rachel, I am just checking that I have covered everything. No, that's absolutely fine.

Q. Take your time.

A. No, that's fine, thank you. So the second point was:

"As the Nursing Observing Policy was used in The Lakes at the time the panel had some concern regarding the task orientated nature of carrying out periodic checks."

Q. Yes.

A. "It is clear that Mr Peck used the 15-minute period of time between checks to take his life."

Nowhere within this statement does it refer to the whiteboard system or the lack of staffing -- sorry, to keep repeating myself --

Q. No, go ahead.

A. -- but I think it bears repeating.

Q. Yes.

A. And I --

Q. Go on --

A. Sorry.

Q. No, no. Please go ahead.

A. In the witness statement by one of the PCs who attended the scene following my dad's death --

Q. Yes.

A. -- he stated, I have redacted the names:

"On returning to Gosfield Ward, I spoke to a member of staff. He informed me that there are procedures in place regarding 15-minute checks. The responsibility of these checks is changed on an hourly basis. This rota is on a whiteboard system in the staff room. The member of staff stated that there is legislation in force that requires them to record these checks. However, he went on to state that this is not being done and never has been. This is the way things are, not only here but at

the other NHS Trusts in the area."

And I thought that was bear -- I thought that was worth mentioning --

Q. Yes.

A. -- and that is taken from one of the PC statements during the inquest.

Q. At inquest.

A. Yes.

Q. Thank you. The other obviously very important point that is dealt with, to a greater or lesser extent in the executive summary that you have seen of the SUI report, is the issue of the ligature point?

A. Yes. This is the next big issue.

Q. Yes.

A. So within this statement, do you mind if I read it?

Q. I don't mind at all?

A. "It is clear that the ligature point was identified by the Risk Management audit. The staff were not aware of the risks posed by the exposed pipe and bracket as they were not aware that it had not been appropriately secured during the remedial work. It is of concern that the work concluded leaving this pipe exposed. It may have caused staff to develop a false sense of security and making assumptions that all ligature points had been dealt with."

I would like to remind you again of the statements, "The panel concludes that no omission or action contributed to the incident"; I find that very difficult to accept --

Q. Yes.

A. -- considering the statements and the fact that there was the prosecution that followed.

Q. Indeed.

A. The HSE prosecution.

Q. Indeed and, Emma, if we look across at page 51 and paragraph 102 and to the first bullet point there under (a)?

A. May I read that, Rachel, please?

Q. Please do.

A. "A ligature point audit was carried out on the ward. The ligature point was identified and an action plan was developed. Unfortunately this ligature point was not removed as part of the remedial" --

Sorry:

"... as part of the remedial work until after the incident."

Q. Yes.

A. "Unfortunately, my dad hung himself."

Q. Thank you.

A. Sorry.

Q. You take your time.
A. The use of the word "unfortunately" is such a flippant remark. It is utterly disrespectful of the person that died. He may have been just one man to the world but he was the world to me. This statement is quite frankly an absolute insult to my dad and the value of his life.

The language is utterly inappropriate in this setting. We are not talking about an error in a risk assessment in a corporate setting.

Q. No.
A. We are talking about an error in a risk assessment that determines life or death.
Q. Thank you. Staying with this very difficult subject of the ligature point. The other thing that you have picked up from the executive summary of the SUI, looking back to page 50 and to the middle of the page there, is the following statement:

"It is the opinion of the panel that it is impossible to mitigate all ligature points. However, given the determined desire by Mr Peck to take his own life, it is impossible to conclude if he would not have chosen to take his life outside of hospital or by some other method. It is important to note he had made a serious suicide attempt on 22 October 2004 while on leave."

Emma, I know that you have comments on that particular statement.

A. I do. Quite frankly, insulting again:

"This point really highlights the culture and attitude that I was faced with at this time: that he would have probably done it anyway and that I was making an unnecessary fuss over something that would have inevitably happened ... I did not accept this then and I do not accept this conclusion now. It is also a fine example of the Trust brushing over the fact that they allowed someone that they considered a 'high risk patient' to enter a bathroom containing a ligature point that had been identified as a risk, when the 'high risk' patient had attempted to hang himself five weeks prior to this incident.

"It was stated that a 'considered approach to risk was evident' in the SUI report. This does not correlate with the previous statements or the facts and the final outcome."

Q. Thank you. I want to go on, please, to your experience of the inquest into your father's death and we will go through some of the key matters about that. Is it right for me to say that that process, you describe it as harrowing from start to finish?

A. It was as traumatising as when he was in hospital, quite

frankly, Rachel.

Q. Yes. Emma, if you want to follow, I am looking at the top of page 53 and, to summarise the key points, the inquest did not take place until a year and a half later, so May 2006?

A. Correct.

Q. As you have told us already, disclosure of key documents from the Trust to your legal representatives did not take place until an hour before the inquest was due to begin and even then was not complete?

A. Indeed.

Q. The main witnesses, and certainly those that you considered to be the key witnesses, were not called to give evidence at inquest?

A. Correct.

Q. The staff member who was responsible on 4 October -- I am so sorry, 4 December 2004 for conducting the 15-minute observations on your father did not attend because that staff member was on holiday?

A. Mmm, correct.

Q. The Trust was reticent to agree to the attendance of key witnesses?

A. We had to fight for it, my barrister and I. They -- we were at the point of adjournment --

Q. Yes.

A. -- and it was only because I stood my ground --
Q. Yes.
A. -- that it was agreed that the inquest would carry over two days rather than one --
Q. Yes.
A. -- because I had waited 18 months already, they had had 18 months to prepare witnesses.
Q. Yes. We have been through some of this conflicting evidence. What was immediately apparent to you and sticks with you is that the statements and the evidence from those witnesses was conflicting and contradictory?
A. Absolutely.
Q. The inquest was incredibly painful process for you and for your family as a whole?
A. It was.
Q. You felt that you were ignored and, in summary, treated appallingly?
A. Absolutely. I think that that summarises it very well.
THE CHAIR: Can I ask, would the rest of your family agree with that too, they weren't in any way treated differently? So you have a sister --
A. I have a sister.
THE CHAIR: -- and he had a partner, your --
A. He had a partner, yes.
THE CHAIR: Yes.

A. They were in agreement. Well, his partner and I, we do not speak any more but --

THE CHAIR: Right.

A. My sister is in agreement, yes.

THE CHAIR: Thank you.

MS TROUP: One of the things that you have told us is that that process at inquest, which you had been assured would provide you with the answers that to you were and remain now so pressing, but the entire process has caused you anguish -- caused you anguish at the time and continues to do so?

A. I didn't get any closure.

Q. Yes.

A. And I was made to feel once again that I didn't matter. The lack of -- the reticence to actually disclose any documents and the fact that even when they did disclose the documents they were incomplete --

Q. Yes.

A. -- because they apparently contained controversial information that may be damaging to myself and my sister. I still do not know what that controversial material is, but whatever that controversial material was, I could have coped with that a lot better than not knowing because it leaves it open. The wound will never close.

Q. Yes.
A. I will not get any closure because I do not have the full visibility.
Q. Yes. In terms of the conclusions at inquest, you have told us that what you understand to have been concluded is that, in relation to the ligature point we have discussed -- and, Emma, I am looking at paragraph 108 on page 57 -- it was established that a risk assessment had been carried out in June 2004, identifying that ligature point as high risk; that during the evidence a representative of The Lakes admitted that that risk had not been identified in earlier assessments?
A. Correct.
Q. That it hadn't been rectified and that no check had been carried out that it had been rectified?
A. Correct.
Q. And, crucially, that the potential risk it posed had not been highlighted to staff actually working on the ground?
A. That's correct.
Q. Your family, in your view, received nothing more than what you consider to have been a forced apology --
A. Indeed.
Q. -- that the Trust would learn from its mistakes --
A. Indeed.

Q. -- and make improvements to ensure that no such thing happened again?
A. Mm-hm.
Q. You consider those promises, I'm so sorry, to have been entirely false?
A. I do. And to clarify that, sadly three more -- there were three more inpatient deaths and one near miss, and this is just at The Lakes hospital, and this is just through ligature points.
Q. Yes.
A. So it's one hospital, one cause of death --
Q. Yes.
A. -- three more deaths and one near miss following my dad's passing. I think that's proof in itself --
Q. Thank you.
A. -- that changes have not been made and improvements -- they have not learned their lessons.
Q. Thank you. I would like to move, if you are content, to the thoughts you have had and the matters you have set out when asked by this Inquiry what you think should have been done differently in your father's case. You have set that out comprehensively if you turn to page 61 and it is paragraph 114.
A. Sorry, Rachel.
Q. No, go ahead.

A. May I, just going back to the inquest --
Q. Please, yes.
A. -- because I was so desperate for answers, I employed a barrister.
Q. Go ahead, yes.
A. And the barrister represented us on the day and asked questions that we needed answers to.
Q. Yes.
A. I noted the very inpatient manner in which he was treated during the inquest by both the coroner and the Trust. They were trying to make him feel the same way that they had me, that I was making an unnecessary fuss.
Q. I see.
A. During -- following the inquest, my barrister provided me with notes of hearing. Would you mind if I read a little summary of what he put, just because it actually -- it backs up what I believed -- how I had been treated but he, as a barrister, had stated that he found the -- his own finding of the entire process was unjust, that they didn't provide the necessary documentation, they failed to call the important witnesses. He highlighted that the coroner was highly inclined to defend the institution and that this was reflected in the way in which she managed the pre-hearing, in terms of lack of transparency of

evidence, which left us terribly unprepared --

Q. Yes.

A. -- whereas the Trust was in a position to prepare thoroughly. The impatient manner in which she treated him on -- during questioning and her attitude towards the verdict and the questionable selection of evidence highlighted during her summary statement, he had to inform the coroner in the strongest terms possible that she could not wash her hands of the evidence.

So I thought that that was important to highlight because this is the coroner as well --

Q. Yes.

A. -- that now I am being treated exactly the same way.

Q. Yes. Presumably, in terms of what you have told us about the overall effect of the inquest process on you, those matters that you have just talked through significantly contributed to the impression that you have been left with?

A. Absolutely. And I think that's a large part of why I haven't really resolved or come to terms with it.

Q. I understand. Thank you.

A. It's prolonged the grief, Rachel --

Q. Yes.

A. -- for 20 years.

Q. Thank you. Emma, do you feel able at this stage to turn

to the matters at paragraph 114 and the things that you think should have been done differently?

A. Yes, yes.

Q. Thank you. Let's go through those.

A. I would like to state at this moment, I haven't had an opportunity to read all of the core bundles or go through it in detail as yet. I have been too busy doing this.

Q. Yes, I understand.

A. I might add to it, if that's okay.

Q. Of course and you are welcome to do so.

A. Thank you.

Q. Emma, the first point you make is that your father resorted to private mental health care in the first instance; what do you want to say about that, please?

A. I am aware that he had contacted his doctor.

Q. Yes.

A. I am not aware of us being made aware that there were any outpatient services available.

Q. Yes.

A. It seemed -- it would seem quite strange, in this day and age, that I didn't question this but, obviously, it was an unfamiliar landscape for me, we were just trying to find our way through it. But had I have known that outpatient care was available, and I am sure my father

would have chosen that, instead of paying privately because he was a financially astute man.

Q. Yes. For the same reason, your second point is about education for families regarding the care options that are available --

A. Indeed.

Q. -- and about that care itself. You go on to recommend more support and outpatient care to avoid sectioning in the first place?

A. Yes, if at all possible.

THE CHAIR: Do you think that was realistic in your father's case though, where he deteriorated so very quickly?

A. Possibly not. It's difficult to say in retrospect, isn't it? But there were -- if we go back to the period of time, so it was mid-March to July, that's quite a few months where he may have been able to receive outpatient care, which may have helped in -- or at least avoided the rapid decline in his mental health as it did, uncared for, untreated.

MS TROUP: Yes, yes. You go on, looking at the next bullet point, and I think in fact many of these are related to the theme that we have discussed throughout your evidence, this is about more and better communication, both with the patient and with that patient's family.

A. Absolutely. Because the patient quite -- more often

than not in these circumstances, is not in a position to help themselves or to communicate how they are feeling.

Q. Yes.

A. And I also believe that communicating with the family is vital because we know what -- how they present when they are well.

Q. Yes.

A. Someone in a hospital, someone in the hospital, who has seen them poorly, wouldn't have any concept of how they present when they are well.

Q. Yes.

A. So how can they compare it? How can they actually measure how poorly they are?

Q. Indeed, and that's part of the reason, as I understand it, that you made repeated and what became increasingly desperate attempts to be allowed to input into your father's care or at least to be able to give that sort of background, so that there could be an understanding of the man that he was when he was well?

A. Absolutely. It comes -- chimes back to when they said that he had declined therapeutic care --

Q. Yes.

A. -- and that he hadn't engaged. Had they known my father, they would have understood that he would have been sitting listening and taking it all in but he was

not a man to draw attention to himself.

Q. Yes.

A. He wouldn't be here doing this, for example. He was a quiet man that kept to himself, in those terms. So they would have understood that, even if he wasn't engaging --

Q. Yes.

A. -- and being the centre of attention, he would have been listening, Rachel, and he would have been taking it all on board.

Q. I understand. You go on, for reasons that I think are obvious, given the details of what happened, to recommend an improvement in risk management and overall processes, as well as accurate recording of data?

A. Absolutely. I was an IT and programme manager --

Q. Yes.

A. -- and we did -- part of my daily tasks was risk management.

Q. Yes.

A. And it was a very important part of my job, and we are talking about money.

Q. Yes.

A. We are not talking about people's lives.

Q. Indeed. Linking back to the communication point, you go on to say that one of the things that should have been

done differently is more empathy towards both patients and family members?

A. Indeed, absolutely.

Q. Then going back to what you have told us and what you learned about staff shortages, you say that neither therapeutic treatment nor psychiatric care nor observations should be compromised due to staff shortages?

A. If this if they cannot provide those key fundamental parts of the care, they shouldn't be allowed to function, quite frankly. It's setting a false sense of security.

Q. Yes. Inquests, you say, should be held in a timely fashion?

A. Yes. It's very painful that that took 18 months.

Q. Of course. Linking back to what we have just discussed, that family members should be supported during the process?

A. Mmm.

Q. You go on to talk about transparency and that family members should be entitled to honest and transparent information regarding any failures --

A. Yes.

Q. -- not only to allow grieving and closure but to ensure that lessons are learned in a wider sense?

A. Indeed. It shouldn't be a blame culture that we are trying to produce here.
Q. Yes.
A. The key is to acknowledge the failures and to start working towards improving things, so these failures do not continue to happen.
Q. Yes.
A. This is -- it is very evident to me that, to date, over the 20 years, that that has not happened.
Q. Yes.
A. And during the core bundle -- within the core bundle of the April hearings, Paul Scott referred to my father's case and I assume that he took the statements from the SUI executive summary, which we have been through in detail.
Q. Yes.
A. Now, if little old me could see the contradictions within those statements, then surely Paul Scott should have been able to recognise the inconsistencies.
Q. Yes. You point out that there shouldn't be a blame culture which helps no one but that covering up failings, quite apart from preventing the learning of lessons, only increases the distress of a grieving family?
A. It's incredibly insulting. It undermines the value of

the person that has lost their life and the love of the families.

Q. Linked to what we have said about the ward environment, you say that ward environments need to be welcoming and nurturing --

A. Mm-hm.

Q. -- and that there needs to be a solid foundation of communication regarding all plans for leave or transfer or discharges?

A. Indeed.

Q. You consider that family members must be supported and consulted and, at the very least, informed of support and care plans?

A. Yes. We form an integral part of the entire process, do we not?

Q. Yes. You think that the outcome of investigations should be disclosed to family members and, in part, that that would assist in the grieving process?

A. Absolutely.

Q. You consider -- and you have told us that you have this background in risk -- that regular assessments should be carried out to ensure that any findings from investigations are addressed to avoid harm, further harm, to other patients?

A. Yes.

Q. You consider that the hospitals should make a proper apology?
A. Yes.
Q. That families should be informed of their rights from the start and know what to do and who to go to and who to raise concerns with?
A. Absolutely.
Q. You also tell us that you consider that staff need to be better supported to avoid a lack of empathy from emotional burnout?
A. Yes, that's right.
Q. Can we turn, please, to page 64. You have looked very carefully through this Inquiry's Terms of Reference and list of issues and there are a number of points you make there.

One of those is that, if you look at the last bullet point on page 64, the internal investigation -- and, as we have discussed, you have seen the SUI executive summary -- appeared to you to be biased, defensive and not at all to expose truth of what happened to your father?
A. Absolutely. I mean, it omitted key facts that arose during the inquest for instance.
Q. Yes.
A. So that's why I suggested that internal investigations

are not sufficient in such cases and that external investigations from an independent body should be carried out in parallel.

Q. Yes. The other point that I know is crucial to you, and you have mentioned this and you have read some sections of your witness statement about it, you feel incredibly strongly that there ought to be parity between the treatment of physical health issues and mental health issues?

A. Yes, that's very important, Rachel. That's probably the key point for me --

Q. Yes.

A. -- out of all of this, is that none of these failings would have been allowed to occur for 20-plus years and for the deaths to occur as they have done in a physical healthcare setting.

Q. Yes.

A. And I think that the term "parity of esteem" between the two healthcare systems really encompasses everything that we are trying to cover here because, if we have parity of esteem between the two healthcare systems, this wouldn't happen.

Q. Yes. Thank you.

Emma, I think if you take a moment, please, just to consider if there is anything else that you want to

cover, before I ask you, as we have discussed to read, please, the very last section of your witness statement that starts at the top of page 68; are you happy to do that?

A. I am there is one thing I just wanted to say.

Q. Please do.

A. Sorry, I understand, as a Core Participant, that I will never receive the answers to the questions that I have regarding my dad's case because this does not fall within the remit of this Inquiry. Our only hope is that we can bring about long-lasting and meaningful change to mental health care.

THE CHAIR: Thank you.

MS TROUP: Thank you.

I understand that you would like to read from the top of page 68 to the end.

A. Please.

Q. Emma, once we have done that, we will go on to your commemorative evidence about your father?

A. Okay. Thank you.

"At the time of writing this, according to the NHS England website, '1 in 4 adults and 1 in 10 children experience mental illness'. Considering the current political, economic and technological complexities that every individual in the country is facing, cases of

mental health issues are inevitably increasing. Mental health issues are not going to miraculously go away; they are only going to increase in number and severity.

"It is evident that very little has been changed or addressed in the 20-plus years since my dad's passing. Society has moved along a little bit; we now have mental health awareness days/weeks and we discuss mental health a little more openly than we did. We still have a long way to go however, before we accept that mental illness is the same as any physical illness. Sadly, there is still a social stigma associated with mental illness all of these years later ...

"While society catches up, the NHS needs to ensure that its mental healthcare system is at the very least, to the same standard of practices, processes and procedures as the physical healthcare system and that a patient and their families can expect the same quality of care, treatment, transparency and compassion. In order for this to happen, we, the public, need to have reassurance that the Government is no longer going to stick its head in the sand and pretend that this is not happening. It has managed very well at blind-siding and ignoring the catalogue of reports and concerns presented to them to date. If real change is going to occur, it must come from the top down. We need to see a sincere

commitment from the Government to ensure that it is invested both financially and practically. Without this, I fear that any recommendations made by the Inquiry will fall on deaf ears (as they have for the past 20-plus years), lessons will not be learnt, more mental health patients inpatients will die and we will be back in this situation in another 20 years.

"It is blatantly apparent that at present there is an enormous disparity between physical health services and mental health services. It is clear to me as a layman that this is both a cultural and systemic issue that needs to be addressed and I understand that the cultural aspect does not fall within the remit of this Inquiry. To ensure that this Inquiry has not been a massive waste of time, money, work and trauma to the families involved, it must be ensured that recommended changes are acknowledged and acted upon. How can we be reassured that changes have been maintained months, years and decades following this Inquiry? How can we ensure that the evidence to prove this is the case is complete, transparent and accurate? I cannot speak for anyone else, but I do not at present, have any faith that this can be achieved without the support and commitment of the Government to ensure that organisations such as the Trust cannot continue to

manipulate and withhold information to protect its reputation as it has done for decades."

MS TROUP: Thank you. Emma, as long as you are ready, would you like to read the commemorative account you have prepared about your father and, after that, we will see the photographs in the slideshow that you have provided.

A. Lovely.

Hello everyone, my name is Emma and this is my husband, David. I am here today to represent my late father Frederick James Peck, born 22 September 1950, died 4 December 2004 at the age of 54.

David is now older than my father was when he died and I am not too far behind him. I hope that we are lucky enough to spend many more years together with our beautiful children. Sadly, my father was not afforded that opportunity.

I will not be recounting my father's entire history. That was done at his funeral. What I will do today is attempt to give you an idea of the kind of man that he was so that you may appreciate, to some small extent, the depth of our devastation when he died.

So who was Fred Peck? It's strange but this is the part of this entire process that I am struggling with the most, talking about Dad as he was when he was alive.

Coming from a poor background as he did, my dad

somehow managed to accomplish what most would not have. He owned his own business, along with his business partner, Tony. Through grit, determination, long hours, high standards and great customer service, they thrived for over 30 years. They ran a well-respected business and it was earned through honest, hard graft. I can remember on many occasions my dad being unhappy with a car's bodywork and spending the entire day redoing it until it was perfect, knowing full well that he would not charge for the extra hours and materials, just because one minuscule thing was not quite right. That was Dad: honest, hard working and proud.

I would spend a lot of time at the garage so that I could spend time around him. I would watch the customers and friends that popped in just to have a chat. He had a magnetic personality that just drew people to him. He wasn't loud, quite the opposite, in fact. He was a good listener. He had a way with people that made them feel at ease, comforted. They could be themselves around him. It was his personality that brought the business alive and made it thrive as it did.

So as you have probably already guessed, my dad was an old school, hard-working, proud kind of guy that enjoyed the basic things in life. He didn't go out very often, preferring to spend his time at home with friends

and family, with good food and a bottle of wine or two. There was continuous flow of people visiting because they were struggling in one way or another, and they knew that Fred would be there to provide a shoulder to cry on, a sympathetic air and solid advice. There was no discrimination or judgement when Fred was around.

When I was a child, Dad worked long hours and was busy maintaining the house and garden. It didn't stop him from finding the time to spend with me though. We would go for long bike rides and play lots of sports. As a teenager, I absolutely loved doing anything that involved helping Dad and being outside. I loved creosoting the stables, gardening, painting sheds and looking after all of the animals. I think that this is why I am still at my happiest when I am outside, enjoying a long work or working hard in the garden.

He kept himself really fit and loved playing squash, badminton and golf. Because Dad and I had played badminton on a weekly basis for years, when I was at university I thought that it would be lovely for him to teach me how to play squash, the sport that he loved so much. I thought I had my youth and fitness on my side, how hard could it be? I waltzed in there thinking I looked pretty cool in my newly-purchased sportswear. Well, within seconds, Dad had me running from front to

back, left to right, like a bee in a bottle. I didn't even see the first few bullets that he served. What kind of holy hell sport was this?

With a massive grin on his face, he was bouncing from side to side, swishing his racket around and looking like a pro. After 10 minutes of utter torture, I was hot, sweaty and I was feeling muscles that I didn't even know existed. I wanted to wipe the sweatless, cool and collected smug look right off his face, which obviously made him laugh even harder. He didn't make things easy for me just because I was a beginner. He taught me well. He always pushed me to be better. I am so grateful to him for that.

Most people remember Fred Peck from the garage that he and Tony Sharp owned, T&F Motors. It was not just somewhere that people could go to get their cars fixed. It became a refuge for so many people and a social hub. People knew that they could go there, sit in the kitchen, have a cuppa, have a cake and talk about anything and everything.

Most Sundays, my now husband and I would meet Dad at the driving range. Dad would not only practice his technique he would take the time to teach and guide us. One memory that I have is of the three of us going to play our first 18-hole course together. Well, on the

first tee, my now husband, who had not played many times before teed off perfectly. My dad, on the other hand, did not tee off perfectly and, oh my goodness, was he cross. Dad hardly ever got cross. He threw his golf club across the fairway and stropped off like a petulant child. I can still remember the sight of his little bum strutting off into the distance as we stood there not knowing whether to laugh or chase after him. If dad did anything, he did it well and nothing was good enough unless he had done it perfectly.

In his late 40s, he decided to study GCSE law, I have never seen him so animated and enthusiastic. He loved learning and he loved the English language. He was always curious about new words and new concepts. I was so proud of him. He read every one of my essays and my dissertation for my first degree. He was hungry to learn.

My favourite memories with Dad are of us gardening together and talking about plants. We would spend hours walking and discussing the plants that we were growing in our gardens, how we were caring for them, what we had newly learned and considering our plans for what we were going to do next. Walking the dogs was another of my favourite memories. We would walk for hours and just talk, or sometimes just enjoy the silence as we soaked

up the stunning nature that surrounded us, all of the while watching as our springer spaniels swished their tails excitedly and ran in spirals around us.

He also taught himself to play the guitar because he absolutely loved all kinds of music. He would get so frustrated when he couldn't get a chord right because of his "fat, short fingers", as he would say. He stuck at it though and he got pretty good. One of the only items that I managed to rescue from the family home was his guitars. I have given his electric guitars to my son who has taught himself how to play fantastically on his grandfather's Fender. I have given our daughter his acoustic guitar and she is keen to follow suit.

I wish that Dad could be here to hear our son play. I know that he would have loved learning and playing with him. He would be so proud of him. He used to love listening to me playing the piano; he did a very good job of pretending that he enjoyed listening to me playing the clarinet.

As we got older, Dad would visit me every week and I would get to visit him at every opportunity, at work or at home. For that, I have no regrets. I knew how much I loved him and I never took him for granted. We would talk about anything and everything, from our literature, law, culture, travel and politics, we would

set the world to rights over a few glasses of wine. We would never talk about people. That was one of the things I respected the most about Dad: he didn't judge or gossip. That's a rare quality these days.

Dad's love of everyone and everything around him was contagious. He would tell a funny story about something that had happened that day and we would all end up chuckling as he attempted to get his words out through his tears of laughter.

It was the observational love of life and people that made Dad laugh. I will never forget the glint in his eyes while he recited a Billy Connolly story. His smile would fill his gorgeous face and as he struggled to get his breath, his wide smile would shine so bright that you couldn't help but smile and laugh with him. His sense of humour was awesome. He was the most kind, genuine gentle human being that I have ever had the honour of knowing. He was inoffensive to a fault.

Dad first showed signs of depression in mid-March 2004 and his mental health rapidly declined over the next few months to the point where his partner and I found ourselves on 24-hour suicide watch. Worried sick about my dad, utterly exhausted, at my wit's end and in desperate need of professional help, I finally signed the papers to have Dad sectioned under the Mental

Health Act 3 on 20 July 2004. It was the worst day of my life. And the beginning of the end of his.

Leaving him at the hospital that first night was horrendous. I will never forget the look of hatred and disappointment in his eyes as he watched me leave. He never looked at me the same way again. He would try to pretend that he was fine with me but I could see the anger and resentment simmering away under the surface of his smiling face.

Within five months as an inpatient under the care of the Trust, Dad was dead. On 4 December 2004, my dad hanged himself with his shoelaces in the bathroom at The Lakes Hospital while under Section 3 of the Mental Health Act. I went into physical shock for about a month. I had to be prescribed sedatives just to calm me down and I had to take a month off work. If it wasn't for the love, support and patience of David, Tony and a handful of dear friends, I do not think that I would be here today.

I wanted to die with him. I felt like when he died, that so should I. I wanted time to stop. The world should have ended the moment that Fred Peck died. I couldn't get my head around the fact that life continued without him. I was emotionally beaten. The person that I had modelled myself on had killed himself

because I had made the decision to section him. To add to this, as a consequence of the lackadaisical and disrespectful manner in which I was treated by the Trust, I found myself utterly defeated and bereft.

At the time, I was a highly qualified and experienced business analyst and IT programme manager with a great career ahead of me. I gave it all up because I had lost all confidence in myself. The self-assured, career-driven, sociable young lady that I had been sadly died alongside her father.

David and I had a small wedding with just eight people attending. I couldn't face having a big wedding without Dad there. I had to walk myself down the aisle. There was no father of the bride speech or father-daughter dance. He couldn't tell me how proud he was of me or how beautiful I looked in my wedding dress.

Our son was born three years nearly to the day after my dad's passing. My first words upon holding my newborn son for the first time were, "Do you think that Dad is watching?" Our daughter was born just over a year later and oh, my goodness, she is so much like him in character: gentle, kind and considerate at all times.

Every milestone, every joyful moment, every struggle, every birthday and Christmas is gut wrenching

because Dad should be here. He missed watching his eldest granddaughter grow up into the beautiful young lady that she has become. He also missed out on meeting and getting to know the four more gorgeous grandchildren that came after his passing.

My whole identity was based around what my Dad had taught me. He had shown me the person that I wanted to be, which was him. I respected and idolised him above everyone. My entire sense of self dissolved the day that my dad took his own life.

If my dad can still hear me, I want to say that I am sorry. I am so sorry for letting you down. I am sorry for placing my faith in the Trust to treat you with the dignity and respect that you deserved. I am sorry for trusting them to actually do something that could help you in your recovery.

I would have cared for you myself and tried to get you better had I known the truth and the tragic outcome. The worst that could have happened is that you had killed -- the worst that could have happened is that you had killed yourself at home, where you belonged and felt safe, and with a glass of wine in your hand.

MS TROUP: Could we have the photos, please.

(Photo slideshow shown)

THE CHAIR: Can I thank you very much for sharing both your

evidence and also your commemorative memories as well.

A. Thank you.

THE CHAIR: Thank you so much for coming.

A. Thank you.

MS TROUP: Chair, thank you. I understand that we are going to pause now for lunch for an hour and then come back after that for our next witness.

THE CHAIR: So we will say 1.30.

MS TROUP: Yes, please.

THE CHAIR: Lovely.

(12.32 pm)

(The short adjournment)

(1.32 pm)

THE CHAIR: Ms Lea.

MS LEA: Thank you Chair we are ready to hear from our next witness, please may she be sworn in. Thank you.

COSTERD LYNDA (affirmed)

Questioned by MS LEA

MS LEA: Please can you state your full name for the record?

A. My, Lynda Mary Costerd.

Q. Thank you. You are the daughter of Geoffrey George Toms, who was born on 11 May 1927 and died on 14 May 2015 at the ages of 88; is that right?

A. Yes, that is.

Q. You would like me to refer to your father as Geoff

throughout my questions --
A. Yes, please.
Q. -- is that right? And you would like me to call you Lynda?
A. Yes.
Q. Thank you, Lynda. By way of background the Inquiry sent you a written Rule 9 request for evidence on 8 April and you attended an evidence session with the Inquiry team on 10 April.

Following that evidence session, the Inquiry prepared a witness statement for you; is that right?
A. Yes, yes, that's correct.
Q. You have a copy of that witness statement in the bundle in front of you.
A. Yes.
Q. It is 15 pages long and it's dated 20 May this year.
A. Yes.
Q. If you could please turn to the last page of that statement, page 15, we see there a statement of truth and then you have signed the witness statement. Have you had the opportunity to read through that document recently?
A. Yes, I have.
Q. I believe there is one correction that you would like to make?

A. Yes.
Q. If we just turn to that together, please, paragraph 9 on page 3?
A. Yes.
Q. You state there that the events leading to Geoff's admission was that your mother found him trying to put a pillow on his face. In fact, he had asked your mother to put a pillow on his face?
A. Yes, yes, that is right. He asked Mum to hold the pillow over his face, yes.
Q. Save for that correction, is your witness statement true and accurate to the best of your knowledge and belief?
A. Yes, it is, to the best of my knowledge.
Q. As you know, Lynda, that witness statement will therefore stand as your evidence to the Inquiry.
I won't go through it line by line with you today --
A. No.
Q. -- or ask you to read it out?
A. Yes.
Q. But I will be asking you some questions about it.
A. Okay.
Q. Please be assured that the Chair and the Inquiry team have read through the entirety of that statement very carefully and that it will form part of the body of evidence upon which the Inquiry relies.

A. Okay. Okay.
Q. I would also like to acknowledge that you provided a commemorative and impact account in relation to Geoff and that was read by counsel to the Inquiry, Rachel Troup, during the November hearing last year.
A. Yes.
Q. The Inquiry is extremely grateful to you for providing that evidence and your oral evidence today.
A. Thank you.
Q. I would just like to remind you I won't be asking you to name any staff members today, so please try not to do so.
A. No, that's fine.
Q. Your evidence will focus on your concerns in relation to Geoff's care and treatment under the care of SEPT?
A. (Witness nodded)
Q. If at any point you require a break, please just flag that to me and we can pause.
A. Okay.
Q. You state in your witness statement that the events therein come from both your recollection and also reading the root cause analysis investigation report provided to you by the Trust after Geoff's death.
A. Yes, because there was quite a few things that we weren't aware of until that report.

Q. What we will do, we will go through the timeline and key events together now, taken from your witness statement, and I will ask you a few questions along the way. Then we will turn to your other concerns and, finally, your recommendations.
A. Okay.
Q. Please feel free to refer to the statement in front of you at any time --
A. Yes.
Q. -- and I will tell you where we are, as we go along.
A. Okay, lovely. Thank you.
Q. As I understand it, according to your witness statement, Geoff started displaying some symptoms, becoming forgetful and confused, around the end of 2012 when he was 85 years old; is that right?
A. Yes, that's right.
Q. At that point, he had no history of mental illness and hadn't had any contact with mental health services?
A. No, none whatsoever.
Q. He was referred by his GP to the Community Mental Health Team for older people and was assessed on 25 October 2013?
A. Yes.
Q. Is that right? He attended outpatient appointments from November through to February 2015?

A. Yes.
Q. The investigation report notes that your father was seen initially with a moderate depressive episode and that he had memory impairment, vascular in nature, since February 2014, but you would like to point out that actually it was earlier than that --
A. Yes.
Q. -- as you say, it was 2012?
A. It was, yes.
Q. You describe your mother battling for answers and you believe she told you Geoff was finally diagnosed with vascular dementia around February 2015; is that right?
A. Yes, that was right.
Q. You don't think any medication or treatment was prescribed at that stage, perhaps just phone numbers for support services, and your mother was told that people would be in touch about helping with Geoff's care, but she didn't hear anything?
A. Yes. No, that's all she was told. She wasn't really given any information to do with vascular dementia and that type of thing but, yes.
Q. On Friday, 1 May 2015 -- Lynda, I am at paragraph 9, now, if you would like to refer to it --
A. Yes.
Q. -- the Alzheimer's Society called your mother to arrange

for someone to come and see Geoff?
A. Yes.
Q. Your mother explained that he had asked her to put a pillow over his face and that he talked about wanting to die; is that right?
A. Yes, that's correct.
Q. On 5 May 2015, a nurse and a woman from Canvey Island Dementia Services visited Geoff at home. After an assessment, a decision was then made to admit him to Rochford Hospital and your mother was informed that was the only option to keep him safe?
A. Yes --
Q. Is that right?
A. -- that's right.
Q. That was the first time an inpatient admission had ever been mentioned; is that right?
A. Yes, it was. It was the first time. It's the first time that anyone had actually come round to see him, so yes.
Q. At paragraph 12, you tell us that Geoff was on Beech Ward for less than six days from 5 May to 11 May 2015?
A. Yes.
Q. During that time, he sustained severe, somewhat unexplained injuries that ultimately led to his death?
A. Yes, that is right.

Q. According to the Trust's investigation report -- Lynda, if you would like to refer to the timeline, you have set it out at paragraph 29(a) on page 7 --
A. Yes.
Q. -- on Wednesday, 6 May, the day after he was admitted, Geoff fell and was found on the floor of his bedroom at 11.30 pm in the evening?
A. Yes.
Q. Is it right you and your mother weren't informed about that fall at the time?
A. No, we didn't know anything about that.
Q. I know you state in your statement that somebody visited Geoff every day --
A. Yes.
Q. -- whilst he was on the ward, can you recall if it was you or your mother who visited on Thursday, 7 May?
A. We all went on the Thursday, the 7th, because they said they just wanted to have a small meeting, just to tell us what was happening, though all they really told us was that they had taken his walking stick and the walker that he was used to away and given him this other walker.
Q. I think you are referring there to a meeting with two nurses and the physio that we will come on to talk about in greater detail?

A. Yes.
Q. Thank you. On 7 May, the Thursday, can you recall whether Geoff had any visible injuries at that stage?
A. No. No, he didn't, that I could see -- we could see, otherwise we would have been very concerned.
Q. Returning to paragraph 29, at 29(b), you record that on Thursday evening, 7 May, Geoff fell and was found on the floor of his bedroom at 9.05 in the evening. Again, you weren't informed about that at the time; is that right?
A. No, that's right. We didn't know about that.
Q. At some point on Thursday, 7 May, or early on Friday morning early, 8 May, he fell and was found on the floor at 2.50 am and referred to A&E. On Friday, 8 May, staff called your mother to tell her about that fall and that Geoff was in A&E; is that right?
A. Yes, yes.
Q. You say in your witness statement that you were aware of that at the time. Did your mother then telephone you to inform you what had happened?
A. Yes, she did, because they just rang her to say, "If you're coming down to visit, he is not here, he is in A&E". So ...
Q. Do you know what injuries Geoff had at that stage, so on Friday?
A. That was all around his wrist because his wrist became

red and just looked inflamed, a bit swollen at the time. I'm not aware that they gave him an X-ray or anything like that.

Q. Was that after he returned from the A&E visit --

A. Yes.

Q. -- when you then visited later that day?

A. Yes.

Q. Returning to paragraph 29 Lynda, at 29(D).

A. Yes.

Q. On Saturday night, 9 May, at around 9.15 pm Geoff fell and was again referred to A&E but, on that occasion, a paramedic assessed him on the ward and decided he could stay there. Again, you weren't informed about that fall at the time --

A. No.

Q. -- is that right?

A. No, not at all. And, of course, they obviously --

Q. Sorry.

A. -- had some concern because they had asked for regular neurological observations.

Q. Yes. Thank you. On Sunday, 10 May, you visited Geoff as it was his birthday the next day.

A. Yes.

Q. You found him slumped in a Chair with his walking frame on the other side of the room out of his reach.

A. Yes.
Q. His drink had been knocked on the floor --
A. Yes.
Q. -- and he was confused and incoherent?
A. Yes.
Q. You describe that he had a light brown fluid coming out of his nose and it was clear that he had injuries to his face, at that stage --
A. Yes.
Q. -- is that right?
Can you recall what time of day you arrived that day, on the Sunday?
A. I can't. It would probably have been early afternoon.
Q. Do you know what sort of length of time you visited for. It may be that you can't recall, that's fine?
A. No, it would have been at least an hour, hour and a half at least, yes.
Q. Thank you. When you arrived that day, did you know how he had sustained those injuries that you could visibly see?
A. Well, as far as the fluid coming, that was here, I did go and speak to the nurses and they just said, "Oh, we have just given him some medicine, that's probably all that is".
So, yes, the other injuries, even though you could

see his nose was a bit crooked and that, it was hard because he was so incoherent. I was more focused on that side of things.

Q. Yes.

A. And, of course, the first thought was fluid under the nose, that something terrible had happened.

Q. Yes.

A. Then they told me, no, it was just medicine and, even though part of you is like, "Is that really what it is?" But then you couldn't get any answers from them.

Q. Yes. Thank you. According to the Trust's investigation report when care was handed over to the night staff that night, around 9.00 pm on the Sunday, Geoff was unresponsive.

A. Yes.

Q. But they simply hoisted him into a wheelchair and returned him to his bed. It appears nobody checked on him or raised any concerns about why hadn't moved all day. Again, that's something you found out since, when reading that report; is that right?

A. Yes, it is. We found out that, apparently, in the morning, the Sunday morning, he was fighting, he didn't want to get the out of bed and get dressed, so they just dressed him, put in the hoist again, took him down to the day room, put him in the Chair, and then just left

him there and, of course, they obviously all went home, without even bothering to take any note that he was there. The night staff were quite horrified to go in there and check -- I think it was about 10.00 -- and find him still slumped in a Chair.

Q. Yes.

A. Yes.

Q. I see. On Monday, 11 May, your mother and daughter went to visit Geoff and, at that stage, his nose was quite visibly broken --

A. Yes.

Q. -- he had two black eyes, bruising all over his face and his wrist was pink and swollen. In fact, you describe him as looking like he had been mugged --

A. He did.

Q. -- is that right?

A. He did, yes. He really did.

Q. Again, did any member of staff explain to your mother or daughter how he had sustained those injuries?

A. No, they just said they didn't know how it had all happened. And when Mum said about, "He really does need to be seen by a doctor", all they could say was, "It doesn't work like that. You can't just say you want a doctor", the same as they told us previously that they didn't deal with medical conditions.

Q. I would like to touch on that in quite some detail shortly --
A. Yes.
Q. -- but is case that, on the 11th, he was only referred for physical treatment because that's something that your mother and daughter pushed for?
A. I think so, yes, or either that, where he deteriorated so badly that there was no way they could ignore it any longer because, by then, he was -- well, then he was out of his head, really, he was just screaming and shouting, throwing himself around, then he would go really still.
He just -- yes, it was horrible. Really, really horrible.
Q. Just returning to the chronology of things for a moment. So your mother and daughter arrived, saw his injuries. I think you state in your witness statement that, at that point, another patient actually informed them that they saw Geoff lose control of his walker in the corridor --
A. Yes.
Q. -- on 9 May --
A. Yes.
Q. -- and that he fell forwards and hit his face on the cross bar of the walker; is that right?
A. Yes, they said it went across the bridge of his nose.

Q. Is that a detail that the staff ever informed you --
A. No.
Q. -- or your mother about?
A. No, they weren't -- they just said they weren't aware of it.
Q. Moving forwards in time then that day, we know that you and your daughter went to sit with Geoff in A&E, as the nurse accompanying him was going off-duty at 7.00 pm; is that right?
A. Yes, Mum just got a phone call letting her know that he had been taken down to Southend Hospital, he was supposed to be going on to the Acute Assessment Ward but they didn't have a bed so he was going to be left in A&E, and we -- some -- one of us would have to go and sit with him because the nurse was just going to go off doubt. I mean, she went off-duty well before 7.00 because, when we got there, he was in a cubical all on his own because A&E said he wasn't their responsibility.
Q. Is it right that around midnight you asked for help and, after 30 minutes, a nurse eventually came and sat with Geoff, so that you could go home for a little bit?
A. Yes, I mean, Dad was -- he was really lashing out and he didn't -- he didn't have a clue what was going on and, every now and again, one of them would go to me "Are you all right, over there?" And I would go, "No, does it

look like we are?" And this went on for quite a few hours and, in the end, I just went over and said, "This isn't right?"

THE CHAIR: Who was saying "Are you all right over there", one of the staff or another --

A. One of the nurses on A&E who actually work at Southend Hospital, yes.

MS LEA: Just to be clear. That behaviour, the lashing out, the incoherence, you say in your statement that was completely unlike your father.

A. Yes, he would have been mortified if he had have known because, at one point, he actually caught my daughter on the head. He would have been beside himself. But he wasn't in there any more, really, as we now know.

Q. So we know that Geoff was then transferred to End of Life Care, on the sixth floor, and you went to visit him on 12 May --

A. Yes.

Q. -- 2015. I am now at paragraph 34 of your witness statement. A scan on 13 May showed a bilateral subdural haematoma and bleeding to the brain. In other words, he had a severe brain injury?

A. Yes.

Q. Geoff also had a urinary tract infection and his wrist and nose were broken; that's right, isn't it?

A. Yes.
Q. You state in your statement that he died around 6.00 am on Thursday, 14 May 2015 --
A. Yes.
Q. -- is that right?
I think in your witness statement you describe a somewhat stark contrast between the lack of care that you felt he received on Beech Ward --
A. Yes.
Q. -- and then the care that he received during end of life --
A. Yes.
Q. -- and, in particular, after he passed away, the staff were caring --
A. Yes.
Q. -- in relation to allowing him to remain, so that everybody could come and say their goodbyes?
A. Yes, they were -- I mean, the consultant met with us on the Tuesday, they went to tell us that what the findings were and he wanted to do the scan, just so that we would know exactly what had caused him to pass, and also to say to us, really, "We need you to withdraw all treatment, apart from things to keep him comfortable". And the nurses were so -- every time they came in to do something, they talked to him, even though he wasn't

aware of any of it, they was -- they were really lovely up there, yes.

Q. Thank you. Lynda, now that we have been through the timeline of Geoff's involvement with mental health services, I would like to ask you some questions regarding other concerns that you raise in your witness statement.

A. Yes.

Q. I would like to go through thematically in the way that you do in your witness statement. Firstly, I am going to ask you some questions about the ward environment when Geoff was on Beech Ward, albeit I appreciate he was only there for six days.

A. Yes.

Q. You state there wasn't anything in the day room for real comfort or interaction on the ward, in particular you refer to a lack of a television. Would you like to say anything about other things that you would have expected to see?

A. Well, it just seems like that he was basically put in a chair and they would take his walker away from him, so that he couldn't get up and move, so much so they even put him in nappies, which I expect you are going to cover later, even though he wasn't incontinent.

There were some staff but they would either be stood

in a corner chatting to each other or on their phones. So it was okay for the other patients that were mobile because they could get around and wander around but, for Dad, he was literally stuck there and, even if he wanted to eat or drink, he would have had to have gone up to the servery in that room --

Q. Yes.

A. -- bearing in mind he had vascular dementia, so he didn't know any more when he needed to eat and drink.

Q. Yes.

A. Yes.

Q. So, put simply, once he was sat in that chair in the day room, there was absolutely nothing for him to be doing?

A. No, nothing at all.

Q. You also say in your witness statement that the alarm to call for attention in his room was behind the bed, where he wouldn't be able to reach it?

A. Yes, it was literally where the headboard was, the alarm was there, which there is no way he would ever have been able to reach it.

Q. His room was behind two sets of fire doors --

A. Yes.

Q. -- and then it was the nurse's office, so you had concerns about whether anyone would be able to get to him quickly, if anything happened.

A. Yes, especially as the reason they had taken him in there is because he didn't want to be around any longer. So, with my experience from the prison service, the one thing you do when someone wants to commit suicide, you have constant watch on them. But, no, there was nothing at all.

Q. Is that something that you were able to raise at the time or did you not feel able to raise it?

A. It was very hard to find someone to talk to because all they would go to us, "Well, you need to talk to the doctor about that", and, "Oh no, the doctor is not here, we can't just ask him to come along and talk to you".

Q. Yes, you also raised concerns about the mattress next to Geoff's bed, given that he hadn't previously had falls and, in your view, it was a trip hazard, it made it more likely that he would fall?

A. Yes, and that's probably why he had all the falls in the bedroom because it was a proper bed mattress on the floor. So we are talking about someone who is unsteady -- well, not unsteady but has vascular dementia so wouldn't even remember it was there and I think, for any of us, if you wake up to then go and step out of bed and suddenly you are on this springy mattress -- yes.

Q. Was that there immediately when he was admitted, can you recall?

A. I don't know because I was away at the time and I only came back on the Wednesday. So I only saw it from the Thursday and it was there from then.
Q. Thank you. As far as you were aware, the purpose of that mattress was what? Was it if he fell out of bed it was something soft to land on?
A. Yes, yes. That was the reasoning behind it, if he fell out of bed.
Q. Was that something that staff said to you as an explanation as to why it was there?
A. Yes. Yes.
Q. Sticking with risk of falls for the moment. You note in your witness statement that, having read the investigation report, you now realise that when Geoff was admitted, he told staff that he was prone to falls?
A. Yes.
Q. So I would just like to talk about that a little bit, if we can?
A. Yes, fine.
Q. Firstly, that's incorrect, isn't it?
A. Totally.
Q. You tell us in your statement that he didn't have a history of falls?
A. No, he didn't have falls.
Q. Taking this in stages: when Geoff was admitted, firstly,

was anybody with him, do you recall?

A. My mum and my daughter took him in.

Q. Yes.

A. But they just did -- they were only asked to do the brief handover, like, "Here's his clothes, this is" -- he had a lactose intolerance, a quite severe one, so Mum had taken all the bits and pieces of food and Mum would say about the hearing aids and the false teeth. That's all they were ever asked about, and then they left.

Q. Yes.

A. So --

Q. So in terms of any assessments that then took place, they weren't present for those assessments; is that right?

A. No none at all. We were never present.

Q. So, as far as you are aware, when he reported that he had a history of falls, there was nobody else there from the family to be able to correct that?

A. No, no, none of us were there.

Q. Do you know if he had any sort of capacity assessment when he was admitted, as to whether or not he had the capacity to be giving that history or if family members needed to be consulted?

A. No, not aware of anything like that being done on him.

Q. So just to be absolutely clear. You first found out

that he reported that history of falls when you read that investigation report?

A. Yes, yes.

Q. Thank you.

A. When he went in, he used to walk with one of those three-wheeler ones.

Q. Yes.

A. And he was like a little demon everywhere, but they told Mum she wasn't allowed to take it in for him because it would get lost, so he went in with his walking stick.

Q. Yes.

A. And what they said, apparently, was that that was not good enough, so they gave him one of those cage-type ones, which he had never used before in his life, all without any input from us or anything.

Q. I think it's right, isn't it, you say in your statement, that he really wasn't comfortable using that walker --

A. No.

Q. -- without the wheels?

A. No, and I think it actually said they were supposed -- he was supposed to have someone with him.

Q. Yes.

A. Yes, but he you never saw anybody with him.

Q. Turning, if we can to your next concern, you have touched on it a little already, and that's in relation

to whether or not Geoff's basic needs were met while he was on Beech Ward. You state in your witness statement that his hearing aid and his dentures were lost with no attempt to replace them for four of five days, during which time he wouldn't be able to hear or eat properly.

Firstly, do you know if a property form of any kind was completed when he was admitted?

A. I honestly don't know. But the way how blasé they were around it, I would say not, because they were just more like, "Oh, really? Oh, well".

Q. Do you know when he lost those items?

A. No.

Q. No.

A. It was only as he got worse, I think, that then we noticed that those weren't there. I mean, because it was such a short time, I think you always think someone is going to have a couple of days settling in time, while all the staff work out what's going to happen and everything else, and I suppose that's what we were waiting for.

Q. Were they ever found and returned to him?

A. No. No. They weren't. Everything -- his clothes and everything were all gone.

Q. Were you ever provided an explanation as to what had happened to them?

A. No, they just went, "Oh, they must have got lost when he was being moved, or something", and that was it.
Q. His dentures, did he wear them in the day and then not in the evenings?
A. Yes, he would take them out of an evening, but yes.
Q. Was that the same with his hearing aid?
A. Yes, he would take his hearing aid off at night, yes, but also as well, because of the vascular dementia, then you would have to often remind him that he needed to put them in and the hearing aids on.
Q. Yes.
A. Because he had deteriorated so much in that way, hence why, in the lucid moments, he was so unhappy.
Q. Thank you. You have told us a little already about the food that your mother took in for him because he had a dairy allergy and lactose intolerance.
A. Yes.
Q. You explain in your statement that your mother was asked to put all of those things in the fridge?
A. Yes.
Q. After Geoff died when, she went to collect any items that remained --
A. When I went to collect them, yes.
Q. -- they were all still there?
A. They were. Everything, the biscuits, everything that

she had taken in, were all still there in their packages.

Q. Do you know whether he was ever offered any of that food?

A. No.

Q. You don't know?

A. I don't know. You never -- whenever you went, there was never anything by the side of where they had left him to even make you think he had had some food. All you would see is like one of them plastic cups of water, which nine times would be knocked over, or something, because he was at that stage, if you didn't say to him, "Right, Geoff, you need to eat now", and then you would have to convince him he needed to eat because, in his mind, he had either just eaten or he didn't need to eat, and the same with the drink.

THE CHAIR: Did you ever expressly say to them, "You need to encourage him to eat and help him to eat"?

A. Yes, Mum told them all of that.

THE CHAIR: Yes.

A. But, as I say, they was just, "We don't deal with medical problems". That was their go-to answer.

THE CHAIR: Did you ever see him eat while you were there?

A. No, never.

THE CHAIR: Did your mother ever see him eat?

A. Not that I am aware of.

THE CHAIR: Thank you.

MS LEA: Just following on from that point, you explain that, actually, after a few days, you could see Geoff's pacemaker because, in your view, he was becoming so malnourished; is that right?

A. Yes, yes.

Q. You have already explained to us that he couldn't get to the serving hatch unassisted and that, often, he had to be reminded to eat and drink. Was there ever a response to you raising that as a concern? You just said it was raised as a concern that he needed to eat and drink?

A. No, they just said -- well, he was probably offered or I think there is even one note somewhere where he drank a cup of tea.

Q. Thank you. I am going to ask you now about your concerns in relation to Geoff's observation levels on Beech Ward.

A. Mm-hm.

Q. You state that, obviously, because he was admitted with suicidal thoughts they should have kept a close eye on him?

A. Yes.

Q. According to the investigation report, he should have been on level 2 observations --

A. Yes.
Q. -- but you personally never saw anybody observe him, essentially?
A. No, and from where his room was located --
Q. Yes.
A. -- it was not where you would put someone that needed to be on observations.
Q. Yes. Did you know at the time that he was on level 2 observations or indeed what that meant?
A. No. No. I say no one actually spoke to us about any of it. As I say, we was -- because we were thinking, right, okay, he is in there. Not always good on a weekend anyway, because of everything going on, but come Monday, that's when we hoped everything was going to start then. But on Monday, it was too late.
Q. Thank you. Just moving on to some further concerns in relation to staff. You say in your witness statement, and this follows a point you made earlier, that the whole ward seemed to run on little or no interaction with patients and when you saw them they were sitting in the office having a chat or on their phones.
Can you just describe the office to us; was it a glass box type office --
A. No.
Q. -- or was it a room?

A. They couldn't see the day room from the office, no. They wouldn't have been able to see it.
Q. Was it an office with a normal door, or a door with a window.
A. Yes, just a normal door.
Q. Normal door?
A. Yes.
Q. Were there any windows from the office through to the ward?
A. No.
Q. No. So when you saw staff sitting in the office having a chat on their phones, was that when the door was open then, presumably?
A. Yes, but there would sometimes be -- I don't know whether they were auxiliary staff, you would find a couple them were just stood in the day room having a chat, or something like that, which was, I suppose for the other patients that were mobile and able to have conversations, and everything else, I suppose they could have gone up and spoken to them.

But where, as far as Dad was concerned, it was literally, and it always was in the same seat they put him, which was tucked over on the side, so he would be put there, and his walker would be put over there, up against the wall, and that was where he would be left

all day, as we now know.

Q. Yes.

A. Yes.

Q. Just one further point on the mobile phones. Were staff in the office on their phones or were staff on the ward also on their phones?

A. You would see the staff on the ward. As far as the office went, because of course, as soon as you came to the door, then they would turn round and look at you to see what you wanted. But, yes.

Q. Do you mean physically on the phone or do you mean, what is the norm now, scrolling on social media?

A. Yes, yes.

Q. Turning to the deliberate steps that you say staff took to keep Geoff immobile, and you say in your statement that you really do think that was to make their lives easier.

A. Yes.

Q. You have touched on some of these already: obviously, he was given a walking frame without wheels?

A. Yes.

Q. He wasn't permitted to have his own walking frame, the reason given: because it would get lost?

A. Yes.

Q. When he was sitting in the day room, as you have just

described, his walker was placed nowhere near him?
A. Yes.
Q. They used a hoist to move him around?
A. Yes, if he didn't want to go, then they would just put him in a hoist and physically take him down there and leave him.
Q. You state that he was in nappies, even though he wasn't incontinent?
A. Yes.
Q. You just touched on that -- sorry.
A. Yes, he was. He was never incontinent. He was more than capable, as long as he gets his walker, of course, to go and take himself to the toilet.
Q. Are you aware whether they did an incontinence assessment or not, at all?
A. No, no.
Q. You describe a specific incident where your mother and daughter were visiting and Geoff said he needed to use the bathroom. He was told, "It's okay, you've got a nappy on"?
A. Yes.
Q. And then they took him to his room, pulled the nappy aside, and the nurse was trying to collect the urine that way?
A. Yes, what happened was he would say he wanted to go to

the toilet, really wanted to go to the toilet, so my daughter walked up to the nurse or -- and said like, "He really needs to go to the toilet", and they just went, "He's got a nappy on, he doesn't need to". So I was smiling because this is Dad being Dad, so he was back in the room, laying on the bed and he literally pulled his nappy off and then started weeing while a nurse was trying to catch it in a cup.

Q. Thank you.

A. Yes, but, no, they flatly refused. He wasn't allowed access to toilet because there was no need.

Q. Just to be clear, when he was at home, he was using the bathroom at home?

A. Yes, yes. Always.

Q. Just further on staff. You state that, after Geoff died following the investigation, the Trust recognised there were problems with staffing, that there weren't enough permanent staff, so people didn't know what was happening on the ward and they said to you they won't let that happen again, but you didn't feel confident in that --

A. No.

Q. -- is that right?

A. No confidence whatsoever. They didn't even know what rooms anybody was in. There was no numbers on bedrooms,

nothing. They didn't have a clue.

Q. Would you like it say anything else about your concerns in relation to staff, in particular qualifications?

A. Yes, I think it all comes back to this same -- we talked again that they are not there to deal with, like, health problems, but they didn't even deal, in any way, with his suicidal thoughts, which I know weren't there all the time because of the vascular dementia, but no concern. It was purely like it was a paper exercise. Take him there, they have done their bit, put him in a room and that's it, job done. And make it as easy as possible on themselves, which someone, like, in dad's position at that time, vascular dementia, there was nothing he could do about it --

Q. Yes.

A. -- because they had taken away any means he had of looking after himself, which he was still capable of doing.

Q. Yes.

A. He had to be reminded about different things, and so much he forgot. But he, with Mum's prompting and that, he could still go out there and do the washing-up. Okay, the washing-up was of no use, it would have to be done again, but he would go and do it. And they just took everything, everything away from him. They just

totally de -- yes, it was horrific because my dad was very proud, funny man.

Q. Yes.

A. Yes.

Q. When you referred a moment ago to medical conditions and physical health concerns, are you referring to pre-existing conditions that Geoff had --

A. Yes.

Q. -- and also to the injuries, obviously, that he sustained and that malnourishment that followed?

A. Yes, at the time, it was more about the pre -- the conditions he already had.

Q. Yes.

A. I mean, he was on because -- he had stents fitted and that, so he had bits on that. But it was like one of the staff even turned -- one of the nurses, I think it was one of the head nurses -- even turned round and one day, "Pfft, I don't even think he's got dementia".

And that sort of said it all, really, because it was as though, I think a lot of people with dementia can hold a conversation with someone but it doesn't mean what they are talking about is right because you don't know that person.

Q. Yes.

A. And that's obviously what had been going on and they

just took it as carte blanche and took no notice over the fact that he had vascular dementia and, from what I understand on that weekend, in particular, none of the staff on that ward were anything whatsoever to do with that ward.

So, therefore, that was their responses to why nothing had been done because none of them were aware of anyone's requirements or what needed doing, or anything else.

THE CHAIR: Remind me it was a specialised older people's ward, wasn't it?

A. It was a specialised mental health ward.

THE CHAIR: But not necessarily for older people?

A. No, no, not necessarily for older people.

THE CHAIR: Thank you.

MS LEA: When you referred to the fact that Geoff had stents fitted -- so you were asking for him to essentially have his heart checked over, were you, and you were just told, "Well, no, we don't deal with that here", we are to do with mental health.

A. Yes, and the vascular dementia side of things. They weren't there to deal with that.

Q. You state in your witness statement that you don't believe Geoff received any rehabilitation or therapeutic care because you could visit when you liked, there were

no plans in place for him to have any sessions?
A. No, and he was always in that Chair.
Q. So as far as you were aware, there was no treatment of that nature --
A. No.
Q. -- during his six-day admission. You told us earlier that the only care plan you were aware of followed the discussion with the physio and the two nurses and that was in terms of his mobility and what walking aids he might need; is that right?
A. Yes, yes. That was the only assessments we were ever told about but, of course, they did that by asking him the questions and, even when we went, "Well, he's not used to one of those", they would just like say, "It's okay, because someone will always be with him", which of course they weren't.
Q. In your witness statement, you go on to say that you as a family weren't consulted about Geoff's care and treatment at all --
A. No --
Q. -- is that right?
A. -- none whatsoever.
Q. In terms of the falls that Geoff had and what you were informed, as we discussed at the outset of your evidence, you were only told about one fall by staff

members.

A. Yes.

Q. That was through a call to your mother; is that right?

A. Yes.

Q. You found out about another fall from another patient --

A. Yes.

Q. -- as we heard. Those other two falls, the Wednesday and Thursday night, how did you come to learn of those; was it through the Serious Incident Report after he died?

A. Yes, through the report, that there were so many things, like, what had happened, Sunday night and everything, we found out all through their report that we asked them to carry out.

Q. Is it right that you still remain unclear what injuries he sustained from which falls?

A. Yes. Again, because it's such a short period of time, it's hard to say what happened when or how.

Q. Yes. I am going to ask you some questions now about the complaint that you made in relation to Geoff's care and treatment after his death.

A. Yes.

Q. You state -- I am at paragraph 36, if you would like to take a look at it.

A. Yes.

Q. You state that around three months after Geoff died someone from the Alzheimer's Society called your mother and she raised her concerns regarding Geoff's care, which prompted them to then recommend that she submit a complaint and they explained how to do it.
A. Well, what they actually rang for was to see if Mum needed them to come and visit Dad --
Q. Right.
A. -- who had already, of course, passed away three months earlier.
Q. Yes.
A. So Mum explained all that to them and, then, yes, she is the one that said about, "You need to submit a complaint".
Q. We can see from the investigation report that you and your mother submitted that complaint on 24 September 2015?
A. Yes.
Q. You state in your witness statement you feel that complaint just wasn't taken seriously and that it got you nowhere. Would you like to say any more about that complaint in terms of why you feel your concerns weren't taken seriously?
A. Their whole -- when they informed us of the findings, it was all excuses, like, "That weekend it was all staff

that didn't -- you know, we need to stop doing that, having staff on, there needs to be someone more who knows the ward over the weekend"; about there being no numbers on the door, and you think "That shouldn't be right, everyone should know where something" -- so it wases all just answers like that, like platitudes, really. That's all they were.

Nothing was ever taken, I felt, really seriously.

Q. Turning then to the Trust's investigation into Geoff's death, is it your understanding that that only came about because of your complaint?

A. Yes. Oh, yes, there had been nothing done prior to that.

Q. You state in your witness statement that an investigation report dated 15 January 2016 was sent to you, alongside a letter dated 29 January 2016, providing some further responses to concerns that you had raised. You felt the findings were worse than you even thought --

A. Oh, yes. Mmm.

Q. -- and at a final meeting, the Trust recognised there were failures but they responded to you as if they had addressed all of those problems --

A. Yes.

Q. -- is that right?

A. Yes, that was really their answers, "Oh, yes, that was -- but it's okay, we have already told people they have got to start doing this and we are going to make sure that happens".

Yes, there was no real ownership of the fact that something was seriously wrong. None whatsoever.

Q. Very briefly, you set out some of the problems that that investigation identified at paragraph 44 of your witness statement. I will just go through a few of those. Geoff was identified as at risk of falls but the detailed falls risk assessment wasn't undertaken and falls prevention equipment was not offered or used?

A. Yes.

Q. It's unclear how he sustained further bruising to his face, swollen wrist and fractured nose. The investigators in fact questioned whether he had another fall that was unwitnessed and unreported?

A. Yes.

Q. Would you like to say anything further about that?

A. I would have doubted it because that fall was on the Saturday night. On the Sunday morning, Dad was -- obviously there was something seriously wrong. He didn't want to get out of bed, as we found out later, but they dressed him, put him in the hoist, taken him down to the day room, put him in the Chair, taken the

walker away and he was still sat in that Chair 10.00 at night when staff realised nobody had been anywhere near him or done anything with him, and he was totally incoherent by then. Their excuse was he was sleepy and that was it.

So there's no way he had another fall because he hadn't been able to even move from that Chair. Mmm.

Q. You state in your witness statement that, following the investigation, an action plan was drawn up but your view is that it was without substance or urgency and you didn't think that it represented a proper attempt to address the serious findings of the investigation; is that right?

A. No, part of one of my previous jobs was doing audits and action plans, and this couldn't even be classed as an action plan. There was nothing that was -- it was all just wishy-washy, nothing that would -- it wasn't even worth the paper it was printed on really, and they were then supposed to update me as each thing was completed. But I never heard anything else from them, and I think it got to the point where there is only so long you can fight and it was just all-consuming and the anger and, yes, and I think it makes you wonder, when you know they are not taking any of it seriously.

I mean, that's -- I don't get how they can't take

something like that seriously. But, yes.

Q. Thank you. When you say they were supposed to update you, you refer in your witness statement to promises that they made to you. Is that in relation to that they were supposed to say what action plans were taken on what dates and to confirm --

A. Yes, they were.

Q. -- that everything had been done, essentially?

A. No, no.

Q. Finally, there wasn't an inquest into Geoff's death; is that right?

A. That's right. I mean, initially, when we put in the complaint, it had actually been given to the Ward Manager of that ward to carry out the investigation. It was only the fact that someone higher up must have thought, "Oh, that's not good", because of what had gone on. So they then appointed someone higher up to go and do the investigation.

Q. Yes, who was more independent?

A. Yes. Yes. They were still part of it but, yes, they were -- yes. So it just shows that, at the beginning, it wasn't even taken seriously, just to ask the Ward Manager to address such -- what had happened, such horrific things, really, that you can do that to someone in six days, for someone to walk in there under their

own steam on the Tuesday, and then have to be taken out of there in an ambulance and never able to have a talk or anything with anyone again because, by the Thursday, he was gone -- well, he was gone really, anyway. He was just waiting for the rest of his body to catch up.

Q. Thank you, Lynda. Finally, I would like to ask you some questions about your recommendations for change. It may be that you feel you have covered everything that you would like to in respect of them but I would like to give you an opportunity to comment further if there is anything you would like to add.

Sorry, I will pop them on the screen, Lynda.

A. Yes, okay.

Q. Amanda, please could we put up paragraph 50(a) on page 14.

Lynda, please do go ahead, if there was something that?

A. Yes, no, I think, having read other people's witness statements and everything, even from my own, there just seemed to be a common theme of "Ah, the staff, they weren't really the staff that should have been on there", or it was all about no one actually having -- no one knew what they was really doing and this was seen to be the excuse across the board, "Oh, we had a shortage in staff or they was all on holiday, so we got all these

people to come and do it instead, and they obviously didn't read the notes, or whatever". That isn't good enough when you are putting someone's life in their hands and they are taking that person, who they are supposed to look after. Yes.

And I think there is a lot of other things sort of like the technical things of the assessments that should be carried out, and everything else, but I think that or most of it comes down to the fact you haven't got the staff in the first place that want to do -- or are competent enough to do those type of things, because without those systems in place, you can't do anything. And the fact that they are more than happy for this to keep going on like it has done, I mean, I was unaware initially about the Inquiry but, when I saw -- because I think everyone -- you always think, "Oh, it is only you, it's only happened to you, they was unlucky".

But then, when you see how much has gone on and the fact that they don't keep a lot of records and everything, so they are more than aware what's happening but they don't -- I don't know. It's like they don't want to really do anything because they have more successes than they have not.

But that's not the point. Everyone should -- if they're taken into their care, families should be

assured that their loved one is going to get the attention and help that they need. Otherwise, why take them in there?

Dad -- Dad didn't necessarily have to go in, I don't think, because, yes, he had vascular dementia, so the chance of him actually ever being able to do anything to himself was slim to none. So that was just, I think, as well, an easy out for them. But when he was in there, they should at least be monitoring him and talking to us about what they thought we could do with him because that wasn't really the environment, we now know, he should have been in. It was totally detrimental to him.

I mean, when my mum went back on the Wednesday, he had packed all his bags, had his coat on and he begged Mum to take him home because he just said, "I am so unhappy and they're not looking after me".

So now, of course, my mum has that --

THE CHAIR: Guilt.

A. -- to live with as well. But, yes.

MS LEA: Lynda, you have just covered your first two recommendations and, in fact, I think you have touched upon the third and that's -- Amanda, we are at paragraph (c) now, if we could just turn to that.

You say:

"It often seems that problems are blamed on a lack of money."

You refer to staff shortages.

A. Yes.

Q. So is that what you are referring to there?

A. Yes, that it is. It is all part and parcel of it all. It's cheaper to get, like, an auxiliary. I mean, I'm not putting down auxiliaries or anyone but you need people who are aware of those people's cases because they have such complex needs that they need people who know them and can help, are there to actually help or assist in any way and, not to even talk to the family about it.

See, if it -- because, again, I keep saying, because it was such a short time, I think we all know, you go into hospital, it will be a while before anything really happens because you have got the weekend and you have got this happening and I suppose we thought that as well. Because he had gone in and he had seen this and that and the doctor wasn't available. But, no, too late.

MS LEA: Thank you Lynda. Lynda, that concludes my questions for the moment.

Chair, do you have any questions?

THE CHAIR: I have no further questions.

MS LEA: We are going to take a 10-minute break to see if there are any further questions for you Lynda, if there are no further questions, then we can let you go and that will conclude your evidence.

A. Thank you.

THE CHAIR: Thank you so much for coming to give us evidence. You have done it very clearly, we have heard you loud and clear --

A. Thank you.

THE CHAIR: -- and you have made us aware of all sorts of things that I am very pleased to have heard about, so thank you.

A. That's okay. Thank you for listening.

MS LEA: Lynda before you leave the witness box, I would like to display your photograph for a few moments please.

Amanda, can we have the photograph on screen. Thank you.

(Photograph shown)

A. He was so proud then.

THE CHAIR: Yes, look at him. Is that your wedding?

A. That was my second wedding.

THE CHAIR: Lovely.

A. You can see by his smile. He loved his girls.

THE CHAIR: Look at his lovely tie.

A. Yes. Thank you.

MS LEA: Amanda, please can you take down the photograph.

Chair, if there are no questions, we will resume 10.00 am on Monday, for the final day of this hearing where we will hear from three witnesses, Jane Maier, Emma Cracknell and Catherine Peck, followed by a closing statement from Counsel to the Inquiry, Nicholas Griffin, King's Counsel.

THE CHAIR: Thanks very much indeed.

(2.33 pm)

(A short break)

(The hearing did not reconvene)

(2.35 pm)

(The Inquiry adjourned until 10.00 am on Monday, 14 July 2025)

I N D E X