Monday, 7 July 2025

(10.02 am)

Opening statement by THE CHAIR

THE CHAIR: Well, good morning and welcome, everyone joining us today, both here in person at Arundel House and following these proceedings virtually.

The work of the Lampard Inquiry continues apace. Much of this work occurs between public hearings and out of public view and Counsel to the Inquiry, Nicholas Griffin KC, will provide an update on the progress of the Inquiry's work during his opening statement later this morning.

I wish to take this opportunity today to speak further about my role in conducting this Inquiry.

The Lampard Inquiry is governed by the Inquiries Act 2005 and the Inquiries Rules 2006. This legal framework is intentionally flexible to allow for Chairs of all public inquiries to run their inquiries in the best way possible to meet their unique subject matter, scope and Terms of Reference.

I, as Chair, have wide discretion as to how the Lampard Inquiry will operate. Our Inquiry is different from other public inquiries, our subject matter is distinctive, ours being the first UK public inquiry into mental health care and we are investigating a wide range

of issues over a long period of 24 years.

The differences in scope between public inquiries mean that, on occasion, I may not adopt the same approach as others. At times, the Lampard Inquiry will do things differently to other public inquiries and this should be seen as a strength in our process and not as a failure. It means that I have chosen, with care and consideration, a particular approach because I believe it to be the best and most effective way to meet my duties under the Inquiries Act 2005 and the Terms of Reference for this Inquiry.

This Inquiry will be investigating the death of mental health inpatients in Essex between 2000 and 2023. The core purpose of this Inquiry is to find out what happened, to undertake a thorough investigation of the systemic issues and failings.

After this investigation, I will publish a report outlining the key facts, evidence and my analysis, along with my findings and my recommendations for impactful change.

I am focused on this Inquiry leaving a positive legacy of change for mental health inpatients. This Inquiry is here to understand what happened in Essex so that I can make recommendations to help ensure that the same failings do not happen again.

I remain mindful of the developments occurring within mental health inpatient care, within the NHS more widely and within Government. Just last week, on 3 July, the Government published its 10-year health plan which sets out the Government's vision for healthcare over the next decade, which includes planned changes that will inevitably impact mental health inpatient care and oversight.

I will ensure that, at the time that I make my recommendations, those recommendations are applicable to the most current systems, structures and setup, so that the changes I recommend are as implementable and impactful as they can be.

As Chair, I act independently. Because public inquiries are inquisitorial rather than adversarial, there are no sides for me to take in this Inquiry process. As Chair, I must consider the views from the whole spectrum of Core Participants and interested parties. The Inquiry's independence is not only from Government and those that are the subject of this Inquiry but also from all participants. I must, and I will, consider and treat all interested parties fairly. They must all have a voice in these proceedings. I cannot favour or promote the interests of any one party or participant or group of participants

over another.

As Chair, I must be fair, independent, and transparent in my actions. I give careful consideration to the views of Core Participants on how the Inquiry is to be conducted and I am grateful for the submissions which were provided to me following the April hearing. I have directed my team to take forward certain matters raised in those submissions.

Understandably, some Core Participants have firm views on their preferred way for the Inquiry to be run. I do not seek or wish to cause frustration or distress for participants by the way in which this Inquiry is conducted but differences in opinions and expectations may make it impossible for me to satisfy everyone participating in this Inquiry at all times.

Furthermore, the Inquiries Act and the Inquiries Rules do set out certain requirements for the conduct of an inquiry. In particular, it is a requirement that in making any decision as to the procedure or conduct of this Inquiry I, as the Chair, must act with fairness, and with regard also to the need to avoid any unnecessary cost. For these reasons, the decisions I make on the conduct of the Inquiry may not always align with the views expressed by participants. This should not be seen as a dismissal of those views, which

I will have given careful thought to, but it is a reflection of my wider duties and considerations as Chair.

I will, of course, keep the Inquiry's processes under review and I will listen to the submissions of its Core Participants and those engaging with it. That includes the matters raised in submissions provided after the Inquiry's last hearing, about which Mr Griffin will say more in his opening statement.

Ultimately, the decisions on how to conduct this Inquiry are mine and mine alone. I feel the heavy weight of this responsibility but I have always and will always continue to make decisions that I truly believe to be in the best, most efficient and effective way for this Inquiry to fulfil its Terms of Reference and to enable me to make recommendations for long-lasting and impactful improvements to the care of mental health inpatients.

To end, I shall say a brief word about the duty of candour. In order for this Inquiry to fully understand what happened, why it happened and to make meaningful recommendations for change we need those responding to our requests for information and asked by us to give evidence to do so with complete candour. Candour is not about responding to the Inquiry's request with the

minimum effort possible. It's not about waiting until being pushed and chased by this Inquiry before sharing all the relevant information or documents.

Candour is about admitting where things went wrong. It is about open and honest sharing so that the Inquiry can learn the lessons that will improve mental health care. It is about putting the public interest first over and above personal reputations and organisational interests. Those asked to provide evidence owe it to this Inquiry, to the public and, most of all, to the bereaved families to be fully transparent, even if doing so is to the detriment of themselves or their organisations.

I say it again and I will continue to say it throughout this Inquiry, I will accept nothing less than full candour.

Thank you. I will now hand over to Counsel to the Inquiry, Nicholas Griffin KC.

Opening statement by MR GRIFFIN

MR GRIFFIN: Thank you, Chair.

This is the Lampard Inquiry's fourth public hearing. In September and November last year, the Inquiry heard powerful and deeply moving commemorative evidence from the families and friends of those who died whilst receiving mental health care from trusts in Essex. In

April and May this year, the Inquiry heard its first tranche of evidence relating directly to its Terms of Reference. Given the stage that the Inquiry had reached and in light of the substantial volume of material that had been received just prior to the hearing, the April hearing was introductory in nature, setting out background and contextual matters. The Inquiry heard some very important and thought provoking evidence from which there emerged common themes and clear lines of inquiry.

In this hearing, however, the Inquiry will hear evidence of a different kind. Over the course of the next week or so, the Inquiry will focus solely on hearing evidence from some of the bereaved family members concerning the deaths of individuals under the care of the South Essex Partnership University NHS Foundation Trust or SEPT, North Essex Partnership University NHS Foundation Trust or NEPT and Essex Partnership University NHS Foundation Trust or EPUT. This hearing provides a crucial opportunity for the Inquiry to hear from those at the heart of its work: the families who have been directly impacted by these deaths.

The evidence shared during this hearing will also help to guide the Inquiry's work and to ensure that

families' concerns, experiences and unique insights are at the core of the Inquiry's investigations. The evidence received and heard will form a key part of the Inquiry's ongoing investigative process into those deaths. We are extremely grateful to all of those who have provided witness statements for this hearing and for their courage in sharing the dramatic details surrounding their family member's death.

In both this opening statement and throughout the next week, the Inquiry will be referring to and hearing about matters that will be distressing and difficult. We will be hearing disturbing evidence about individual deaths and experiences. The details may be deeply painful as they will also resonate with the trauma, grief and loss suffered by many of those who are here today or watching online.

Indeed, after this opening statement, we will be hearing from Ben Jackson and Adam Rowe about their and their families' experiences in connection with the deaths of Ben's brother, Ed, and Adam's mother, Mandy.

At the start of each day and evidence session we will briefly summarise the evidence that will be heard in order to give those attending, watching and listening the opportunity to decide whether or not they wish to, or indeed are able to, engage with that evidence. The

timetable for this hearing is also available on the Inquiry website. As I have said, people attending or watching remotely may find some of the matters I am going to talk about and that we hear evidence about distressing.

Before I go any further, I would like to make clear that emotional support is available for all of those who require it. The well-being of those participating in the Inquiry is extremely important to the Inquiry. I would like to be clear that anyone in this hearing room is welcome to leave at any point. We have two support staff from Hestia, an experienced provider of emotional support, here today and for each day of this hearing, and there is a private room where you can talk to Hestia support staff if you require emotional support at all times throughout this hearing.

The Hestia support staff are wearing orange lanyards and orange scarves and are raising their hands; or if you want to, you can speak to a member of the Inquiry team and we can put you in touch with them. We are wearing purple coloured lanyards.

If you are watching online, information about available emotional support can be found on the Lampard Inquiry website at lampardinquiry.org.uk and under the "Support" tab near the top right-hand corner. We want

all those engaging with the Inquiry to feel safe and supported.

The role and remit of the Inquiry is to investigate mental health inpatient deaths. It's not the role of the Inquiry to intervene in clinical decisions for current patients or to act as a regulator or in the role of the police. However, the Inquiry has a safeguarding policy and takes safeguarding matters seriously. Where we receive any information which meets our safeguarding threshold, we will pass it on to the appropriate organisation. This is something which has been done since the Inquiry was established and which we will continue to do.

I, Chair, am assisted at this hearing by members of the Counsel to the Inquiry team, Rachel Troup, Kirsty Lea and Kyan Pucks. They have been working very closely and directly with bereaved families and, where applicable, their legal representatives, particularly in advance of this hearing.

As I have mentioned previously, the counsel team also works closely with the Lampard Inquiry solicitor team under Catherine Turtle. We also work closely with the Secretariat Team and the Inquiry's Engagement Team, who are part of the Secretariat, and with whom many of those engaging with the Inquiry have been in contact.

I want to be clear that my Counsel to the Inquiry colleagues and I have been instructed by you, Chair, to assist you in your important task. We are part of the Inquiry team working for you. As you have explained during the course of your opening statement, we are independent from all other organisations and individuals involved in this Inquiry and we must be very careful to ensure that we remain so.

I would also like once again to introduce the lawyers who are representing Core Participants.

Representing first bereaved families and those with lived experience: Bates Wells, with their instructed counsel, Sophie Lucas; Bhatt Murphy, with their instructed counsel Fiona Murphy, King's Counsel, and Sophy Miles; Bindmans, with their instructed counsel, Brenda Campbell, King's Counsel and Tom Stoate; Deighton Pierce Glynn; Hodge Jones & Allen, with their instructed counsel, Steven Snowden, King's Counsel, and Eleena Misra, King's Counsel; Dr Achas Burin, Rebecca Henshaw-Keene and Jake Loomes; Irwin Mitchell with their instructed counsel, Maya Sikand, King's Counsel, and Laura Profumo; Leigh Day, with their instructed counsel, Maya Sikand again, Tom Stoate and Laura Profumo.

Representing the organisations: Bhatt Murphy for INQUEST, with their instructed counsel Anna Morris,

King's Counsel, and Lily Lewis; Browne Jacobson for EPUT, with their instructed counsel Eleanor Grey, King's Counsel and Adam Fullwood; Kennedys for NEFLT, with their instructed counsel, Valerie Charbit; in-house representation and DAC Beachcroft, for NHS England, with their instructed counsel Jason Beer, King's Counsel, and Amy Clarke; the Government Legal Department for the Department of Health and Social Care, with their instructed counsel, Anne Studd, King's Counsel and Robert Cohen; Mills & Reeve for the Integrated Care Boards, with counsel Kate Brunner, King's Counsel; Jenni Richards KC and Rachel Sullivan for the Care Quality Commission; and Bevan Brittan for Oxehealth, with Fiona Scolding, King's Counsel.

I would like to take the opportunity in giving this opening statement to cover the following areas: firstly, I will report on progress made by the Inquiry since our last hearing in April and May, particularly the work that is taking place outside the context of our hearings and, secondly, I will turn to the very important evidence that you will be hearing over the next week.

Starting then with the progress of the Inquiry.

Your team continues to progress work in a variety of areas, much of which will take place outside our hearings. We are undertaking specific and targeted

further work following the April hearing, examples of which I will come on to in a moment. Chair, following the April hearing, you invited Core Participants to provide written comments on pertinent issues and matters that arose during that hearing. A number of Core Participant legal teams took you up on that offer, between them representing many individual Core Participants. The Inquiry's legal team has been working through all the submissions sent in and considering each and every one of the actions proposed, as have you, Chair.

The actions included, amongst other matters, possible lines of inquiry and investigation, potential sources of evidence and proposals for how the Inquiry should be run. The Inquiry was very pleased to receive a number of helpful and persuasive proposals from Core Participants' legal teams, including those representing bereaved families and those with lived experience, as well as the providers.

Some of the actions proposed, particularly the more straightforward ones, have already been actioned or are in the process of being actioned. Others are under active consideration and, as part of that, I have invited the counsel teams who provided submissions to meetings with me to discuss those submissions.

Some of those meetings have already taken place and they will continue into this month and a little beyond. I welcome this dialogue. I will report back in relation to principal points raised, once those discussions have concluded. The meetings to date have proved positive and helpful. I also intend to invite the teams of Core Participants who did not provide submissions at the end of the last hearing to meet with me.

Core Participants who do not have legal representation form an important part of those engaging with the Inquiry. We will, of course, be hearing the evidence of several this week. The Inquiry will be in touch with them after this hearing to offer meetings to discuss the ways in which the Inquiry is operating.

Finally, on this point, Chair, the Inquiry team will also now run a series of in-person drop-in sessions in Essex. This will be an opportunity for those engaging with the Inquiry to meet with the Inquiry team and to ask any questions or raise any concerns which they may have, face to face.

Work following the April hearing. Chair, by way of update, the areas for more detailed investigation identified by the Inquiry team and suggested by Core Participants, following the April hearing, include but I should stress are not limited to:

Investigations and information collated by regulatory bodies, for example the Health Services Safety Investigations Body, local Government and Social Care Ombudsman and Patient Safety Commissioner;

The regulatory landscape more broadly, particularly when there are systemic issues and failures at play;

Further information on the role, remit, activities of the Care Quality Commission during the relevant period;

Further information in respect of the Health and Safety Executive prosecutions of EPUT and its predecessor trusts, and any correlation with the CQC's position and responsibilities at the relevant time;

Notification, monitoring and oversight of patient safety concerns more widely;

A variety of specific topics and issues arising from EPUT disclosure and the evidence of Dr Milind Karale, examples include: policies and documentation, evaluation and monitoring, governance, risk assessment, the use of the Electronic Patient Record, neurodiversity and autism, screening of referrals, challenges or limitations related to assessments, psychiatric medication versus psychological therapy, coercive and restrictive practices, the care plan, the Care Programme Approach, the community mental health framework and

specialist units;

Next, further questions following the additional evidence of EPUT's Zephan Trent, relating to the use of Oxevision;

The Culture of Care programme and the issue of race equality;

Issues relating to the care of neurodiverse patients more widely;

Further examination of the duty of candour;

The death certification process; and

The quality and availability of data about deaths in mental health detention.

The Inquiry continues to engage proactively with relevant organisations and individuals to secure further evidence in these areas. Rule 9 requests for disclosure have been sent out by the Inquiry since the last hearing and we are in the process of formulating and sending out further such requests. This is to ensure that the various matters arising from the last hearing are thoroughly and robustly followed up. The Inquiry continues also to progress its work in many other areas, from actively exploring issues of physical and sexual safety and engaging with Essex Police, with whom the Inquiry has in place a Memorandum of Understanding, through to its investigation of private providers.

I would like to say a few words now about one of the other healthcare providers the Inquiry is looking closely at, the North East London NHS Foundation Trust also known as NEFLT. In addition to providing extensive mental health services for people living in various London boroughs NEFLT provides mental health services for people living in Essex and did so throughout the period with which the Inquiry is concerned. Notably, NEFLT currently provides Children and Adolescent Mental Health Services or CAMHS to young people in Essex.

Dealing first with the criminal trial. Those following and engaging with the Inquiry will have noted that, despite being a relevant and significant NHS provider of mental health services, NEFLT did not feature in the Inquiry's April hearing. It had originally been intended that NEFLT evidence and witnesses from NEFLT would form part of the April hearing. At the beginning of April, however, you decided, Chair, to remove NEFLT evidence from the hearing. That was because a long running criminal trial -- in which NEFLT was one defendant, and a previous NEFLT employee, a Ward Manager, was another -- had reached a sensitive stage at the Central Criminal Court. Its jury was about to be sent out by the trial judge to consider its verdicts.

When you made that decision, the Inquiry had been made aware that it was possible the jury would still be deliberating throughout the time of the Inquiry's April hearing and beyond. That turned out to be the case and, in fact, the jury in that criminal trial did not return verdicts until early June of this year.

Whilst in many circumstances a public inquiry and criminal investigation or trial can continue alongside each other, Chair, you were concerned that adverse comments about NEFLT made in public at the April hearing could have had the potential to prejudice the criminal trial at that particularly sensitive time.

You therefore instructed the Inquiry to act accordingly. In the event, NEFLT was acquitted of an offence of corporate manslaughter, and the Ward Manager was acquitted of gross negligence manslaughter but both NEFLT and the Ward Manager were found guilty of breaching the duty created by Section 3 of the Health and Safety At Work Act 1974, in that they failed to ensure others were not exposed to risks to their health and safety. These criminal offences related to the self-inflicted death of an inpatient at one of its hospitals in the London Borough of Redbridge, in July 2015. In short, NEFLT had failed to remove known risks to the inpatient who was able then to take her own life.

Moving to NEFLT disclosure. Quite separately, a significant amount of material requested from NEFLT was provided to the Inquiry too late to form part of the bundle put together for the April hearing. The Inquiry also requested a position statement from NEFLT, which was returned after the extended deadline. Given the volume of material received so late in the day, it was not possible properly to review and include it in the bundle for the April hearing.

The evidence from NEFLT will therefore form part of a future hearing at which we will also require NEFLT's CEO to attend and to address you.

Moving on to a new topic.

The Inquiry has been working hard to ensure disclosure is made to Core Participants and witnesses in a timely and efficient way. Up until now, disclosure of large volumes of material and of hearing bundles has taken place by way of upload to the Inquiry's evidence portal, Exchange. The Inquiry has looked carefully at how best to assist Core Participants in their review of the documentation disclosed by the Inquiry and it has also taken on board the representations and views of the Core Participants as how they might best be assisted.

As a result, the Inquiry will now extend the use of the Relativity platform to all Core Participants,

material providers and their legal representatives. This will also improve the material provider review process. Relativity is a disclosure platform that facilitates efficient review and analysis of documents. The Inquiry intends to secure access to Relativity for all Core Participants no later than August, at which time all material already disclosed will be accessible on that platform.

Any future disclosure will then be made via Relativity, including material relevant to the October hearing and the material for future hearings in 2026. Once Relativity is up and running for Core Participants, the Inquiry does not intend to provide material through any other means, unless of course there are circumstances where reasonable adjustments are required.

From August onwards, therefore, all disclosure will take place via Relativity, save in the case of unrepresented Core Participants with whom the Inquiry will be in touch individually to put into place suitable and workable arrangements. The Inquiry will ensure the effective deployment of Relativity by issuing detailed user guidance, providing scheduled training sessions and offering technical support.

At the same time as Relativity becomes available to Core Participants, the Inquiry will provide its

disclosure plan. This plan will set out the Inquiry's proposals for the disclosure of evidence for its hearings, along with the proposals for disclosure of material not connected to those hearings. The plan will be provided with a timetable as to when disclosure of witness statements and other materials relevant to the Terms of Reference is likely to take place. This will allow Core Participants to plan their work and resources in advance.

I would like now to address the list of deceased. Chair, the Inquiry continues to prioritise its efforts to compile as best it can a definitive list of deaths that fall into its scope. At the April hearing, you set out a revised approach to two of the particulars listed under your definition of inpatient death. In particular, you clarified the entry at (g) of your explanatory note that accompanied the Terms of Reference in relation to deaths following a mental health assessment.

An amended version of the explanatory note was circulated on 10 April this year. I addressed it in some detail at the start of the last hearing. Since that revised approach was announced, the Inquiry has sent further requests to the relevant care providers requiring them to revisit the information that they hold

and provide the Inquiry with revised details of those who died whilst under their care.

The Inquiry understands that, for some providers, that is going to involve adopting a broader approach to the disclosure of information and may take some time.

The Inquiry will provide further updates on this important work as soon as it is able to do so. It will be clear, therefore, that we still do not yet have a definitive figure for the number of deaths that come within the scope of this Inquiry. The Inquiry is acutely aware that this number is of particular interest. As you stated in September last year, Chair, the Inquiry recognises that it may never be possible to provide, with confidence, a final or definitive number of those who died in the relevant period whilst under the care of trusts in Essex.

The Inquiry considers, however, that it owes a responsibility to those who died and to their loved ones, including those who are not Core Participants, to finalise the list of deceased to the very best of its ability. We will provide the most accurate number that we can when we have, with expert assistance, collected the data we need and analysed it appropriately.

It's not just the number of deaths in scope that's important, although that is very important. The

information obtained about those deaths is also required to enable reliable and robust findings to be made about the themes and patterns revealed by the data.

Chair, I would also like to make clear at this stage that, until the Inquiry receives updated information relating to those whose deaths fall into the scope of the Inquiry, we are simply not in a position to say how many of those involved serious failings or issues of concern or were deaths that could have been avoided. The Inquiry will continue to do all that it can to provide clarity in this area. We are determined to get the most accurate figure available using all of the information and expertise available to us.

I am talking here about statistics. As I have said before, as an investigative process, we do have to look at information obtained in an analytical and objective way to see trends, to spot issues and to make findings. But we recognise that, behind the figures, each death was of a person with their own life and individual circumstances.

One of the important reasons for obtaining the best information available in relation to the Inquiry's list of deceased is to inform the work of Professor Donnelly, the Inquiry's expert statistician, and her team. They have continued their work analysing the list of deceased

and in helping to identify trends and matters of statistical significance to further inform the Inquiry's work.

Although it has been possible to prepare an initial analysis, there remains important work to be done before that output can be of assistance to the Inquiry and can be shared with Core Participants. The key strands of their further work include the following:

Firstly, as already outlined, obtaining the best available evidence to ensure that the list of deceased is accurate and that, where possible, it is triangulated against other available data, such as records of inquest.

Secondly, obtaining denominator data. It is recognised that the list of deceased, even when complete, will represent only part of the picture. To draw meaningful conclusions about patterns, risks and potential systemic issues, it will also be necessary to obtain information about the population of patients who were admitted to the same wards during the same period. This data, known as denominator data, is being sought but there are challenges in obtaining it.

Following this hearing, we intend to provide Core Participants with an interim report from Professor Donnelly, setting out in outline her approach and work

to date. Although this will not represent any final analysis, we aim to share this to help inform further discussions at the data discussion, which I will now come to.

Chair, you will recall during the April hearing that the Inquiry heard interesting and helpful oral submissions from Core Participants touching upon the topic of data, along with constructive suggestions from counsel such as Fiona Murphy, King's Counsel, Brenda Campbell, King's Counsel, and Steven Snowden, King's Counsel, on behalf of a number of the Core Participants, as to how the Inquiry might approach the questions of data and data analysis in various different areas.

Certain of those submissions were echoed within the written representations provided at the conclusion of the April hearing. This is an area in which the Inquiry is particularly keen to hear further views from the Core Participants and is currently considering the most efficient way to facilitate the sharing of those views.

To this end, the Inquiry intends to host a data discussion involving the Inquiry and Core Participant representatives. This may take the form of a chaired roundtable discussion to allow constructive suggestions as to avenues the Inquiry may wish to explore. Further detail about the data discussion will be provided as

soon as possible following this hearing.

The Inquiry has received and is considering submissions from Core Participants in respect of expert evidence heard at the April hearings. A number of points raised require careful contemplation moving forward. Core Participant proposals include an expert instruction protocol and additional ways in which Core Participants may contribute prior to the instruction of an expert.

Chair, you have firmly in mind the need for further expert evidence and we are actively considering other areas and other potential experts. We have, for example, already identified the need to obtain further expert evidence in respect of autism and neurodiversity.

The Inquiry is currently finalising the investigation strategy by which it will examine the circumstances of those who died on mental health inpatient wards in Essex. This is one of the matters I have been discussing and will continue to discuss with Core Participant counsel. Further detail about the Inquiry's investigation strategy will then be provided to Core Participants.

As part of its investigation work, the Inquiry will liaise with the families and friends of those who have died, together with their legal representatives, about

the matters which are of key importance or concern to them. The Inquiry will ensure that they are kept updated of its work.

Chair, you have chosen to receive witness statements and hear first from the families and friends. The evidence they give and the concerns they raise will provide the foundation for and will inform the Inquiry's investigations.

Chair, we have reached a stage where it may be convenient to take a break. May I therefore suggest that we break now and reconvene at 11.05.

THE CHAIR: Thank you.

(10.51 am)

(A short break)

(11.17 am)

THE CHAIR: Mr Griffin.

MR GRIFFIN: Chair, we have had a slightly longer break than we were hoping because the transcript has ceased functioning. This is what we propose to do: I am going to continue with my opening statement, a written and hyperlinked version of it will go on the website as soon as possible and if anyone feels they need it even more quickly, they can contact me and I can email it to them.

In the interim, we hope that the transcript functionality can be reinstated by the time of our first

witness but we will reconsider the situation over the break, following this opening. My apologies to those affected by the loss of the transcript.

So continuing my opening and I would like now to talk about staff evidence. The Inquiry's investigation strategy will also influence and inform the evidence the Inquiry seeks to obtain from staff members who worked for the healthcare providers during the relevant period. It has been well reported that, in its non-statutory phase, the Essex Mental Health Independent Inquiry failed to secure meaningful engagement from staff who had worked for the relevant trusts and private providers. It was one of the most influential factors in securing the Statutory Inquiry.

This Inquiry remains disappointed with the level of staff engagement. We are very grateful to those who have come forward and provided relevant evidence with openness and candour. They are few in number, however. The Inquiry's investigation strategy will now allow it to take a targeted and focused approach to obtaining staff evidence. The Inquiry's investigations, which will begin with the firsthand account provided by the bereaved family, will identify the key figures involved in providing care and treatment to the deceased, both on a ward level and those in positions of management.

The Inquiry will determine which staff are best placed to provide evidence that assists its work, particularly when looking at systemic issues. The Inquiry will also continue to seek staff co-operation more broadly. You will recall, Chair, that in April the Inquiry heard evidence of a culture of fear amongst staff working in NHS settings, a fear on the part of staff to speak up at the time they were aware of concerns and a fear on the part of staff to speak up later when the matters were being investigated.

Sir Rob Behrens told the Inquiry that he had dozens of clinicians get in touch with him indicating that they wanted to raise issues but they feared they would lose their jobs and careers. The Inquiry continues to encourage any person who has information that may assist the Inquiry to come forward and provide that information, particularly those who worked within NHS Trusts in Essex or for relevant healthcare providers.

Chair, you have ensured the Inquiry has in place a whistleblowing protocol to provide whatever protection it can for those individuals. You are seeking the views of the Core Participants as to whether providers and regulators should be asked again to give narrow undertakings in order to facilitate the flow of full and frank disclosure to the Inquiry. I referred at the

start of the last hearing to those undertakings. Following that hearing, the Inquiry has amended the proposed undertakings in order to make absolutely clear what their intended purpose is and their narrow remit: they seek to safeguard the interests of those who would like to raise issues, they relate only to the provision of material to the Inquiry and would not enable any individual to avoid accountability for serious misconduct.

Those amended proposed undertakings will be provided to all Core Participants following this hearing so they have a better idea of what the Inquiry is requesting.

Core Participants will be invited to provide views in writings in the first instance. The Inquiry has been invited by one of the corporate Core Participants to consider organising a combined discussion with various providers and regulators to discuss the undertakings you are seeking. Chair, whilst your team proactively engaged with providers and regulators last year on this precise topic, the Inquiry remains amenable to any joint and concerted effort which might assist in the furtherance of its work.

I would like to turn now to say a few words about the Oxevision evidence. During the April hearing, the Inquiry was due to hear evidence about Oxevision,

a technology that uses infrared sensitive cameras to monitor patients' vital signs, such as pulse and breathing rate, in mental health settings. Chair, you took the decision to postpone the corporate part of that evidence on the Inquiry's receipt, very late in the day, of a new witness statement from EPUT which set out a material change in their approach to Oxevision. In the interests of fairness, and to give all interested Core Participants and the Inquiry time to review the new evidence, you determined that the evidence from EPUT and Oxehealth should be heard at a later hearing.

On 14 May this year, the Inquiry did, however, hold a prerecorded evidence session with Hat Porter, a representative of the campaign group Stop Oxevision. As you made clear at the time, Chair, the use of Oxevision remains a matter of significant interest to the Inquiry. We are acutely aware that it is also a matter of particular concern for a number of the Inquiry's Core Participants, and I can say now that the Inquiry intends to hear the delayed Oxevision evidence at the start of the October hearing.

At the outset of the April hearing, Chair, I outlined how you had directed that a Lampard Inquiry Recommendations Forum should be set up and that it is now referred to as the Lampard Inquiry Recommendations

and Implementation Forum, this is to reflect the importance not only of the making of recommendations but also the fact they need to be accepted and implemented.

All Core Participants will be able to engage with the forum. We also announced in April that the Inquiry has secured the assistance of a noted academic with expertise in public inquiries for the forum, Dr Emma Ireton. Dr Ireton will provide a paper this autumn which will be circulated to its Core Participants. Its purpose will be to provide a contextual briefing on the framing, implementation and monitoring of inquiry recommendations. In broad terms, it will cover the purpose and construction of recommendations, implementation and monitoring, relevant recent developments and current themes in inquiry practice, and a summary of recent inquiry approaches to implementation and monitoring.

The Ireton paper will be provided to Core Participants along with a paper from the Counsel to the Inquiry team, which includes our suggestions for how the forum should work. We will then seek the views of Core Participants and other key stakeholders about the best way forward for the forum.

May I also remind those following and engaging with the Inquiry that it has in place various protocols.

This is with the aim of assisting those who wish to engage with the Inquiry in providing the best possible evidence in a way that also ensures they are supported throughout the process. All documents are kept under review. They include protocols on restriction orders, redaction, anonymity and special measures, on vulnerable witnesses, on witness statements, and principles of engagement for the July hearing.

Chair, you have a wide discretion to put in place measures to support witnesses giving evidence. We will continue to work with witnesses and, where they have them, their legal representatives to take an individualised approach, as far as is reasonably possible. The Inquiry also offers emotional support to all individuals engaging with it.

The Inquiry has been working to finalise the arrangements for how it will receive evidence from witnesses with lived experience of mental health inpatient services in Essex. The Inquiry has developed a framework to ensure that evidence from those with lived experience is obtained in a trauma-informed way, which allows each witness to provide their best evidence. A draft version of the Inquiry's lived experience framework, along with the associated questionnaire, was sent out to all relevant legal

representatives in April with an invitation to provide observations. All comments then provided by legal representatives were carefully considered and taken into account. Consequently, an updated and final version of the lived experience framework, along with the updated and final version of the questionnaire, was sent out to legal representatives last week and will be published on the Inquiry's website.

The Inquiry will afford those Core Participants and their legal representatives an extended period of time in which to complete the framework questionnaire. The Inquiry will then circulate a proposed timetable for the taking of that evidence, once Core Participant responses have been received.

We are grateful to the Core Participants and their legal representatives for their helpful engagement in the exercise.

I would now like to say a few words about this hearing, which runs from today until Monday, 14 July.

As I set out at the beginning of this statement, over the five days of this hearing, the Inquiry will focus solely on evidence from bereaved family members. The Inquiry has invited these witnesses to give evidence of their recollections and concerns, and we have also invited them to give their current views on what

recommendations should be made for change.

This week's evidence will therefore comprise, for the most part, family members' firsthand accounts and observations of what happened to their relatives. Hearing this evidence from families now and in October is crucial. As I have mentioned, Chair, you were clear that you wanted to hear first from the families at the heart of this Inquiry. This will ensure that this evidence is the driving force in informing the Inquiry's investigations. The Inquiry is aware that many families and friends have, through their experiences, sadly become experts in various different areas of mental ill health, care and treatment. It values that knowledge and intends to liaise with families engaging with the Inquiry and their representatives in relation to the investigation of systemic issues, where relevant, in each case.

The Inquiry will not be seeking comments or analysis from the witnesses on documents that relate to their relative's care and treatment during the course of this particular hearing nor will the Inquiry be hearing other evidence relating to that care and treatment at this stage. Other evidence will, however, form part of the Inquiry's investigations and may form part of later hearings.

Over the course of this hearing, Chair, the Inquiry will hear oral evidence from 12 bereaved family witnesses. We will hear about the following people who have died:

Edward Jackson, known as Ed, who died on 31 December 2007, aged just 18. We will hear evidence from his brother Ben Jackson.

Amanda Susan Hitch, known as Mandy. Mandy died on 12 February 2022, aged 59. We will hear evidence from Mandy's son, Adam Rowe.

Terrence Joseph Pimm, known as TJ. TJ died on 26 August 2016. He was 30. We will hear evidence from TJ's mother Karon Pimm.

The person known to the Inquiry as W4. He died on 17 February 2015, when he was 57 years old. We will hear from W4's sister, Janet Carden.

Liam Patrick Brennan, who died four days after his 29th birthday, on 14 August 2012. We will hear evidence about Liam from his father, Patrick Brennan.

Pippa Whiteward, who died on 29 October 2016, when she was 36. We will hear evidence from Pippa's sister, Lydia Fraser-Ward.

Stephen Oxton. Stephen died on 1 April 2012 when he was 53. We will hear from his son Alan Oxton.

Frederick Peck, known as Fred. Fred died on

4 December 2004, at age 54. We will hear evidence from Fred's daughter, Emma Sorrell.

Geoffrey George Toms, known as Geoff. Geoff died on 14 May 2015, when he was 88 years old. The Inquiry will hear evidence about Geoff from his daughter, Lynda Costerd.

Daniel Fairman, known as Dan. Dan died on 17 August 2018, he was 53. We will hear from his sister Jane Maier.

Susan Spring. Susan died on 1 February 2012. She was 54. The Inquiry will hear evidence from her daughter, Emma Cracknell.

Richard Harland Elliott. Richard died on 4 May 2002, at age 48. We will hear evidence about Richard from his sister Catherine Peck.

From these witnesses, all of whom have set out their recollections, observations and their views on the need for change with courage and clarity, the Inquiry will hear about a number of the key themes it will be examining during the course of its work. Those include but are by no means limited to:

A lack of a clear or settled diagnosis;

Those with dual diagnoses, described as being bounced around between different services with no proper oversight of care and treatment;

Failures to adequately assess or in some cases to assess at all;

Failures to admit or section in the face of clear and clearly reported deterioration and/or suicidal intent;

A revolving door of repeated admissions and discharges, with no apparent improvement in mental health and in many cases a deterioration;

Failures to ensure appropriate inpatient placement and a lack of availability of beds, particularly in mother and baby units;

Ward environments, variously described as a holding pen, cold, sparse and inhospitable;

Physical injuries sustained on the ward without proper explanation;

A lack of staff on wards;

A lack of psychological or therapeutic treatment on wards;

Confusion and general mismanagement of proper checks and observations on patients who were at high risk.

Serious failures in recordkeeping and management, including in relation to failures to record properly incidents of harm or injury;

Dismissive attitudes amongst staff at all levels and at all stages of treatment, both to patients and to

families;

A woeful lack of engagement with families, friends and support networks of patients at all stages and across all aspects of care and treatment;

Failures to listen to families or to seek input on patients from those who knew them best;

Failures to carry out proper checks, to ensure that patients could not access items with which to harm themselves;

Systemic failures in relation to ligature points;

Concerns in relation to medication, including failures to warn in respect of side-effects and signs to look out for in the case of deterioration;

Concerns in relation to discharge and inadequate assessments prior to discharge;

A failure to engage with families in respect of the discharge decision and process;

Poor responses to complaints or concerns raised;

Closed, defensive, dismissive and disrespectful attitudes from the Trust and from Trust staff towards families following a death;

Inadequate and error-ridden investigations and investigation reports; and

A lack of support before, during and after inquests into deaths.

As I have said, many families have sadly become experts in some of these areas and are uniquely placed to speak to these important issues in a way that no corporate organisation can.

I should also reiterate, as I said in April, that the witness statements provided for this hearing by those witnesses will stand in full as their evidence. I say this as the statements will not be read out in full during the course of the hearing, rather the witnesses will be asked careful questions about what they have written. Those witness statements will be published on the Inquiry's website once each witness has given their evidence. The copies of the statements that are published will be redacted in line with the Inquiry's published approach. There are three main categories where redactions may be applied:

Staff names. Staff names including those of junior staff will generally be disclosed in the course of the Inquiry. Individuals can apply for their names to be withheld, however, in line with relevant law and the Inquiry's protocol on restriction orders. Each application for a restriction order will be considered individually by the Chair. Some staff may need time to decide whether to apply for anonymity and to seek legal advice. While they are given this time, their names

will be restricted temporarily. This ensures fairness.

The second category, methods of self-inflicted death or self-harm. Details about specific methods of self-inflicted death or self-harm, as well as other highly distressing content, may be redacted to protect the public from potential harm. The Inquiry may also apply redactions where it considers the information is unusual and could instruct others.

The third category, other information which may fall under the Inquiry's privacy information protocol. This will be information which is personal in nature and which, Chair, you do not consider relevant and necessary to be made public. This would include details such as someone's address or other personal sensitive information.

Moving now to the timetable.

The Inquiry will sit on Monday to Thursday during this week and again next Monday. For this hearing we will generally start at 10.00 and finish by 4.00. There will be a short break in the morning and in the afternoon in which teas and coffees will be provided free of charge for those who are attending.

There will be a one-hour break for lunch each day which will usually be from around 1.30 to 2.30 pm. This is all subject to the need for the Inquiry to proceed

flexibly and take more breaks or make other arrangements as required to support witnesses.

It's not necessary to attend the hearing in person to follow the Inquiry's proceedings. Core Participants and their lawyers who are not attending in person can watch the hearing live on a secure weblink. The hearing is also being live-streamed on the Lampard Inquiry YouTube channel for anyone who wishes to follow us remotely. Please note, however, that this will be streamed with a delay of 10 minutes.

Moving now to the changing mental health landscape.

I have previously referred to the changing mental health landscape against which the work of the Inquiry is taking place. Chair, you made reference in your opening to the NHS 10-year Health Plan for England, which includes proposed measures of relevance to the work of this Inquiry. The plan, published last Thursday, includes the suggestion that, and I quote:

"The NHS' history is blighted by examples of systemic and avoidable harm."

It makes specific references to:

"... neglect and poor care of patients under the care of mental health services, including Essex inpatient services 2000 to 2023."

Reference is made to other suggested examples of

systemic and avoidable harm in mental health and other health settings. The plan says that:

"The failures that underpin each are consistent: incompetent leadership, toxic culture, rampant blame, workplace bullying and a failure to learn from mistakes. There is also a fundamental lack of transparency which means low quality or neglectful care does not come to light quickly, that the response is not fast or decisive enough and that patient, staff and public attempts to sound the alarm go unheard. It is time for the NHS to learn."

The Inquiry is considering this and other parts of the plan.

Recent cases. Chair, when I delivered the opening statement at the April hearing, I observed how sad the Inquiry had been to learn of deaths in mental health settings occurring in 2024 and a death as recently as April 2025. I observed that these further tragic deaths may point to serious and ongoing issues in Essex.

The Inquiry remains deeply concerned that patients are still dying. We will continue to monitor any recent deaths of mental health inpatients in Essex. We also continue to monitor the inquests that are taking place into the deaths of those who died in the latter part of the period covered by the Inquiry's Terms of Reference.

We are aware of a number of inquests having taken place in the past few months in relation to deaths of mental health inpatients in Essex in 2023 and from previous years, following which the coroner has issued a Prevention of Future Deaths report.

The recent inquest of Elise Sebastian, who died under the care of EPUT in 2021, gives rise to serious issues that this Inquiry is investigating. The coroner has indicated that a Prevention of Future Deaths report will be forthcoming.

Other inquests are listed for hearing later this year. In short, the Inquiry has noted that recent inquests have explored the same or similar failings and systemic issues with which this Inquiry is concerned.

It is against these ever present and growing concerns, Chair, that the Inquiry is determined to scrutinise what has taken place in Essex over the relevant period. You have made clear that you will make appropriate findings of fact, ensure accountability and propose robust recommendations for long-lasting change. We are mindful now more than ever, Chair, that the landscape into which you will be making those recommendations is a changing one.

That brings me to the end of my opening remarks.

A written version of this opening statement will

shortly be available on the website. Chair, we will rise now until 12.00, when we will reconvene to hear the evidence from our first witness, Ben Jackson. He will be asked questions by my colleague Rachel Troup, so until 12.00, please.

(11.47 am)

(A short break)

(12.15 pm)

MS TROUP: Chair, there is one brief matter.

An announcement has been made to the room but, for the benefit of those watching more widely, I understand that there is currently a technical issue with the live transcript feature and that work is being done to resolve that. A transcript is being kept but it is just to make those watching more widely aware.

THE CHAIR: Thank you. Thank you Ms Troup. Thank you very much.

BEN JACKSON (affirmed)

Questioned by MS TROUP

MS TROUP: Thank you. Can you please state your full name for the record?

A. Benjamin Charles Jackson.

Q. You are the brother of Edward Jackson --

A. That's correct.

Q. -- known as Ed --

A. Yes.
Q. -- who died on 31 December 2007 when he was 18 years old?
A. Yes.
Q. When Ed died, he was an inpatient on Maple Ward at Severalls Hospital in Colchester?
A. That's correct.
Q. Yes, you would like me to refer to you throughout your evidence as Ben; is that right?
A. Yes, please.
Q. And to your brother as Ed?
A. Yes, please.
Q. By way of background, the Inquiry sent to you some months ago a request for evidence under Rule 9 of the Inquiry Rules and, in response to that, you have provided the Inquiry with a witness statement.
A. Correct.
Q. Do you have a copy of that in front of you?
A. I do.
Q. It's 42 pages long and, if you turn to page 42, we can see that it is dated 27 May of this year --
A. Yes.
Q. -- and that you made a statement of truth and then signed on that same page?
A. That's correct.

Q. Have you had the opportunity to read through your witness statement recently?
A. Yes.
Q. Is that document true and accurate to the best of your knowledge and belief?
A. Yes.
Q. That witness statement, as you know, will stand as your evidence to the Inquiry?
A. (Witness nodded)
Q. Ben, you also provided, back in November 2024 a commemorative and impact account about Ed and that was read for you?
A. Yes.
Q. The Inquiry is extremely grateful to you for that evidence, as well as for your evidence today?
A. Thank you. I am grateful to have the opportunity to give it.
Q. Before we begin going through your evidence, I want to make clear, as you tell us on the first page of your witness statement, that you have prepared this witness statement to be as full an account as you can and it's based on your own recollection of events from the time --
A. Yes.
Q. -- as well as impressions that your parents had at the

time?
A. Yes, yes.
Q. It is also based, do I understand correctly, on your consideration of some documents that you had not seen at the time but you have seen more recently?
A. Yes, that's correct.
Q. It's right, I think, that Ed was two years your younger --
A. Yes.
Q. -- and, for much of the time, looking at the time period between about the summer of 2005 and the end of 2007, you were away at university?
A. Summer of 2006, just before I left.
Q. You were away for that last part of the events --
A. Yes.
Q. -- we are going to go through.

You have explained in your witness statement, as you did during your commemorative account, that your own recollections from the time are not full and that your memories of that period of your life are less clear --
A. Yes.
Q. -- than they are; is that right?
A. Yes, that is true. It was reassuring to me that the memories that I had upon reviewing documents were often validated.

Q. Yes.
A. I found that reassuring, so I have confidence in my memories from the time, although they obviously don't cover everything.
Q. Yes. No.
But you have also, as we have said, reviewed certain reports and documents that you refer to in your witness statement and I think you told us, in your commemorative account in November, that actually, at the time, you understand now, that your parents sought to protect you from some of the more distressing details about what was happening for Ed?
A. Yes, I think that that's -- that's the truth of the matter.
Q. Yes, and also that there's -- you have experienced what you described in November almost as a sort of a temporal disassociation, that may well be trauma related?
A. Yes, I think so, and that specifically applies to the period that covers his illness.
Q. Yes.
A. It doesn't apply to the years after that and it doesn't apply to the inquest years, I don't think.
Q. Yes.
A. It was, I think, a stress-related response to him being ill.
Q. Yes, yes understood. Ben, you also make very clear, and

I think this is important to note at this stage, on the first page of your witness statement that you are still seeking further documents in relation to what happened to Ed --

A. Yes, that's correct.

Q. -- and that, in particular, you do not have a number of documents relating to the Health and Safety Executive's prosecution of the Trust --

A. Yes.

Q. -- in 2020 and 2021, or medical records?

A. That's correct.

Q. I think it is the case, is it, that you would have preferred to have prepared your witness statement and be giving your evidence having seen those documents?

A. Yes, I think so. I think, in terms of being able to do a good job, it would be nice to have the fullest account of the situation at the time but also I think, for my own sense of well-being, the lack of them is a little bit sort of disconcerting --

Q. Yes.

A. -- on some level.

Q. You understand that, during your evidence today, on the basis of your witness statement, what we will be taking from you and what is of immense value, despite those gaps that you feel in your knowledge, are your own

recollections and your parents' impressions and what you have to say --

A. Yes.

Q. -- about the documents that you have seen.

A. Yes.

Q. I'm being asked, if you could, when you are speaking, just lean slightly further forward --

A. No problem.

Q. -- just because you have got -- I think, possibly a little bit difficult to hear you.

In any event, you have also made clear that, when you are in receipt of further documents and those that you consider centrally important, it's very likely that you will be submitting further evidence to this Inquiry?

A. That's correct.

Q. Thank you. I would like to take you through, in summary form, but taking you through some of the most important dates and events, the background to the development of Ed's mental ill health and to his care and treatment, and what I would like you to do, it is a lot of me speaking, I'm afraid, but you must stop me if I make an error or there is something that you want to add.

A. I understand.

Q. So taking all of these matters from the information you have provided to us in the witness statement, your

parents believe, I think, looking back, that it was in the early summer of 2005 that Ed started to show some signs of illness; is that right?

A. Yes, I think that that's fair to say. I mean, my own impressions were that I was growing up with a teenage brother who was difficult.

Q. Yes.

A. But I think at the beginning it was quite hard to separate those two things.

THE CHAIR: He was about 16?

A. He was about 16, yes.

MS TROUP: Your own recollection is that Ed began to become increasingly unwell in the autumn of 2005 and I think it was at that time, is this right, he had transitioned into a new school for Sixth Form --

A. That's correct, yes.

Q. -- and dropped out at October half-term?

A. As far as I remember, yes.

Q. You explain that, during that period, so after around about October 2005, his behaviour began to change?

A. To the best of my recollection, my memories of him being difficult in a way that I guess I didn't feel like was just growing up with a little brother was pretty coincident with his starting Sixth Form.

Q. I see.

A. So that was that time, yes.
Q. Thank you. You say that during that period, so we are talking about October 2005 up to around about Easter 2006, his behaviour seemed to fluctuate in severity, at times he was quite aggressive?
A. Yes, I think so. Again, it's difficult to pinpoint exact times over that two-year period but, certainly, there were -- there was -- we felt threatened in terms of threats of violence. Ed threatened violence to himself as well as to us.
Q. Yes, yes.
A. Yes, I think it would be fair to say that that was going on at that time.
Q. Thank you. You go on to explain in your witness statement that, at around Easter time in 2006, there came a really marked deterioration and a change in his behaviour, and I don't know if you are following it, but if you want to in your witness statement this is on page 4, at paragraph 3.1?
A. Thank you.
Q. You say, in fact, that your parents described this as a marked deterioration and you make reference to him being unable to sleep, pacing the house, speaking incoherently and curling up in a fetal position?
A. Yes, certainly, I mean, my recollection of his behaviour

was that it was a marked change from, you know, the person that he was up until that point.

Q. Yes. At that stage, as I understand it, a CAMHS mental health nurse did visit at home.

A. Yes.

Q. I think the night after that, Ed, under a delusional belief that your parents were trying to harm him, called police?

A. I think so, yes, and then fled the house. I think he ran to a friend's house, I think he ran to a particular person who he felt safe with.

Q. Yes. Thereafter, as I understand it, he was detained by police under Section 136 of the Mental Health Act --

A. Correct.

Q. -- and an attempt was made to have him admitted to a local psychiatric unit but, of course, he was a child, he was 17, and they were unable to accommodate him; is that right?

A. Yes, it seems that there wasn't a place for him in Suffolk at that age at the time, on that occasion.

Q. Yes. So he spent that night in police custody --

A. Yes.

Q. -- and was seen -- we are now on 16 April 2006 -- by a mental health nurse and an approved social worker --

A. Yes.

Q. -- and arrangements were made for him to be admitted to Longview, which was an adolescent unit?
A. Yes, in Essex.
Q. Yes. Looking at paragraph 3.5 of your witness statement, you tell us there about the admission information that you have seen from his admission to Longview and there is quite a long quote there --
A. Yes.
Q. -- again reporting an inability to sleep, flight of ideas, racing thoughts, paranoia, anger and a preoccupation with physical symptoms.
A. Yes.
Q. There is also a comment --
A. Sorry.
Q. Sorry, go ahead?
A. No, no, please.
Q. I didn't mean to interrupt you.
A. No, I was just going to say "yes".
Q. There is also a comment here that -- this is about four lines down:

"He speaks of hearing voices, although I think this is more likely an internal debate rather than true hallucinations."

A. Yes, I suppose I don't know --
Q. No.

A. -- I don't feel qualified to say what the difference between hallucination and an internal debate is.
Q. No. At the time, the diagnosis that was reported, when he was admitted to Longview, you have set it out at paragraph 3.6 was impression mixed affective disorder or manic episode, either discrete or possibly with the context of an emerging bipolar disorder?
A. That's right. So I guess that's the first sort of diagnosis that Ed is going to receive. There will be multiple more and they will mostly be different.
Q. Yes. Is it right for me to say, just setting matters in context, that at the time of his death, there was no definitive or settled diagnosis?
A. That's my understanding, based on my recollection of all of the evidence from the inquest, yes.
Q. Yes. You tell us here about a fundamental error that then took place, where, on admission to Longview, Ed was needlessly and unjustifiably detained under Section 2 of the Mental Health Act.
A. That's right. So I believe that the social worker involved signed a form that was only there as an emergency measure, in the event that he worsened he could be admitted, presumably, like, for everyone's safety.
Q. Yes.

A. But the social worker signed the form and he was then detained under the Act by mistake.
Q. Yes. So I understand that he did formally meet the criteria for detention but the key is that he had agreed to the admission --
A. Yes.
Q. -- and, therefore, he should have been admitted as a voluntary patient?
A. And that was the understanding of the two clinicians at the time, that he was not going to be detained.
Q. Yes.
A. That's right.
Q. Essentially, when your parents complained about that matter later to Suffolk County Council, the explanation given was that it was an error made without thinking.
A. Yes.
Q. The form was simply signed. You go on to say there that that needless detention or that error was a matter of serious concern to your parents, for obvious reasons, because your brother was a child at the time.
A. Yes.
Q. You also tell us there that it had a noticeable effect on Ed. What was that, as far as you can remember?
A. I mean, my recollections of speaking to Ed about, like, the possibility of having a mental illness at the time

was that Ed was really defensive about that.

Q. I see.

A. It made him angry, he didn't want it. I mean, I suppose it is incredibly frightening to be told that, as a child. So, I mean, there was some degree of maybe -- stigma is not right word but in Ed's mind that's perhaps what it was and it upset him, for sure, to be considered as having a mental illness at that time.

THE CHAIR: Would it be diagnosis or the differing but possible diagnosis or was it the detention that particularly upset -- the fact that he could be detained?

A. I don't -- I don't -- I couldn't honestly tell you what would have been more important to him now. I think my impression is that, in general, he -- I mean, later on we will go on to hear that he was defensive about being diagnosed with a mental illness, so I think he found it problematic being told that he was unwell, when I think he perhaps believed that he wasn't and I am sure that the detention was, you know, not -- played into exactly those fears that he had. Does that make sense?

THE CHAIR: It does, so it added to his sense that there was something wrong?

A. Yes, I think so, or maybe it was the first time that that sense was brought up in him. I couldn't tell you

for sure.

THE CHAIR: Yes, yes, thank you.

MS TROUP: Thank you. I understand that Ed was discharged from Longview on or about 14 June 2006; is what you tell us?

A. Yes.

Q. Also that when he was discharged, no discharge summary was prepared; is that your understanding?

A. That is my understanding.

Q. You now know, having reviewed some of the documents, that his discharge from that unit followed a meeting, a CPA or Care Programme Approach meeting, for which a number of reports had been prepared?

A. Yes.

Q. One of those was a medical report and one was a psychological assessment and the conclusion of both of those reports was that Ed was not suffering from any form of mental illness?

A. Yes, that's correct. And that conclusion will be criticised later on.

Q. Yes. I mean, we can speak about that a little now.

I understand that, in particular, the psychological assessment came in for criticism when the Serious Untoward Incident Panel reported?

A. So the basis of the psychological assessment was, in

part, on two psychometric tests, one of them was the Rorschach test, which you might understand as the inkblot test, which I think is Edwardian perhaps in origin --

Q. Yes.

A. -- and the other is a -- was a drawing game of the psychologist in question's own devising --

Q. Yes.

A. -- which -- I mean, I don't think it was in any way validated. I think in the SUI later, we will hear it has "no psychometric valuation associated with it", or evaluation. So --

Q. It was essentially a sort of squiggle line on -- so we had the -- I don't know how to say it, either, I think it's Rorschach -- inkblot tests -- I had to look it up, the pronunciation, I mean. An inkblot test, which is a sort of image test and what do you see?

A. Yes.

Q. And then a drawing game or test that that particular psychologist had --

A. Invented.

Q. -- him or herself devised, that was not in any way externally validated?

A. That's my belief, yes, and then I think it's worth saying that, as a result of the report of no mental

illness, although perhaps that was pleasing to Ed, it made it harder for my parents to access care for him in the coming months.

Q. Of course. So on that, I mean, what you go on to say is that, after his discharge into the community, there was essentially almost a total lack of support?

A. Yes, that's my understanding from reading the documents. My memories from the time are quite unclear.

Q. I understand. I understand that because this conclusion appeared to have been arrived at that Ed was not suffering from any form of mental illness, as you say, it was even more difficult for your parents to access appropriate support?

A. I think that's true.

Q. You tell us that they visited the GP several times to try to access help for him?

A. Yes, I mean, some of the reasons that they couldn't access help for him was that the GP had their hands tied in terms of they couldn't discuss Ed without Ed consenting to it.

Q. Yes.

A. Because he is over 16, in a way perhaps that's fair enough, but it was difficult for my parents.

Q. So they advised your parents -- the GP advised your parents, essentially, that the request for help had to

come from Ed?
A. I understand that to be the case.
Q. I understand. There was one follow-up appointment from the local CAMHS team in Suffolk and then when Ed, essentially, disengaged from that nobody followed up with him?
A. Nobody followed up and then, yes, that, that single follow up will also be later criticised in the SUI report after his death.
Q. Yes, the finding of the SUI Panel, in effect, was that this was not a low level event where one follow-up appointment --
A. Was appropriate.
Q. -- was appropriate.
A. That's correct.
Q. You also tell us that after being discharged into the community from Longview, Ed made the journey to an aunt and uncle of yours in Yorkshire --
A. That's right.
Q. -- a long journey --
A. Yes.
Q. -- and that, whilst he was there, his mental state continued to deteriorate and he displayed out of character behaviour --
A. Yes.

Q. -- essentially?
A. That's true, and so my memory of that time is I guess my aunt and uncle hadn't been exposed to Ed subsequent to his onset of illness, at that point, so they also presumably weren't sure what was happening.
Q. Yes.
A. But, at some point, did relate to us that they were now, having met him, much more certain that there was something wrong.
Q. Yes, and I think through a GP they did manage to access one appointment with a psychiatrist?
A. That's correct.
Q. But, thereafter, essentially, Ed, for the reasons that you have explained to us, disengaged?
A. Yes.
Q. When Ed returned home, back to your parents' home, which I think was in June 2007 --
A. Yes.
Q. -- at that stage, as I understand it, your parents did manage to secure a referral to the Early Intervention in Psychosis team in Suffolk?
A. Yes.
Q. During that period, so this is June 2007 onwards, there were a number of home visits from social workers and mental health nurses; is that right?

A. I understand that to be the case, yes.
Q. Were you by then away at university?
A. Yes. I was.
Q. Yes. Taking matters forward into October 2007, I understand that on the 23rd your brother was picked up by police at the side of the road?
A. Yes, so he would have been at the side of the A1, I think, almost certainly heading back to Yorkshire.
Q. I see.
A. I imagine in an attempt to find safety again, which is something that I think is going to happen to him a lot in the coming months.
Q. Yes, attempts to flee to find safety?
A. I imagine that's what was going through his head, yes.
Q. Yes, I understand. On this occasion, he was picked up near Grantham --
A. Yes.
Q. -- and police have reported that he was so agitated that tranquilisers were required?
A. Yes, the records report that. I'm not sure who said it exactly.
Q. Yes, he was taken to Grantham Hospital for a check and then the intention was for him to be taken to a psychiatric unit?
A. Yes, yes.

Q. Another error occurred and, in fact, he was returned by ambulance to your parents' home?
A. Which is precisely, I assume, the place that he was trying to escape from, for good or not reason.
Q. Yes. When he arrived home, the GP attended, as did police --
A. Yes.
Q. -- and, by 25 October, so just two days later, he was detained under Section 2 of the Mental Health Act and police took him to Wedgwood House?
A. Yes, that's correct.
Q. Wedgwood House is where?
A. Bury St Edmunds in west Suffolk.
Q. Yes. The records show that whilst he was at Wedgwood House, although Ed was ambivalent about taking his medication, he did comply with it --
A. That's correct.
Q. -- and that, although he denied it, he was found to be at that stage psychotic or in psychosis?
A. Yes, and then I think this is the first mention of schizophrenia as a possible diagnosis.
Q. Yes. I understand that there had been a mention, when, Ed was with your aunt and uncle in West Yorkshire, I understand that an approved social worker had made mention then for the first time of possible emerging

schizophrenia?
A. Yes, that's correct.
Q. And then this is the second time that we see that potential diagnosis coming up, isn't it?
A. Yes.
Q. You were aware at the time, you tell us -- and if you are following it Ben, I'm looking now at page 10 and paragraph 5.7 of your witness statement?
A. Okay.
Q. You were aware at the time that there were serious concerns about Ed escaping?
A. Yes, for sure, I remember being told he had stolen a taxi at some point and I know now from reviewing the documents that there were multiple absconsion attempts.
Q. Yes. So I think what the records show and what you have learned from them is that he did manage to escape on 3, 9 and 12 November --
A. Yes.
Q. -- 2007 from Wedgwood House and that, on each of those three occasions he was returned to the unit by police?
A. Yes, that's correct.
THE CHAIR: Sorry, remind me, was he under section there?
MS TROUP: He was.
THE CHAIR: Yes.
MS TROUP: On 6 November, a decision had been made to

maintain Ed's detention and, Chair, that's at paragraph 5.9 on page 10.

During that decision, which was at a review tribunal on 6 November -- I am so sorry I am looking at paragraph 5.9 -- quite importantly, it was noted -- so here is where we see a description of a possible emerging psychotic illness and reference to schizophrenia, and there is reference to his guarded and suspicious nature.

A. I mean my -- I think possibly, if you were involved in a, like, set of circumstances where multiple mistakes had been made --

Q. Of course?

A. -- you might feel like being guarded and suspicious is a reasonable response to the treatment that he had had up to that point.

Q. Of course.

A. So I guess I find that problematic, especially to the extent that that behaviour seems, to some extent, justified --

Q. Yes.

A. -- but contributed to a diagnosis which may well have been correct, which then would have then gone on to further upset Ed.

Q. Yes.

A. So I find that sort of set of circumstances quite difficult to come to terms with.
Q. Yes. In addition to his defensiveness, again, that we might say was perfectly understandable, particularly given his age, around being told that he was mentally ill or a diagnosis of any kind, which is not at all uncommon?
A. Yes.
Q. One of the matters I wanted to note was that, during this review tribunal panel, a note was made of him once having told your parents that he might as well not be living --
A. Mm-hm.
Q. -- and reference to knives and other sharp items being found in his bedroom when they were sort of clearing it or tidying it, whatever, for admission, that he had said he had been using to harm himself?
A. Yes. So I am not clear whether or not those rooms were his room at home or his room in hospital. Reading this was the first -- yes, sorry, I can't -- I don't know.
Q. No, I am not sure either, that's a good point. In any event, what is key is that we see here a clear notification to staff that he had made reference at some point --
A. To self-harm.

Q. -- to self-harm and to suicidal intent?
A. Yes, that's correct and this was the first time -- reading these documents was the first time that I understood that he might have used knives to self-harm.
Q. Yes. We know from the records that on 10 November 2007, Ed was placed on continuous nursing observations and that was due to his repeated absconsions from the ward?
A. That's right.
Q. There are also records from that date of him acting more bizarrely and making threats to kill your parents?
A. Yes.
Q. And that his administration of anti-psychotic and tranquiliser medication was increased at that stage?
A. That's what I understand.
Q. On 16 November, plans were first made to move Ed to a more secure unit --
A. Yes.
Q. -- and on the 20th, he was detained under Section 3 of the Mental Health Act?
A. Yes, I'm not sure if -- I mean, presumably that detention was based on the previous absconsions and self-harm but I am not certain exactly why that was.
Q. Yes. Most crucial, given the concerns we are going to go on to discuss, the records show that on 27 November

2007, Ed was found with a belt around his neck that he had secured to his bedroom door by a knot?

A. Yes, so this is still in the same facility in Bury St Edmunds in Suffolk.

Q. Yes, so we are still in Wedgwood House?

A. That's right.

Q. He is now detained under Section 3. That event took place on 27 November --

A. Correct.

Q. -- and he is recorded of having reported to staff that he -- expressing thoughts of suicide that were especially intrusive when his mood was low?

A. Yes.

Q. On 5 December 2007, he made a further attempt to escape, literally trying to run from the premises and scale a wall. At that time, he is recorded as having made comments to staff, first of all, of wanting to throw himself under a train --

A. Yes.

Q. -- and, secondly, asking that his shoelaces be removed from him because he didn't trust himself?

A. Yes. So I guess the all of those previous paragraphs speak to an increased frequency in absconsion. So he is more at risk, I guess, the public are more at risk because he is stealing things, he has been found with

a ligature tied around his neck, he has talked about wanting not to be here and he's expressed some specific plans, to an extent --

Q. Yes.

A. -- and then he's, yes, asked for his shoelaces to be taken away from him, which I mean is incredibly sad and -- but also speaks to the fact that it may not be that he really wants to die at that point.

Q. Of course.

A. But, okay, so there is like -- now there's built up over the course of about two months, like, a high frequency of quite extreme events --

Q. Yes.

A. -- in Suffolk.

Q. Now, my understanding, in relation to the 27 November and how Ed was found and the comments that he made at that time, is that your parents were not made aware of that incident; is that right?

A. That is my understanding. It's based on reviewing the documents. I don't have exceptional memory of that at the time.

Q. Yes. As far as you are aware, were your parents made aware at the time of the events of the 5 December and that attempt to escape from the premises and the comments he made in terms of suicidal intent on that

date?
A. I am not aware in either direction. I don't know if they did or did not know.
Q. I understand. We know that Ed was transferred from Wedgwood House to Maple Ward at Severalls Hospital on 7 December 2007?
A. That's right.
Q. I have now moved, Ben, to page 12 and to paragraph 6.1?
A. Yes.
Q. That transfer took place under an SLA or Service Level Agreement between the NHS Trust in Suffolk and NEPT, yes?
A. That's correct.
Q. I know you are going to have further comments about that agreement.
A. Yes, certainly my parents will discuss it, especially in light of information that they received at the inquest.
Q. Indeed, and I think, is it fair for me to say, that many of their concerns centred on what due diligence or what checks were carried out in relation to that agreement and the environment at Maple Ward?
A. Yes, so I mean the circumstances are that Ed had been referred there because of the behaviour that he exhibited in Bury St Edmunds, where he is about to leave --

Q. Yes.
A. -- and, of course, his referral there was an attempt to make him more safe.
Q. Yes.
A. That's presumably what the aim was.
Q. Yes.
A. But, in fact, the exact opposite, as we are going to see, is what occurred, and that's really important and obviously it was really important to my parents.
Q. Of course. In fact, what the records show is that the reason for the transfer or the basis for the transfer to Maple Ward given were the ongoing risks of absconding -- this is at the very bottom of paragraph 6.1 -- self-harm and fleeting suicide ideation?
A. Yes, that's correct.
Q. Those were the recorded reasons for exactly, as you say, moving him to a more secure unit in an attempt to make him more safe, that was the intention?
A. Yes.
Q. We are going to come on to talk quite a lot about Maple Ward, for obvious reasons but, is this right, I think you make this fairly clear in your witness statement, your position, Ben, is that it is entirely possible that, had Ed not been transferred to that particular ward, he would not have died?

A. Yes, I think that's certainly fair to say. I mean, of course one can't speak of then the years that might have come later but, I mean, I think it's going to be markedly obvious that he was transferred there and three weeks later he was dead --

Q. Yes.

A. -- and that was due to serious failings and, of course, my position is that, if he hadn't gone there, he wouldn't be.

Q. Yes. You tell us in your witness statement that your parents -- and you are not completely sure for the reasons why -- but they were very impressed with the environment at Wedgwood House?

A. Yes, I believe that to be the case. Again, that's from reviewing the documents rather than my understanding at the time.

Q. That, I understand, is in very stark contrast to their impressions and views about Maple Ward at Severalls?

A. Yes. Concerns about the physical environment in terms of it being an old Victorian asylum --

Q. Yes.

A. -- concerns about there being nothing to do for patients there.

Q. Yes.

A. Perhaps further concerns.

THE CHAIR: Ben, did your parents ever talk to you directly about what they had seen at Severalls? They visited him there?

A. They visited him there often, yes.

THE CHAIR: Yes.

A. I find it really hard -- I don't have a clear memory of them doing that. But I do have a clear sense of knowing what it was like, so it may be that they did. But it also may be that my memory was based on evidence at the inquest.

THE CHAIR: Right.

A. I couldn't tell you, for sure.

THE CHAIR: Right, thank you.

MS TROUP: In summary, your parents' views, I think this is right and it is as you set out, is that neither the environment nor the staff on that ward were fit for purpose?

A. Yes, I mean the staffing issues -- I am not certain how much their opinion of the staffing issues were formed by the inquest material that was received.

Q. Yes.

A. But, certainly, that was the opinion that they would reach eventually.

Q. Yes. They described it as a depressing environment and, as you have said, one of the things that they noted was

that there was almost nothing for patients to do, other than watch television.

A. Yes, and so it is notable that Ed was referred there on 7 December. On the 8th, my parents visited and brought him a personal CD player.

Q. Yes.

A. They weren't allowed to give it to him because there was a headphone cable, so that was deemed too risky. And the day after that, staff at Maple Unit returned his belt to him, which I think may have been linked to a change in risk assessment or a change in level of observations for some reason.

Q. Yes.

A. The day after he died, they planned, before he died, to be bringing him a PlayStation. So, yes, lack of therapeutic activity.

Q. So that he had something to do?

A. Exactly.

Q. I understand. As I understand it, what they also discovered was that there were no psychological or occupational therapy services available?

A. Yes.

Q. Your parents were told that they couldn't visit in the evening?

A. Yes, and that was factually incorrect, it was

miscommunication. They apparently were allowed to visit in the evening but, as a result of that, they did not.

Q. Yes.

A. Then, obviously, they had limited time.

Q. They were both working --

A. Yes.

Q. -- so they tried to visit in the day, if they could --

A. Yes.

Q. -- and at weekends --

A. Yes.

Q. -- but later discovered that they could have been there in the evening, is that it?

A. That's correct but they were informed by a member of ward staff that evening visits weren't permitted.

Q. Yes. Ed's key worker, you have discovered, was on night shifts throughout?

A. Yes. Yes. I -- I am not sure completely 100 per cent throughout but, yes, the -- certainly the majority of the time, to the extent that disciplinary action into that was recommended at the seven-day panel.

Q. Yes.

A. It was a theme of the inquest, it is the part of the inquest that I remember most clearly asking whether -- that person whether or not them being on night shifts whilst being a key worker meant that they could fulfil

their duties to Ed. It is something that I have talked about, like, in other contexts with prior to this Inquiry, so I think that's something that's really stayed with me.

Q. Okay.

A. So the person that was responsible for coordinating his care --

Q. Yes.

A. -- was not available to him.

Q. Yes. All right. We will come back to that, I think.

The other things that your parents noted that are very important and relate to the matters you have told us about, about your parents trying to bring him -- bringing him a music player but not being allowed to give him the earphone cables, so the cable wire, and wanting to bring him a PlayStation. I understand that Ed lost a lot of weight while he was an inpatient on Maple Ward?

A. Yes, I think so, to the extent that his trousers were falling down because he was so thin --

Q. Yes.

A. -- which was, I think, justification -- at least my memory of the inquest was that was verbal justification for the return of his belt.

Q. Yes, I understand that the records seem to show that

staff were concerned by the amount of weight that he had lost and there was a suggestion that, because his trousers were falling down, that other patients were teasing him.

A. Yes, no, I think he did experience bullying on that ward --

Q. Yes.

A. -- and, in particular, the day of his death I believe he experienced some sort of bullying.

Q. Yes, on that day there is a record that shows that there was -- and this is the 31 December, so moving forward a few weeks in time, there is a suggestion that there had been an altercation between Ed and a male patient and a suggestion in the records that that particular male patient had been --

A. May have been picking on him.

Q. -- intimidating Ed and possibly targeting him?

A. Yes.

Q. We bear in mind he had just turned 18 in the spring of 2007, yes, and this was an adult unit?

A. Yes.

Q. When Ed first arrived on Maple Ward, he was placed on Level 2 observations, the records show?

A. Yes.

Q. As you said, the next day, 8 December, your parents were

prevented from giving him a portable music player because of the risk presented by the earphone cables?

A. Correct.

Q. Nonetheless, as you have told us, the next day, 9 December, both Ed's belt and his shoelaces were returned to him.

A. Yes.

Q. We will come back to this but the seven-day report found that no risk assessment had been carried out?

A. Yes, and there was no written rationale of any kind associated with that decision.

Q. It appeared to have come about just on the basis of a sort of discussion between staff?

A. A sort of ad hoc discussion, yes.

Q. At this time, you still have no clear information about who decided to return those items to your brother or on what basis?

A. No, that's correct. I mean it -- I mean, obviously, I think one of the things that one thinks about is that there are no therapeutic activities available but you can't have a music player but, hey, you can have your belt back. It is just speaks, I think, to a sort of chaotic and not coherent programme of care.

Q. Yes, or a coherent or consistent approach --

A. Yes.

Q. -- to risk --
A. Yes.
Q. -- which is a huge concern of yours that we will come on to.
A. Yes.
Q. On 9 December, we know that a NEPT -- well, we don't know -- it is said that a NEPT risk assessment was completed for Ed?
A. Yes. It was.
Q. That risk assessment is dated 9 December?
A. That's right.
Q. But I understand, and we will come on to this, that there is some doubt about when that assessment was actually completed?
A. So that assessment was not included in the electronic care record programme care base.
Q. Yes.
A. It only appeared to anyone post his death.
Q. Yes.
A. So there is some, I think -- and looking into those matters was recommended in the seven-day report, so there is some confusion, and I think --
Q. Yes, we will come to that. I understand that the author of the seven-day report asked for found that it wasn't in the file --

A. That's right.
Q. -- it wasn't on the file, asked for it, it was said to be a handwritten note that Ed's key worker said he did have --
A. Yes.
Q. -- and would be produced?
A. Yes.
Q. In fact, the original was never produced, a photocopy was provided on 2 January 2008?
A. I believe that that, at that point, it was asked to be added to his file.
Q. Yes.
A. I guess on the electronic care --
Q. I understand. In any event, quite crucially, what that risk assessment recorded, if we look at this, please, this is -- you and I, if we look at this, this is at page 14 and paragraph 6.8. That risk assessment recorded this, that Ed has not expressed suicidal ideas and no previous known attempts -- I am just going to wait for a moment.

(Pause)

So sorry. I am just being reminded of the time?
A. That's okay.
Q. I told you I wasn't great on time. I will just finish this section and then I think, as long as you are happy

and, Chair, you are happy, we will perhaps take a break then, so very shortly. I am going to read that again it being crucial.

That NEPT risk assessment recorded that Ed has not expressed suicidal ideas and no previous known attempts?

A. Yes, so that's factually incorrect.

Q. Demonstrably wrong?

A. Demonstrably, categorically wrong.

Q. Yes, and, actually, we have been through all of those events that --

A. Occurred.

Q. -- were notable in and of themselves but had built up a picture which make that categorically incorrect?

A. Yes, and I mean they were over the previous two months only --

Q. Yes.

A. -- and they were expressed, I understand, in a comprehensive risk assessment by Suffolk --

Q. Yes.

A. -- provided to Essex upon his admission --

Q. Yes.

A. -- to Maple Ward.

Q. So we will come to this but my understanding is that, on file, was a comprehensive nine-page report from Suffolk?

A. (Witness nodded)

Q. But of the nine staff who were interviewed for the Serious Untoward Incident report, only two of them had seen it?

A. And five of them were not aware of any suicidal risk.

MS TROUP: Yes, all right. So we will come on to that.

Ben, as long as you are happy, I think this might be a good time for us to break, Chair.

THE CHAIR: Thank you.

MS TROUP: Thank you.

THE CHAIR: We will come back again at 2.00.

MS TROUP: 2.00, thank you.

THE CHAIR: Thank you.

(1.03 pm)

(The short adjournment)

(2.03 pm)

THE CHAIR: We have got a transcript.

MS TROUP: Yes.

THE CHAIR: Good.

MS TROUP: Thank you.

Ben, where we left off was in mid-December 2007, while Ed was an initial on Maple Ward at Severalls Hospital. We have talked through the NEPT risk assessment that was dated 9 December 2007 --

A. Yes.

Q. -- and just to follow this chronology through,

I understand, and you have understood, from the records that on 12 December 2007, the records note that Ed again expressed feelings that life was not worth living?

A. That's correct.

Q. It was recorded that he was low in mood and an antidepressant was to be added to his medication regime?

A. Yes.

Q. Yes?

A. Yes.

Q. One of the things you tell us about, having been granted a short period of ground leave on 19 December, you tell us that a decision was taken on 21 December not to grant Ed home leave for Christmas and I think you have particularly strong feelings about that; is that right?

A. Yes, well, I mean, I think inevitably, as someone who has got to have many more Christmases and New Years, it's nice to spend them at home. I mean -- and I'm not clear obviously on the clinical decision-making exactly that went on in that case and I don't really want to second guess it, but it's a little bit upsetting in the context of what was about to happen.

Q. Of course.

A. Yes.

Q. Of course. Essentially, in summary, the records show

that Ed's mood remained low during the period up towards the end of December. Your parents visited him on the 29th --

A. Yes.

Q. -- and then spoke to him by phone on the 30th and that was when they were discussing the PlayStation that they wanted to bring to him?

A. Yes, that's correct.

Q. We know, Ben, that Ed took his life on the following day, the 31st --

A. That's right.

Q. -- and that he died by ligature?

A. Yes.

Q. That was the same day on which it had been recorded that there was some sort of altercation with another patient that we have discussed --

A. Yes.

Q. -- and you told us in your commemorative account about police attending your home on New Year's Eve to tell you that Ed had died.

A. Yes.

Q. I want to move on to some of the matters you have told us about and some of the concerns both that you raise and that were dealt with in the two reports you refer to. Those are the seven-day report and the full panel

Serious Untoward Incident, or SUI, report?

A. Okay.

Q. I also want to talk to you about your recollections of the inquest --

A. Okay.

Q. -- into Ed's death and some of your comments on that, about your knowledge of the prosecution of the Trust by the Health and Safety Executive much later and then a little about Edward House --

A. Okay.

Q. -- before we move on to some of your recommendations. My understanding is that, as we have already discussed, the assessment that was carried out at Longview, which was Ed's first admission and that was the adolescent unit, was particularly criticised by the SUI panel?

A. Yes, so, for example, I mean, the final word was no mental illness, which was, you know, after the fact, not correct.

Q. Yes.

A. That had the effect of making it harder for my parents to access care for Ed. I think it -- the findings, whilst acknowledging that it's difficult to diagnose maybe burgeoning psychotic illness in adolescents, the very fact it is difficult to diagnose should be, like, you know, a warning sign that maybe that is

a possibility, rather than it being discounted because --

Q. Yes.

A. -- of the same reason.

Q. In fact, I think you tell us that clinicians consulted for the purposes of the inquest concluded that, although it is fair to say that it's easier to diagnose in hindsight, there was sufficient evidence to suggest an emerging psychotic illness, such as schizophrenia and we have heard that that had started to come up and be mentioned as a potential diagnosis?

A. Yes, and obviously that had a knock-on effect in terms of -- sorry, I muddled my words somewhat.

Q. Not at all.

A. There were there was a lack of follow up post that, after he left Longview, which I guess was, to some extent informed, by the --

Q. The conclusion that they had reached that he wasn't suffering from any form of mental illness?

A. Exactly.

Q. I think for those reasons, a number of recommendations were made in the SUI report about reviewing the evidence base for using the inkblot tests and the squiggle drawing test that we have spoken about --

A. Yes.

Q. -- auditing -- and that an audit should be carried out -- if you are looking at it, I am so sorry, I am on page 21, paragraph 9.5 -- that an audit should be carried out of discharge summaries, that any reports should be signed and dated and then, as we have just discussed, that early onset psychotic illness in adolescents can be very challenging to diagnose but this really was about a lack of alertness to that.

A. Yes, absolutely.

Q. I think the findings were that, at Longview certainly, and this is reflected in the fact that there was almost no follow up, there was no indication that staff recognised the cumulative events and deterioration that led to what was later a very acute presentation?

A. Acute presentation, yes, absolutely, yes.

Q. Yes. The SUI report also, looking now at paragraph 6, found that the referral process from Wedgwood House to the Maple Ward at Severalls had been what is described as haphazard and informal?

A. So, for example, there was no direct consultant-to-consultant discussion, like, on admission or as soon as possible thereafter, I think they recommended. There was no indication that the ward manager had any involvement in the referral process. I assume that's the ward manager at the Maple Unit --

Q. Yes.
A. -- and there was no formal referral procedure, so there was --
Q. Yes.
A. -- the scope for a lot of lack of clarity, I think.
Q. Yes. In relation to those recommendations and the ones we have discussed about Longview, as far as you are aware, as of this date, were those actioned?
A. I am not aware whether they were.
Q. Thank you. One of the major areas that is of concern running through all of your evidence and all of the points you raise is around risk assessment and the adequacy or otherwise of risk assessment processes?
A. Yes, and that's both risk assessment, in terms of patient care, but also environmental risk assessments.
Q. Exactly, well, if we deal with those in turn. If we look, first, at risk assessment in terms of patient care and, in particular, a failure to properly assess risk or to acknowledge or understand the risk of suicidal intent or to acknowledge properly the history of suicidal intent, we know from your witness statement that the first report, the seven-day report -- this is on page 17 at paragraph 8.2 -- essentially concluded that all relevant procedures were carried out?
A. Yes.

Q. Now, you comment there that this is in spite of the fact that all of the CPA care plans -- there were three, dated 9, 18 and 21 December --
A. Yes.
Q. -- from Ed's time in Severalls Hospital failed to reflect any reference at all to low mood, suicidal intent or a history of suicidal intent?
A. Yes, and that's obviously despite evidence being available to the contrary in multiple regards.
Q. Indeed. No new care plan was created after 12 December when --
A. He expressed low mood.
Q. Yes, and an antidepressant was added to his medication regime. In fact, when this matter was dealt with in the full panel SUI report, a number of findings were made in relation to inadequate risk assessment processes. If you are trying to find it, that begins at page 22, paragraph 9.8.
A. Thank you.
Q. So I think we mentioned it previously before lunch. The comprehensive, nine-page Suffolk risk assessment that was on file and came with Ed to Maple Ward had been seen by two of the nine staff who were interviewed, yes?
A. Yes.
Q. Five out of those nine staff were unaware of any risk of

suicide?
A. And specifically his care worker had not seen the risk assessment -- sorry, his key worker.
Q. His key worker had not seen the Suffolk risk assessment --
A. Yes.
Q. -- and, in fact, didn't see it until March 2008?
A. Correct.
Q. It did not appear that risk had been discussed at any point during admission?
A. Yes.
Q. Then a number of recommendations were made as a result around putting in place appropriate systems of clinical risk assessment, mandatory training on risk assessment and ensuring that risk assessments were available on Care Base, on the electronic system?
A. I mean, I think it's also striking to me that Ed had been transferred to Maple Ward specifically because of risks and it demonstrates, like, not only a lack of mechanisms to, you know, have those risks available to staff but also a lack of curiosity as to why he might be there in the first place, which doesn't speak, I don't think, to particularly high quality care.
Q. Yes, yes, I understand one of the baseline reasons for his referral to Maple Ward having been suicidal

ideation?
A. Yes.
Q. Yes. All of this, of course -- I am so sorry -- all of this, of course, feeds into the matters we have already discussed about the return of Ed's belt and shoelaces to him on 9 December --
A. Yes.
Q. -- because there was what is described really as a fundamental lack of knowledge amongst staff across Maple Ward as to the risk that existed?
A. Yes, and, I mean, that date is two days after he was admitted to that ward. So, I mean, it seems to me that that information should still have been present in the minds of whoever was making those decisions at that point --
Q. Yes.
A. -- as even like a bare minimum.
Q. In related comments -- if you turn to page 24 of your witness statement, and to paragraph 9.14 -- the SUI panel found that there was very little monitoring or recording of his depressive state in the notes and of his mood and, in exactly the same way, that there was no record of suicidal intent or a previous attempt to take his own life, which would have very obviously been crucial information, yes?

A. Yes, that's correct.
Q. You go on to talk in your witness statement about staffing and about very serious concerns around staffing and those are matters that obviously bring in overlapping concerns around ward culture and ineffective risk management. One of the first things we discussed earlier today was that Ed's key worker worked night shifts?
A. That's right.
Q. You pointed out then that one of the things that the SUI panel concluded was that key worker primarily working night shifts made that process of ongoing assessment and planning particularly difficult?
A. Yes.
Q. If we look, please, at paragraph 9.16 of your witness statement --
A. Okay.
Q. -- you tell us there that there were comments within the SUI report about the use of the bank system of staff --
A. Yes.
Q. -- and that that did very little to alleviate the pressures on the ward?
A. Yes, and I think possibly it may have even hindered it. I recollect comments to the effect of it was possible to spend two hours at the beginning of a shift trying to

obtain appropriate staffing levels, which was, like, a waste of time and obviously not time that you would be spending with patients.

Q. Yes. Then at paragraph 9.17, you quote from the report, which actually says, looking at the second line, that the concern was, and I quote:

"... that the current staff are unable to provide the care required within a PICU environment particularly in light of the repeated assertion that there is little for clients to engage in on the ward."

A. Yes, so more reference to lack of therapeutic activities but also fundamental problems with staffing levels.

Q. Yes. There were recommendations around supervision of staff, if you go over to page 26 and to your paragraph 9.24. What the report, again the SUI report, concluded was that, although there was a supervision structure in place, it hadn't been implemented in any kind of appropriate or effective manner?

A. Yes.

Q. In terms of ward culture, if we look at the summary you have given of the SUI panel's findings there, at the bottom of page 26, the comments are in terms of -- I am so sorry -- ward culture, "institutionalised and of haughty superiority, with no therapeutic activity available"?

A. Yes, which are quite damning, I would suggest.
Q. And tie in with your parents' impression of the environment on that ward --
A. That's right.
Q. -- and their attempts to give Ed some activities to take up his time?
A. That's right.
Q. Then, in fact, recommendations were made about staff support, that's at paragraph 9.28, because staff interviewed were reported to be angry and disillusioned?
A. Yes, subsequent to the debriefing session after his death, I presume.
Q. Yes.
A. I don't have any further information about in what specific way they were angry and disillusioned.
Q. Yes. You make a point -- and I am looking now, you don't need to go to it but if you wanted to, at page 37, paragraph 18.4 -- about what seemed to your parents to be and what appears to you from the documents to be a total lack of coordination of care --
A. Yes.
Q. -- on the ward?
A. Yes, I mean, that's spoken to, I think, by multiple lines of evidence, like, "No, you can't have headphones", "Yes, you can have your belt", "No, there

is no risk of suicide", repeatedly, "Yes, there is a risk of suicide".

Q. Yes.

A. Yes.

Q. Such that, in a way, I think the way that you have expressed it, is that he was essentially left to his own devices --

A. Yes.

Q. -- and left, as a very young man in an adult unit, to fend for himself?

A. Which presumably was not conducive to his getting better.

Q. Yes. Over on page 39, and this is at paragraph 20.5, you describe your parents' concerns about the staffing levels on Maple Ward being inadequate, and incompetence, and that incompetence, one of the examples you give, is that the SUI panel heard evidence that there were staff nurses on the ward who did not know how to complete a care plan or a risk assessment?

A. Risk assessment, yes, and that's -- I mean, I think that speaks for itself, to be honest.

Q. Yes. Turning to environmental risk assessment and looking first, if you turn, Ben, to page 19 of your witness statement and then to paragraph 8. 8. The seven-day report deals with the issue of ligature points

on Maple Ward and, essentially, in summary, tells us that the last ligature risk assessment had been carried out in October 2007?

A. That's right.

Q. At which time it had been decided that no further remedial action was required?

A. That's right.

Q. Nonetheless, the seven-day report made four recommendations and you list those at paragraph 8.9, and three of those at (a) to (c) deal with fixed ligature points. A review is recommended on page 19?

A. Yes, yes.

Q. Do you have it?

A. Yes.

Q. A ligature review of Maple and another unit called Cedar is recommended, that's at 8.9(a)?

A. Yes.

Q. It is recommended that existing curtain pelmets be removed and rails be replaced with suitable alternatives, and then that a full SUI panel is to be convened to look into the matter. When that occurred, in summary, the SUI panel was given a great deal of conflicting information about audits or assessments of fixed ligature points on the ward; is that your understanding?

A. Yes, that is my understanding and my understanding is that, like, responses to those concerns varied from concerns about pelmets have not been raised, to concerns have been raised but pelmets aren't a ligature risk and other concerns which didn't agree with either of the first two, to the best of my recollection, as well, so a really confused picture coming back from staff. And the SUI, I think, also went on to recommend that staffing levels in the risk management department were addressed as well.

So, I mean, that obviously points to the possibility that the risk management department itself was not capable of performing its duties properly.

Q. Yes. In fact, the SUI panel also found that there were no written records in relation to those risk assessments, partly leading to this confused and contradictory picture, with which they were provided by interviewing staff because there were so many different recollections of what have had been decided and what was needed and when; is that right?

A. Yes, yes, and with no concrete evidence of what the facts might be.

Q. Yes. If we go, please, to your page 25 and to paragraph 9.21, you make clear there that it's, this is obviously a matter of significant concern for you and for your

family, that this picture remains unclear?
A. Yes.
Q. You have sought further documents in relation to the HSE prosecution, which you hope might shed some light --
A. That's correct.
Q. -- on the matter, and may then, as we said at the beginning of your evidence, want to give further comments about this particular aspect of your concerns.
A. Yes, that is right. I mean, that seems not just applicable to Ed's case, and it would be nice for my own sense of well-being to understand most fully what had happened, but it's also touches upon that as very important in terms of the ability that the Trust had to learn from these sorts of situations, sort of at a broader level that would carry forward into future and might inform, you know, future care of patients, whether or not that was even possible.
Q. Yes, and I think, in fact, it overlaps with some of the other preliminary thoughts you have on recommendations for change, but one of the things you would like this Inquiry to consider, is this right, is a proper mechanism for learning?
A. Yes, that's right. I mean, we can return to it when we discuss the HSE prosecution but it seems quite clear that there isnt a mechanism for learning in this

case --
Q. Yes.
A. -- that these problems have reoccurred over a long period of time and that's heartbreaking, basically.
Q. Yes.
A. I mean, there is no need for this to happen once, really, but there is certainly, certainly no need for similar events to happen over and over again and failings and learning from them should, I think, really be scrutinised why they occurred.
Q. Yes. One of the recommendations that the SUI panel made in relation to environment risk assessment and fixed ligature points was that urgent reconsideration or urgent consideration be given to the re-provision of Maple Ward and it is your understanding, I think, that this is part of what led to the establishment of Edward House; is that right?
A. That's my understanding, yes.
Q. Yes, could you tell us just, in a sentence or two, what Edward House is?
A. Edward House, I think, is a low-secure environment for people detained under the Mental Health Act that, at the time of its opening, was explained to me as offering, like, all of the things that Ed's care lacked --
Q. Yes.

A. -- at the time, so therapeutic activities, and I assume much, like, safer environment and better staffing, I assume.
Q. Yes. We will come back to that. I would like to ask you a little bit about the HSE prosecution which took place in 2020 and 2021. My understanding is that you were only fairly vaguely aware of it at the time; is that right?
A. Yes, I think that my parents mentioned that it was happening to me at the time but that's the extent of my memory of it. I first became aware of it at the same time that I became aware of this Inquiry and --
Q. I see.
A. -- subsequently, I read the sentencing remarks after finding them and those remarks are, I think, what spurred me to engage with you and I think represent my -- the beginning of my understanding that these problems are likely systematic in nature.
Q. Yes.
A. But, at the time, I wasn't aware of it to any great extent.
Q. Yes. You have read more about it now and, as we have said, you want to -- there are documents from that prosecution that you are very keen to see.
A. Exactly.

Q. Yes, I understand. Just turning for a moment to the inquest into Ed's death that took place in 2011, and you deal with this in Section 10 of your witness statement.
A. Yes.
Q. You have explained there that, as with some of the earlier events, your parents sought to protect you from a lot of it but you were present for the inquest; is that right?
A. Yes, I don't think I was protected particularly during the inquest.
Q. Fine.
A. I missed, certainly, the first day of it, I think, because I had work commitments.
Q. Yes.
A. But I was present for all of the rest of it, I believe. Yes.
Q. One of the things you tell us is that your family was not legally represented during those proceedings but that the Trust was legally represented?
A. That's correct. I don't know why we weren't. I retain a sense of my mum's anger about that --
Q. Yes.
A. -- inequality of arms.
Q. Yes.
A. I think just a basic level of justice, what was just.

But then also, obviously -- yes, I think also, like, she had -- I think she felt that taxpayers' money spent defending an institution that had failed her was, yes, unjust, I think, when she wasn't able to meet them on their own terms.

Q. Yes, yes. That's helpful. Not able to meet them on their own terms and, in fact, it is one of the matters that you record in your witness statement that you feel very strongly about, that that inequality of arms has a very particular effect on families in those circumstances?

A. Yes, and well, I think it has -- I think I find it problematic in multiple ways. One is, I guess -- like, to an extent, one feels guilty that one hasn't done the best job that one could to protect others, like, that may not be reasonable but it's still a feeling.

Sorry, could you repeat the question?

Q. Of course. To be quite honest, I had forgotten what it was --

A. Me too.

Q. -- because I was listening to you.

THE CHAIR: Can I ask you something: but you shouldered the burden of the engagement with the inquest process; was that right? You made the submissions on --

A. I made the submission but we were -- as a family, we

shouldered the burden equally. In fact, my parents, I am sure, asked more questions of witnesses than I did but, as a family, we shouldered the burden of asking questions of witnesses.

THE CHAIR: Did the coroner make that easy for you to ask those questions and to make your submissions or did -- how --

A. I don't recall any sense that the coroner was acting in any way that was prejudicial to our interests.

THE CHAIR: I was just thinking about -- I wasn't suggesting that so much as whether you felt able to engage, whether you felt overwhelmed by it or whether you felt comfortable. How did that feel?

A. I can't speak to how we -- my parents felt in terms of dealing with disclosure because I wasn't there. In terms of the in-person events, I think we felt okay about engaging with witnesses at the time. But, for sure, it was burdensome. Like it's -- there was, like, a -- it felt like a really large amount of dissonance, one felt one was being asked to hold someone to account --

THE CHAIR: Yes.

A. -- which felt unjust because one was also dealing with the fact that this was incredibly painful on a personal level.

THE CHAIR: Yes. Thank you.
MS TROUP: In fact, I think that's another of the matters that you have listed in your preliminary thoughts on recommendations for change: that a way be found to alleviate the burden on families at that particular time, to try to hold a state institution to account in the midst of grief and hearing that evidence and all of the difficulties that that brings.
A. Yes. I think that's -- yes, I feel strongly about it, not just for my own sake but because I think that it's not an efficient way of going about things --
Q. Yes.
A. -- which is important for future patient safety.
Q. Yes, I understand. At the time you wrote your witness statement, you did not have a copy of the record of inquest?
A. No.
Q. But my understanding is that that has very recently been provided to you by this Inquiry and by your representatives?
A. That's correct.
Q. So you were writing a witness statement, I am so sorry, from memory.
A. Yes.
Q. But we do have it and what it records in terms of its

conclusion is this:

"Edward Arthur Jackson killed himself whilst the balance of his mind was disturbed. The following factors more than minimally contributed to his death: ineffective communication, inadequate risk assessment and lack of therapeutic activities."

A. That's right.

Q. Now, you said earlier that, as you begin to see documents in some ways or to a certain extent, it is reassuring because it sort of validates your own memory and what you had recollected.

A. Yes.

Q. Is that true in this case?

A. Completely. Yes. So apart from two of the factors, I had more or less word perfect recollection of the verdict as it turns out and that was -- it was reassuring to know that.

Q. Yes. All of those are matters which you cover in your evidence and which we are discussing today. One of the things you tell us is that you did have to prepare some submissions because representatives for the Trust at inquest essentially submitted to the coroner that neglect should not be left to the jury and that there should not be a narrative conclusion and you, on behalf of your family, prepared submissions arguing against

that; is that right?
A. That's right. So my, when writing my witness statement, my recollections of the situation were based on the Trust's legal representatives' verbal arguments.
Q. Yes.
A. So I remember her verbally arguing against neglect being a possibility.
Q. Yes.
A. I don't remember but am now aware that they argued against a narrative verdict but, I mean, we argued for the possibility that the jury should be allowed to decide because I think that felt most appropriate to us --
Q. Yes.
A. -- at the time. Yes, and I prepared those submissions.
Q. Was any support provided, as far as you can recall, to you or your parents before, during or after the inquest?
A. Vague recollection of, from some direction, pointed towards therapy. But I am really not in a position to comment what my parents might have received or not.
Q. No, fine. I understand. Could we talk a little, Ben, about Edward House?
A. Yes.
Q. You have described what that is and it was opened in August 2013. You understood, as you said, that

essentially it was intended to be everything that Maple Ward was not --

A. Yes.

Q. -- modern and --

A. Safe.

Q. -- safe, indeed, light and therapeutic activities and psychological services. You have set out a section there from the annual report in its opening year.

A. That's right.

Q. You also tell us that, thus far, and from the exhibits that this Inquiry has disclosed to you, you are not aware of any deaths having taken place at Edward House?

A. That's correct.

Q. But you are aware of a number of what we might describe as near misses and of a set of regulatory proceedings in terms of staff conduct?

A. Yes.

Q. Could you tell us a little about what effect that has on you and what you are carrying, in terms of that?

A. I mean, to be clear, I don't think that deaths or near misses at Edward House are more or less important than at any other Trust ward but they are more complicated for me to deal with because, obviously, it interacts with the loss of my brother more specifically, and it also -- I suppose, it feels that it is a more explicit breaking

of the implicit promise of the -- of the facility, if there is misconduct or a death there, to me personally, but I don't -- but to be clear, I mean, there shouldn't be deaths in any facility.

Q. Yes. Thank you.

Can we turn -- there is a section of your witness statement where you have addressed some of the specific matters that the Inquiry raised with you in its Rule 9 request and you start those comments on page 32 of your witness statement at paragraph 14?

A. Yes.

Q. The first matter that you mention there is diagnosis and I think we have covered the fact that -- and you say this, in fact, in paragraph 14.2 -- as far as you can see it, looking back in hindsight, there is an almost 18-month period that appears to you to be a missed opportunity to have spotted an emerging psychotic illness?

A. Yes, absolutely, and so that -- yes, there is a lack of certainty over that period that is later criticised by professionals. It contributed, certainly at the time, to my parents' distress --

Q. Of course.

A. -- because they didn't know what was going on. And I suppose one could argue that, well, it wasn't possible

for anyone to know what was going on definitively but that doesn't mean that it wasn't possible to have a clearer understanding than they had of the possibilities.

Q. Yes.

A. And I think that, on some level, they knew that at the time, that was the sense that I got from them and I am sure I had it, too.

Q. Yes. As you have explained, the other effect was that it made it more difficult for your parents to access appropriate support for him?

A. Yes, I think that that's true. I mean, it is also complicated by the fact that Ed didn't want support, not believing that he was ill.

Q. Yes.

A. So it is worth acknowledging that but that's also, I think, probably important to be aware of in these circumstances, sorts of circumstances.

Q. Of course, and we might think not necessarily uncommon either?

A. Yes, for sure.

Q. You also raise here issues, and this is at paragraph 15 on page 34, around admission, and here I think really what you are referring back to is the failure to identify or to take into account the cumulative events

and the deterioration that then led to a much later -- a much more acute presentation?

A. Yes.

Q. Is there anything more that you want to say about that?

A. Bear with me.

Q. Of course, take your time. I think principally, Ben, it is in relation Longview, isn't it?

A. It is. I mean -- yes, sorry, I am not sure.

Q. Please don't apologise.

A. I don't have anything further to add, I don't think, to previous concerns about the fact that the diagnosis was misleading, certainly after the fact --

Q. Yes.

A. -- that some of the criticisms of the behaviour of staff at Longview, in terms of the tests, were, like, very painful to have played out in a coroner's court when they seem so obviously to be not good clinical practice.

Q. Yes.

A. And then obviously in a practical sense, as we have already discussed, Ed found it difficult -- or my parents found it difficult to access care for Ed directly as a result of the care that he received at Longview.

Q. Yes.

A. I believe.

Q. Yes. The same is true, and this is something that we have noted at paragraph 16, you raise the concerns we have discussed about the follow-up from CAMHS in Suffolk, which you consider to have been wholly inadequate?
A. Well, there was one appointment, which Ed did not attend, and there was no follow-up and that was criticised, I think.
Q. Yes, and given the severity of how he was presenting at the time, that therefore came in for particular criticism?
A. That's correct.
Q. Yes. In relation to -- because we have heard that when the referral was made from Wedgwood House to Maple Ward that was under an SLA between the Suffolk NHS Trust and NEPT?
A. Yes.
Q. What you have set out very helpfully in your witness statement are the particular concerns that your parents had about that Service Level Agreement and I think, in particular, in relation to due diligence, given --
A. What we now know.
Q. Yes, given what you know now about the fact that he was unsafe and the environment that they saw on Maple Ward?
A. Yes. So Suffolk prepared submissions for the coroner's court, where I think they more or less said that they

weren't aware of any problems in Maple Ward, which raises concerns, multiple concerns. But at the inquest we heard, you know, that, well, self-evidently Maple Ward wasn't fit for purpose but also it shouldn't necessarily have been unknown to NEPT that that was the case and --

Q. Yes.

A. -- therefore why didn't Suffolk know that as well, which is an important point.

Q. Yes.

A. And I've seen correspondence from my parents to the Suffolk NHS Commissioner that says -- you know, that outlines all of their concerns and asks what has been done about it why didn't you know, and all of this is in -- my parents' motivation in doing that is clearly so that it doesn't happen to anyone else --

Q. Yes.

A. -- and they sent a similar to social services in Suffolk when Ed was improperly sectioned --

Q. Yes.

A. -- where they were explicit that this shouldn't happen to someone else's child.

Q. Yes.

A. And, I mean, it's just heartbreaking that they were in the position that they felt they had to do that, like,

they were holding these people to account and now it seems like it didn't -- I don't know.

Q. Go on.

A. It feels a little bit like the extent of the problems are such that it kind of diminishes your memory of what you were trying to do at the time. Maybe I have phrased that badly.

Q. No, I understand.

A. I am ad libbing.

Q. I don't think you phrased it badly at all.

I understand. These matters and the particular concerns that your parents raised about the SLA and what due diligence was carried out, the answer to which appeared to be none, unless particularly serious concerns were brought to our attention, are matters that, in your witness statement, you say that you would like this Inquiry to investigate, yes?

A. I think so. Yes. I mean, one of the things that Suffolk responded with was suspending allocations to Maple Ward pending the review of the SUI and its recommendations, but we also now know that SUI recommendations don't necessarily really help.

So what is the appropriate mechanism by which recommendations are implemented to maximise patient safety?

Q. Yes.
A. I am not convinced that it is an SUI by EPUT in the 2000s.
Q. Because, as you have pointed out, in some of what you say about a mechanism for learning, there were previous SUIs and those links not being made, rehashing conclusions in a SUI I mean I don't want to put words in your mouth but is that right? Am I --
A. Yes, so, so, for example, upon reading the HSE sentencing remarks, there are 12 deaths and one near miss. Ed is chronologically death number 3, there were two previous deaths in 2004. The sentencing remarks discuss that. One SUI found that the ligature used had previously been identified but not removed and, for the other deaths, the SUI recommendations weren't implemented.
Q. Yes.
A. Ed's SUI doesn't refer to either of the previous SUIs and, in the HSE prosecution alone there are nine further deaths by ligature.
Q. Indeed.
A. So it speaks to a complete inability to learn from previous events, with like the most tragic outcome, and I don't know -- really have the words to describe how not okay that is.

Q. Yes. Thank you. One of the other things that I wanted to ask you about, we have spoken about the ward environment and staffing in relation to Maple Ward and Longview, in fact in terms of diagnosis and the conclusions reached.

One of the issues you raise more generally in relation to risk management and Ben, this is at page 36, paragraph 18.1 --

A. Thank you.

Q. -- you talk about the missed opportunities to address ligature points, to safeguard him and the failings in his clinical care and management that we have discussed?

A. Yes.

Q. But you also go on to make comments about counsel to this Inquiry's opening statement in April, in relation to Dr Davidson's and Ms Nelligan's evidence?

A. I do. I watched it live, I didn't have -- I haven't revisited it, my recollection of the note I took at the time as I stated there is no such thing there can be no such thing as a risk-free environment, so on the proviso that my memory is accurate, I found that really troubling, that proposition, because, well, it lacks nuance, to start with, but it felt to me like it had the possibility of excusing circumstances that was like so beyond the pale so completely unacceptable that it is

a distraction to dealing with those situations.

I mean, that was my personal feeling. I don't -- I mean, I didn't -- yes, it grated with me, it sat badly with me when I heard it in the context what I know about Ed's care.

Q. Yes, I understand. Thank you.

Ben, what I would like to do now is to take you to the final section of your witness statement which is titled "Recommendations for Change", but I think it's important that we make clear that really, as far as you are concerned, these are preliminary thoughts because there is still evidence you wish to see and, of course, there is other evidence that this Inquiry will hear that may change your views or add to them?

A. That's absolutely correct.

Q. So if we can go through those. The first -- well, actually, if we can go please to paragraph 21.3?

A. Yes.

Q. There you tell us that, thus far, you have been quite unassured listening to the evidence of the Trust. Tell us why?

A. I mean, it is a gut feeling but, like, in the situation, like, I think you will understand that I wanted to listen to the Trust and feel like everything was going to be okay.

Q. Yes.
A. Just as a natural urge and, for whatever reason, I didn't, in the previous sessions, and I thought that that was worth commenting on --
Q. Yes.
A. -- just from my own personal experience.
Q. Yes. I understand. The first thought you give at paragraph 21.4 is that you consider that there should be a central record of all deaths and near misses in mental health settings?
A. I think that those data would make it so much easier to be able to evaluate where things need to change or whether they need to change and it just seems to be a really sensible parsimonious thing to have and I note that INQUEST submitted that that sort of record does exist in other contexts, for example, in prisons.
Q. Yes, that also feeds into what you have said about a mechanism for learning because a central record would enable patterns to be spotted or matters to be picked up in a way that it appears to you at the moment --
A. Aren't.
Q. Yes.
A. Absolutely.
Q. You say at the next paragraph, 21.5, that you support the submissions that were made by INQUEST that there

should be a national oversight mechanism, which is independent and can properly scrutinise the implementation of recommendations?

A. Yes, I mean, I would just emphasise that the fact that there seems to have been no mechanism for learning in this case --

Q. Yes.

A. -- leads me to think that such a mechanism should exist that it should be independent and it -- I mean, I don't -- I have no comments on what it looks like exactly but I have a strong feeling that learning -- like, the ability to learn, needs to be baked into the system.

Q. Yes.

A. Such as it is.

Q. Yes, and part of the structure, an inherent part of the structure?

A. Exactly.

Q. One of the other things we have already touched on is the burden that is placed on families, following deaths in these circumstances, to hold institutions and/or individuals to account and to sort of take up that fight, if I can put it in that way. You refer here again to Ms Coles' evidence and the need to somehow find a way to alleviate that burden on families.

A. Yes, and I think that's for two reasons: one is it seems unfair to those families themselves; but also, I think, that it doesn't -- the current situation is not necessarily the best way to improve future patient safety --

Q. Yes.

A. -- such that, like, whilst you are grieving, you are not necessarily best placed to do the best job.

Q. Of course.

A. Or you may be able to but I am not sure that's always going to be true in every case and it should be.

Q. Of course. Then at 21.7, you talk about equality of arms and I think, unless there is anything that I have missed in relation to that point, I think we have covered it, have we?

A. Yes.

Q. The other point that you raise, which I think is crucial and it is at paragraph 21.8, is what I have -- in summary, it is the fact that you consider that the involvement of family members should be a core part of clinical decision-making; is that a fair summary?

A. I think that that's a fair summary. I mean -- I mean, just the facts of Ed's care -- I mean, my parents would have done anything for him and that includes bringing him different trousers, full stop.

Q. Of course. You talk at the next paragraph, Ben, about a culture of institutional defensiveness. Can I take it from the evidence you have given thus far that you are talking across the board?
A. I am talking across the board from what I've seen in this Inquiry but also specifically for example the Trust's behaviour at Ed's inquest --
Q. Yes.
A. -- arguing against a neglect verdict --
Q. Yes.
A. -- arguing against the possibility that the jury should be allowed to decide what caused his death.
Q. Yes.
A. I mean, such -- it seems totally at odds -- I understand why you would do it, cynically, but it seems totally at odds with what their concern should really have been, which is the safety of all and future patients.
Q. Yes, and candour --
A. Yes.
Q. -- and openness.
Moving on, you note here that you would welcome recommendations that properly address whistleblowing safeguards?
A. My recollection of Sir Rob Behrens' testimony was that, not necessarily in Essex, but a tactic is to refer

whistleblowing doctors to the GMC, is my memory. I was -- I hated that. That's also, in my opinion, to the extent that it's true, completely contradictory with patient safety.

Q. Yes.

A. So I had a gut reaction against that when I heard it.

Q. Yes, that's helpful. There appears to you to be scope -- this is at 21.11 -- for recommendations about CAMHS and transfer to adult services?

A. I mean that -- based on my reviewing the documents, the facts of Ed's care seem to suggest that there were deficiencies in CAMHS.

Q. Yes.

THE CHAIR: Can I just ask about that. You make it plain that the Severalls, the Maple Ward, seemed a hostile environment, as it were, for your brother. Do you think that was something that was peculiarly difficult, as an environment because of his age or do you think it was universally a poor environment?

A. I would imagine -- I mean, I never saw it. I would imagine it was universally a poor environment. I have concerns about the fact that he had just turned 18 and it was an adult ward and that he was targeted by another patient there. So I imagine my answer is a little bit of both.

THE CHAIR: Yes.
A. But, in terms of CAMHS, more specifically, I think the concerns are more about the engagement that he had with services after his first admission to hospital.
THE CHAIR: From Longview, yes, thank you.
MS TROUP: Yes, moving to the bottom of page 41, you then -- and I think we have covered this -- talk about concerns about commissioning processes and that you would welcome the Inquiry investigating that area further.
A. Yes.
Q. Then, last, you refer here to the Chair's opening to the April hearings and her reference to the fact that the Inquiry is minded to investigate the extent to which all suicides are preventable.
A. That's right. It chimed with me and it chimed with me in the sense that I would like to understand better the extent to which that's true. I don't -- I am not presenting you with what I believe at this point.
Q. Yes.
A. But I think that that is a really important undertaking because I think it has -- understanding of that has the potential to inform aspects of care and I think that that's really important.
MS TROUP: Yes. Ben, I think that I, for now, have come to the end of my questions for you and, unless the Chair

has any questions now, what I would propose is that we take a five or ten-minute break to see whether there are any further questions, and then perhaps come back?

A. Okay. Thank you.

THE CHAIR: Thank you.

(2.58 pm)

(A short break)

(3.12 pm)

MS TROUP: Chair, thank you, there are no more questions for Ben and that therefore concludes his evidence.

THE CHAIR: Can I thank you very much indeed for coming to give evidence, it's really appreciated. Thank you.

A. Thank you.

THE CHAIR: Thank you.

MS LEA: Chair, next Adam Rowe will give his evidence. We are just taking a moment to pause for him to get to the witness box.

THE CHAIR: Thank you.

Mr Rowe, welcome, please make yourself comfortable.

ADAM ROWE (affirmed)

Questioned by MS LEA

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

A. Adam James Rowe.

Q. You are the son of Amanda Susan Hitch, who was born on 20 October 1962 and died on 12 February 2022 at the age

of 59; is that right?

A. Correct, yes.

Q. You would like me to refer to your mother as Mandy throughout my questions; is that right?

A. Correct.

Q. And you would like me to call you Adam?

A. Mm-hm.

Q. For the record, sitting next to you is Maxine Rowe, your wife. She is sitting next to you for support and won't be answering any of my questions today.

By way of background, the Inquiry sent a Rule 9 request for evidence to you on 24 January this year and, in response to that request, you have provided a witness statement to this Inquiry.

You have a copy of that witness statement in the bundle in front of you, it is 21 pages long, with a two-page appendix listing documents that are within your possession. It is dated 14 May this year, if you would like to turn to page 20 internally of that statement, please, you made a statement of truth and then you signed the witness statement over on page 21?

A. Mm-hm.

Q. Have you had the opportunity to read through that document recently?

A. Yes.

Q. Are you happy that the contents are true and accurate to the best of your knowledge and belief?
A. I am.
Q. Adam, that witness statement will therefore stand as your evidence to the Inquiry. As you know, although I am going to ask you some questions about it, I won't take you through line by line today. But please be assured that the Chair and the Inquiry team have read and considered everything you say in that statement very carefully and it will form part of the body of evidence on which the Inquiry will rely.

I would also like to acknowledge that you provided a commemorative and impact account in relation to your mother, you read out that account during the hearing last September, on 24 September.
A. (Witness nodded)
Q. The Inquiry is extremely grateful to you for that evidence and I will ask you a couple of questions arising from that account today as well?
A. Sure.
Q. I want to just remind you that I won't be asking you to name individual staff members today, so please try not to do so.
A. Mm-hm.
Q. Your evidence today will focus on your concerns in

relation to Mandy's care and treatment under the care of EPUT. If at any point during your evidence you require a break, please do tell me and that's absolutely fine and possible. You are very clear in your witness statement that the dates and events that you have set out therein come from both your knowledge and also a review of the medical records and inquest documentation that you have in your possession and that you obtained since your mother died; is that right?

A. Correct.

Q. Before we begin, I would like to set out a brief timeline of your mother's involvement with Essex mental health services?

A. Mm-hm.

Q. As you know, I will summarise the timeline and key dates, all taken from your witness statement, and, at the end of my summary, I will check that you agree with it, but please do stop me at any point if I summarise anything incorrectly. You have your statement in front of you and please feel free to refer to it as you wish.

I will then move on to ask you about your concerns in relation to Mandy's care and treatment and your recommendations for the future.

So, as I understand it, according to your witness statement, you are now aware from your mother's medical

records that she had a history of longstanding chronic mental health problems for which she was treated both as an inpatient and outpatient for many years?

A. (Witness nodded)

Q. You first became aware of your mother's mental ill health around the time of your parents' separation in 2011, when you were 17 or 18 years old?

A. (Witness nodded)

Q. Thank you. I can see you nodding, which is extremely helpful. If possible, would you mind also saying "yes", just for the purposes of the transcript. I know it doesn't feel natural.

A. Yes.

Q. Thank you. Mandy was admitted to the Linden Centre in 2015 with symptoms of psychosis and she told you that she was hearing voices and thought that buildings were moving and talking to her?

A. Yes.

Q. From that point on, she was in and out of hospital?

A. Yes.

Q. During an admission in 2017, you recall being told by the medical staff that the medication she had been prescribed was not having the desired effect and there was nothing more that could be done?

A. Correct.

Q. On 9 July 2021 -- I am looking at your paragraph 12, if you would like to refer to it --
A. Yes.
Q. -- when your mother was being treated in the community, a meeting was convened between EPUT, British Transport Police, the National Rail embedded mental health nurse, your mother and her partner, as her mental health was deteriorating and her trips to railway stations were becoming more frequent?
A. Correct.
Q. In January and February 2022, Mandy attended numerous outpatient appointments in relation to her mental health and, on multiple occasions, she stated that she was actively feeling suicidal or low in mood and visiting the railway station with a view to jumping in front of a train.

I will go through some of those key instances now with you that you have set out in your statement.

A. Mm-hm.
Q. Adam, I am at your paragraph 16, if you are following along?
A. Yes.
Q. On 4 January 2022, she reported to her care coordinator that she was going to the train station when feeling suicidal and, at another appointment later that day, she

said to a nurse that she felt low in mood all of the time.

A. Yes.

Q. On 20 January 2022, during a home visit from her care coordinator, she informed her she was going and sitting on the train platform again?

A. Yes.

Q. On 24 January 2022 you called her care coordinator because you were concerned about your mother sitting at train stations again, thinking if she runs and jumps that will end her life.

A. Mm-hm.

Q. On 28 January 2022, your mother called her care coordinator as she was struggling to sleep and it was noted that her presentation had deteriorated?

A. Yes.

Q. She was advised to call Crisis if the sleep medication made no difference?

A. (Witness nodded)

Q. I am now at paragraph 27, Adam, if you are following along.

A. Yes.

Q. On 31 January 2022, your mother telephoned 111 and spoke to the crisis team, as she was having thoughts of going in front of a train and wasn't sleeping.

A. Correct.
Q. A Sanctuary support worker called later that day and your mother disclosed an intention to kill herself that night. The call was passed to a manager and your mother then indicated no intention to harm herself that night.
A. Mm-hm.
Q. On 1 February 2022, your mother saw a nurse for her monthly depot injection and reported suicidal intent and a specific plan to end her life by jumping in front of a train. She indicated she had thought about doing it that day but wasn't sure of the speeds. She later reported to a duty worker that she planned to jump in front of a train maybe that day when she goes home from seeing her friend and partner.
A. Correct.
Q. The Home First team were contacted on that occasion and it's recorded that Mandy was well known so they didn't accept the request for referral. Instead, the records state that she would be followed up by her care coordinator the next day and have the planned consultant psychiatrist review the day after?
A. Correct.
Q. On 2 February 2022, she was seen by the duty team and reported thoughts of ending her life but denied an active plan or intent to harm herself and said she

does not want to harm herself but reported low mood, the same for eight years?

A. Yes.

Q. Adam, I am at paragraph 35 now.

A. Mm-hm.

Q. On 3 February 2022, Mandy was seen for her planned medical review by her consultant psychiatrist. She said although she would like to act upon her thoughts of jumping in front of a train, she strongly denied any intention to do so. The risk was recorded as low at present but unpredictable.

This was your mother's last contact with an EPUT clinician prior to her death.

A. Correct.

Q. You confirm that sadly, on 12 February 2022, Mandy ended her life by jumping in front of a train, the very method that she had told services about during her contact with them in the weeks prior to her death?

A. Correct.

Q. Adam, are you happy with that summary of the key chronology of dates and events --

A. Yes, I am.

Q. -- that I have taken from your witness statement?

A. Yes, I think there were some other admissions that were in that time but yes.

Q. I will now ask you some questions about your concerns in relation to your mother's care and treatment.

Firstly, I am going to ask you about your mother's diagnoses. You state in your witness statement at paragraph 5, if you would like to refer to it, that your mother's initial diagnosis was bipolar affective disorder and resistant depressive disorder. You further state that a further diagnosis of enduring personality changes following mental illness was made later down the line?

A. Yes.

Q. Were you aware of those diagnoses before your mother died?

A. To an extent it was always very, very unclear and felt very kind of -- there was a lot of flitting between the diagnoses and it also felt the diagnoses changed when the doctor changed. So, yes, it didn't really feel like the diagnosis was necessarily driving what was happening and if the diagnosis changed, I would question it, and I didn't really get a clear answer to why it changed and what that would mean for kind of her treatment plan going forwards, and so on, so yes.

Q. So following on from that point, were you provided with any information as to what those diagnoses meant, coping strategies on how you as a family could assist your

mother in dealing with those diagnoses?
A. Not necessarily in relation to those specific diagnoses, only to look out for the warning signs and to raise concerns through the care coordinator and go through normal channels in that way.
Q. Adam, I am going to ask you some questions about your mother's admission to the Linden Centre in 2015 when she was admitted with symptoms of psychosis. Was that her first admission to an inpatient mental health facility in Essex?
A. It was, for a long time, yes. There was a brief admission before I was born, yes, which was kind of unrelated to this particular episode.
Q. In your commemorative and impact statement, you stated that, during this admission to the Linden Centre, you felt extremely frustrated by the failure of the staff to listen when you tried to convey to them how independent your mother had been prior to that admission?
A. Yes, yes.
Q. Is it right that that was an informal admission, ie your mother wasn't sectioned under the Mental Health Act?
A. I believe it was an informal admission. I had to do a lot of persuading of her and people around her to try and get her to make the right -- kind of make the right choice because she was -- I had seen her low, I had seen

her anxious prior to this, but I had never seen the extent of the psychosis around the inanimate objects talking to her, thinking that someone was going to come and kill her, and so on.

I think in terms of not being -- it felt very much she was just being housed there and not necessarily being pushed to get better and while -- yes, in fact, from my side, it was really hard to convey what she was normally like a year, two, three years earlier, which was -- she was a full-time teaching assistant, she ran a family household, she had done qualifications with the University of Cambridge in special educational needs, she used to be very physically able and, at this point, kind of wasn't and it just felt there was a lack of understanding of the extent of the deterioration and an acknowledgement around the -- that something had gone seriously wrong and there was a need to -- there -- a need to get her back to how she was before. But it almost felt like there was no going back and it was just, "This is how she is, we will make sure she doesn't do anything silly", and that's it.

Q. Would you like to say any more specifically about the failure of staff at the Linden Centre to listen to you?

A. There was -- yes, there was a -- not necessarily a failure to listen but a point around alternative

treatment options that came up at the Linden Centre and it was around where she was non-compliant with her oral medication, and she would either forget to take it, not want to take it, feel like it wouldn't make any difference, and I would really be thinking what else is there to do, there must be an alternative option, and it just happened to be that my wife is a medical doctor and we would have conversations around what other -- if there were any other options that hadn't been thought of.

And, on that, my wife suggested that I mention a depot injection to try and reduce the dependency of her taking oral medication, and it felt very much as if that had not been considered by the clinicians, and it wasn't a matter of, no, we are not going to do that, we have already talked about that and we are not doing it because. It was very much -- it felt like I had provided that suggestion. My wife is not a psychiatrist or involved in psychiatry, and that we had put that forward, it was considered and then it ended up being part of the treatment plan.

THE CHAIR: So you are suggesting that they weren't proactive --

A. Correct.

THE CHAIR: -- in exploring what treatment might be

available?

A. Correct, correct. In fact, it was always very -- I mean, throughout the whole period of this, her illness, it was always very, very reactive and not proactive, and there was a second specific example with this as well around the medication, again, not having its desired impact, and my wife suggested the use of ECT electrotherapy and, again, I remember the meeting around -- and I have got the notes kind of from Maxine about questions for me to ask the clinicians, and there was almost the same thing around "It's not like we have considered this, and we are not doing it because", it was actually they pondered on it and did it and it felt very much like that was not thought of as part of an alternative treatment, and that it was very much me specifically as someone who is completely out of the medical field, and my wife who is not related to the psychiatric field of medicine, coming up with these ideas and, yes, adhered to, but why should it have got to that point in the first place.

And, again, thinking about the other families and other individuals who might not have someone with medical experience related to them and what the possibility -- what would have happened if those treatment options hadn't been considered and, again,

other people who might, if they had had the knowledge or the -- not -- drive is the wrong word but the kind of the will to challenge the professionals about whether there were other alternative treatment options for their families. So, yes, it was -- it felt very much like we were -- the family were driving the care, not the clinicians driving the care.

Q. Helpfully, you have covered the next topic that I wanted to cover with you very comprehensively but just to clarify the timeline in terms of those two suggestions of treatment from you, I think you say in your statement that the depot injection suggestion came from you during the admission to the Linden Centre in 2015 and the ECT suggestion was during the admission to the Derwent Centre in 2017 --

A. Sure.

Q. -- is that right?

A. That sounds about right. Can I also come back on your diagnosis point quickly?

Q. Of course.

A. I just thought something, just around how there was also quite a lot of physical side-effects that she had later down the line, probably two or three years before she died, around -- and again it's in the statement -- around hunched back, drooped face, to the point where

I enquired at one point whether she had had a stroke, and things like that, lost dexterity in her hands to really like do her shoelaces up and basic -- she used to be a competitive cyclist, as kind of a younger person, cycled to and from work until she became ill, and she couldn't do any form of kind of fast or physical activity that required coordination.

And I never quite got an answer as to -- that was never diagnosed and I never really got a concrete reason as to why that was happening. And it was kind of just left to almost be "It's just kind of one of -- your mum is a complex case, it's just one of the things that's going to happen with all the medication she is on", but it was never really -- was it a side-effect of the mental health illness, was it a side-effect of the medication, was it something completely unrelated that wasn't being addressed. So that was just something that I wanted to bring up.

Q. Thank you. I am going to ask you some questions now about your mother's last mental health inpatient admission prior to her death. As I said, you explain in your witness statement that, from 2015 onwards, you recalled that she was in and out of hospital. You have discussed the two admissions in 2015, 2017. You confirmed to me this afternoon during a discussion that,

looking at the documentation that you have from the inquest, you believe the last time your mother was admitted prior to her death was 28 May to 15 July 2020 at the Derwent Centre --

A. Correct.

Q. -- pursuant to Section 3 of the Mental Health Act; is that right?

A. Correct.

Q. On that occasion, do you recall, were you as a family consulted about the discharge decision?

A. So the -- that particular -- I can't recall the actual finer details of that particular discharge and I think it was also during Covid when it was all very kind of locked down and things like that. The general -- my views during the discharge process and also in any other discharge meeting were very -- I don't think my views or the views of my family were considered in discharge meetings.

There was a point where at the Linden -- one of her admissions in the Linden Centre, she was -- she had basically over these years of engagement with the services had -- she had learned who to say certain things to, to avoid being sectioned or put in -- or admitted to the ward and -- which is why you will see in the statement that she says certain things to some

people and certain things to other people. So she knew if she was talking to that Sanctuary manager, she was going to say "No, I'm not going to kill myself", when a minute before that, she is talking to a worker who she knows won't necessarily have the decision-making power to admit her, she would say, "I'm going to kill myself in front of a train tonight". And the same with the consultants. She knew exactly what to say to the consultant psychiatrists to avoid either being admitted in the first place, sectioned in the first place, or being discharged -- about being discharged.

And it got to the point where, at the Linden Centre, there was one particular discharge meeting where she was being explicit to me, she had -- exactly what she wanted to do, she wanted to throw herself in front of a train, that hadn't changed, she was being really, really, verbal about it, and telling the psychiatrist something completely different, and I knew from previous discharge meetings that they would only really just take her word for, "I don't want to live any more but I am not going to do anything". "Great, let's discharge her". And I knew if that was going to happen it would be a real significant risk.

So I actually -- I got to the point of asking her closest friends and family, including myself, to write

formal letters to the psychiatrist and I brought them with me to the ward, to the discharge meeting, and it actually went from her being discharged to her being kept admitted for another kind of two, three weeks, at which point she had become, definitely not better, but was in a better state and a slightly less crisis state.

And that, for me, kind of summarised how, without that level of kind of galvanising almost a group of people and having it formally written on paper how you had to go that far to almost say "I am being serious here, like, you need to listen because, if you don't listen, something bad is going to happen", which, I mean, we can talk about the actual incident itself later but that's exactly what happened and why she died because of a failure to listen to views of the people who knew exactly what was going through her mind.

But yes, it was on the discharge meetings, as well, in terms of what to look out for, it was very much call the care coordinator, she's got Samaritans, she's got Crisis, but it was the warning signs were always there. That's my point, is that in either all of or almost all of her discharge meetings the warning signs for me were always well, well above where they should be for someone who's going to be discharged into the community. So she was still attending said train stations, she was still

talking explicitly how she wants to kill herself, and actually no matter how I -- how much I raised that as a concern that she would actually do something, it was always deemed as too low risk to be admitted or to even have the home treatment team involved.

Q. When you say no matter how much you raised that as a concern, is that at discharge meetings specifically or was that --

A. All the time, in any interaction. So for example with that call to -- the call that I made to the care coordinator around where was it in the statement --

Q. I think we will turn to that later.

A. Fine. Yes, fine.

Q. So we can go through.

Just finishing up on this line of questioning and just following that through?

A. Yes.

Q. When you refer to the occasion where you essentially stopped the discharge for a period of two weeks, was that an informal admission to the Derwent Centre in 2018?

A. That sounds about right.

Q. I want to briefly turn to lack of planned action and then I promise we will get on --

A. Sure.

Q. -- to the call --
A. Yes.
Q. -- and all of your key concerns as we go through. You state that, following your mother's depot injection appointment on 4 January 2022, the clinician emailed your mother's consultant psychiatrist to ask if they would consider your mother's case ahead of the planned appointment on 3 February --
A. Yes.
Q. -- but nothing was actioned and she wasn't seen ahead of that scheduled appointment.
A. Mm-hm.
Q. It's paragraph 20 --
A. Yes.
Q. -- if you would like to refer to it. Do you know what side-effects are you referring to there? Where you say, given the side-effects?
A. From what I remember, it was those physical side-effects that I mentioned to do with the diagnosis. So the broad picture of how she presented was, when she first started becoming ill, she was still physically active but it was very much kind of mania, anxiety and then kind of a period of being low and then depressed, but then probably, I don't know, we are talking over an eight-year period, maybe three or four years before she

died, these physical symptoms started happening, where like pretty much what I said before kind of, she literally had a drooped face, mouth kind of hanging open, hunched over, gained a huge amount of weight, was always very, very conscious of her weight but gained a huge amount of weight and loss of kind of dexterity and co-ordination and that was where I've that was where I said, like -- at least, at least prior to these physical symptoms she was physically able.

She was, she was mentally ill, she was really in a horrible, horrible place mentally but she could at least go to the shop, take herself for a walk, do basic life things, like do her shoelaces, and things like that. I remember vividly having to do her -- me and her partner had to do her shoes for her and he had to dress her, shower her, things like that. At least prior to, this she was able to physically look after herself, despite being depressed.

Q. Have you ever been provided to date with any reason as to why that wasn't actioned and she wasn't reviewed by her consultant psychiatrist sooner?

A. No.

THE CHAIR: Did anybody concede that that was a side-effect of the drugs?

A. No, no, I never got a clear response as to why that was

happening.

THE CHAIR: Thank you.

A. And also, in answer to your question around do I know if anything happened, I didn't even know that this kind of -- this has obviously kind of come from the records and I didn't know that this request for an early meeting had happened and, when I read this whole series back, I was raising my own concerns and I thought my concerns on their own warranted an admission, let alone when I went through the inquest and all this has come out from other professionals. Yes, so, no, I didn't know that but it doesn't surprise me that that happened.

MS LEA: Just staying on the topic of medication for a moment, did you have any other concerns -- you have mentioned side-effects -- but did you have any other concerns about your mother's medication generally?

A. It did just feel very kind of trial and error, around, "This hasn't worked for an X period of time, let's try this", "this hasn't worked, let's try this".

Or it would go -- I would suggest something based on what my wife had said for me to ask and then that happened. So it was very much kind of almost like a rotation of let's try these different things. Whereas, in my opinion, I feel like, again, coming back to the reactive not proactive theme, I feel like there

could have been much simpler therapeutic and kind of psychological intervention right at the very early stages of when she only really presented with mania and anxiety, and it was very much left to get worse, and worse, and worse, and worse.

So, yes, I don't think -- I can't remember your original question; what was the original question?

Q. You have answered it, thank you.

A. I have answered it, great.

Q. I asked about concerns in relation to medication generally?

A. Yes, yes.

Q. So you said trial and error?

A. No, apart from the trial and error stuff, as in, yes, I just felt like she was left to get as bad as she was, that even I started to become convinced that the medication on its own is just not going to shift this.

Q. Thank you. Turning to your concerns in relation to clinicians not properly considering information that you have provided and you have touched on this a little already. You have referenced the call that you made to your mother's care coordinator. If you would like to refer to it, Adam, it is paragraph 24.

A. Yes, got that.

Q. It is 24 January 2022, whereby you clearly reported that

she had been sitting at train stations again and was thinking if she runs and jumps that will end her life.

A. Yes.

Q. You state in your statement you were not reassured, despite the fact that it states clearly there that you were reassured --

A. Yes.

Q. -- and you felt extremely worried but you didn't know what else you could do to make the clinicians take on board how unwell your mother was?

A. Yes.

Q. Can you recall what the care coordinator said to try and reassure you?

A. This was a real, real pivotal point for me, so this was her -- Mum going from, "I want to kill myself in front of a train, I don't want to live any more", to talking about specific -- like the detail of how she was going to do it and the thinking behind it.

So she would explicitly -- what's been written here by the care coordinator is slightly wrong, in terms of she was -- Mum was telling me "I have been thinking", and this is kind of casual conversation, as if you were talking about what you had for dinner, "I am trying to work out if I run and jump or if I just jump from the edge, what's going to have a higher success rate".

And that was the first -- that's the first time she had talked to me about that level of detail and in such a candid way. That obviously raised alarm bells in my head and this was the day before this call, that evening before this call. I went out for dinner with her and she told me this and then, obviously, I have gone to work the following day and I remember calling probably like every minute, an hour before the offices opened, to get hold of the care coordinator and got through and said this and the response was that "We still deem the risk to be not" -- I was basically saying she has to be sectioned or she has to be admitted or there has to be some kind of significant increase in intervention here, and the response was there is it's not, it's not high risk enough let alone for a section, let alone for admission and not necessarily even home -- sorry, I'm crossing over with another incident but definitely not significant enough for admission or section.

And my question was, was around, well, what is like -- what is high risk enough. If you have got someone who has been saying who's been saying that -- who's been frequenting train stations, saying they want to kill themselves in front a train, and she is telling me exactly how she is going to do it and I'm supposed to be one of her protective factors, what's

the -- what's -- I specifically asked what would be high enough? And the response was: kind of attending every day or multiple times a day or being on the track itself.

At which point, I was just blown away by that response around -- that's obviously why people die in these situations, because you have given it one chance too many and, again, that's exactly what has actually happened and yes, I just, I couldn't believe there was kind of an arbitrary number on that, that, that that would lead to some kind of admission or some kind of section, and -- yes, go on.

Q. Is that what brings you to the view there in your statement where you say that you just felt they didn't take on board how unwell your mother was?

A. Yes.

Q. Because you were telling them this information and then you were presented with an explanation as to how she could be more unwell, for example?

A. Yes, yes, yes. So this -- I mean, this crosses over two themes, really. It is (1) the listening, to me and family members and (2) the risk assessment process. That if -- and I remember I am a public sector professional in a school, and very much being like, "I have told you this, I am trusting you to make this right decision, I completely disagree with you, I think

it is a section, I think it is an admission, if you are saying, as the mental health professional here, that that is not an admission, like, I am not happy about it, but, like, you need to know I am trusting you effectively with my mum's life here".

And that obviously, this whole process has completely broken all trust with what kind of mental health clinicians would say to me if this were to happen again in the future.

Q. Were you provided with any information or guidance at the end of that call as to what to do or what the next steps would be; do you recall?

A. It was just always the same. Just kind of, "If you are worried about something again, call them again, if she -- if Mum has the Crisis number to call, the Samaritans line to call, if she needs to", and basically just to keep an eye and, again, I was just, like, well, okay, fine, what if she does this again, what if she does run and jump tomorrow and is successful. Like, I didn't necessarily say that to them but that's what was going through.

THE CHAIR: Sorry, can I ask a question?

MS LEA: Yes.

THE CHAIR: You spoke earlier about her ability to identify who she spoke to and what she said to them; do you think

that played a part in their slight dismissing of you and your concerns and anxieties.

A. 100 per cent, yes 100 per cent.

THE CHAIR: So they had taken everything she said at face value.

A. Yes, correct. That is absolutely correct.

THE CHAIR: Thank you.

A. And -- but then there is also the flip-side where she is clearly crying out for help because she is telling certainly people exactly what she is going to do, but she's not telling the people who she knows are the decision makers --

THE CHAIR: Yes.

A. -- what's happening. And there was another incident around -- this ended up -- started to end up, actually, being almost reflected on, on me, in that she also realised that by telling me the things I have told you she is telling me she now knows -- she is starting to put together that when she tells me certain things, she is getting a knock on the door the next day or she's getting phone call the next day.

And there was a particular incident, I can't remember if I am coming on to it later or if it's -- if it is an opportunity to bring this up later, but she there was one particular incident where she was at

a train station and was going between stations, trying to work out which one was the best to kind of -- to be successful at ending her life and, for the first time, she called my brother, who also suffers with mental health concerns, and anxiety and -- anxiety and she would deliberately not call him, before she knows that he struggles with his own mental health and would call me because she knows I can kind of handle it and manage it --

THE CHAIR: Really?

A. -- and, yes, so I started also being put into that camp of, "I am not going to call Adam now because I know what's going to happen". And it was actually only then -- I mean, that was a completely traumatic time that was. That was her flitting between stations, my brother being on the phone to her, she -- her not telling him where she was, he could hear the train announcer in the background, and that was a real kind of red flag around almost like is it a goodbye phone call, then him texting me, at the time, during the phone call, saying you need to call the police or you need to call someone because she is at a train station. I don't know where she is, I am going to try and get it out of her. So, yes, she was very, very selective in who she spoke to and she knew what the outcome would be if that was

the case.

MS LEA: Can you recall -- obviously, that conversation between her and your brother was after your telephone call to the care coordinator on 24 January.

A. I can't.

Q. If you can't help us any further, that's absolutely fine?

A. I can't remember where it stood in the chronology I can probably find out.

Q. That's okay. Your telephone call with the care coordinator on the 24 January, was that the only telephone call or discussion that you had with a clinician that was of that nature, where you were raising concerns, or were there other calls?

A. No, that was the -- that was definitely the one where I was most blown away. There were many -- I mean, almost every call or interaction in a ward round or any, any kind of meeting was me saying, "She is saying this, this and this, I believe it". And it not being -- and her, her views being taken for face value and not mine. And, like, look, I get needing to hear the patient's views and put at the centre but you also need to ground it in some kind of -- some kind of sense around there is a logic here to what she's doing.

Q. You say that, in that call, you raised your concern that

she should be sectioned is that something that you or other family members had ever raised before or was that the first time you --

A. Yes, again, this was part of a pattern over probably three or four years of times she would attend the train station frequently. Also, I know of all these times that she attended the train station. I don't know about all of the times, she could have attended twice as much as I think, she could have been attending every other day. But, whenever there was a kind of spike in attendances or the level of detail in what she was telling me or the frequency of which she was telling me that she wants to end her life, yes, I would be frequently saying -- not just to the care coordinator but also to the Crisis line because there is a bit, again I think we are going to come to it later, on out of hours and out of hours kind of contact and again I remember speaking to the Crisis line, I think it was on a Saturday or a Sunday, and again saying, she is saying these things she saying she wants to kill herself, she's saying she want to do in front of a train, and I am worried about her mental state right now. But it would just be, the risk is not enough, kind of call the care coordinator on Monday and go from there.

Q. I am going to ask you some questions now in relation to your mother's last appointment with an EPUT clinician before she died, so the review by the consultant psychiatrist on 3 February 2022. Firstly, were you in attendance at that appointment?
A. No, I don't believe I was.
Q. Do you know if you were aware of it at the time?
A. I don't, I think I was probably aware that it happened, yes. But as in no, not fine detail.
Q. Can you recall -- and it may be that you can't -- but can you recall if you had any conversations with your mother after that appointment, about how it went or what was discussed?
A. No -- I can't recall but then I think it was a pretty -- from what I saw, a pretty run of the mill appointment in that, sadly, all these -- I mean, like I said, when you actually -- when I actually saw the wider context of what's going on with other professionals' concerns it was obviously an extraordinary -- that should have been an extraordinary meeting but, as far as I was concerned, she'd been telling me very similar things for a long time. I kind of knew what the psychiatrist was going to say. She went with her partner, I had -- there is only kind of a certain number of times I could take off work for it. But no, I wasn't -- wasn't aware --

All I know was, was it was again deemed low risk, she was deemed low risk and I obviously completely disagreed with it and, actually, the first time I really read the -- those notes from that meeting where it says she was low risk and that no, I can't remember what the quote was that no other kind of -- no significant increases required, or whatever, was when that letter was on her doormat two days after she died, and I am clearing out the flat, and I've opened this letter and there is the quote that she is low risk.

Q. You helpfully -- at paragraph 39 you clearly state that the record of that review doesn't mention the period of crisis that your mother had been experiencing just in the days prior to that consultation. We have discussed those key events but, just to be absolutely clear, you are talking there about the contact and call on 31 January, where your mother reported the plan to kill herself that night, the contact with the duty worker on 1 February after she reported a plan maybe when she goes home that day --

A. Yes.

Q. -- and then the call on 2 February where she reported low mood?

A. Mm-hm.

Q. You go on at paragraph 41 to stay that you consider the

consultant psychiatrist failed to consider the records added in those days prior to the consultation which showed the sustained period of crisis and repeated contact with services with direct suicidal intent with a plan?

A. Yes.

Q. It may seem obvious but what brings you to that conclusion that the consultant failed to consider those records?

A. I mean, this is just -- when you said about it kind of appearing obvious, like this is I think what I struggle with, is it was obvious and I remember at the inquest that I said she was kind of having -- all of these things having happened, that she was still flagging up kind of green or amber on the risk scale, and, like I said, it being -- it appearing to be a completely run of the mill normal routine appointment and, actually, you mention kind of the start of sequence of events being on 31st but, even kind of on the 4th, she saw the depot nurse and was suicidal, on the 24th I am making the call to say she's talking about running, versus running and jump. You have then have the care coordinator there's been a significant deterioration in physical appearance and various other things. You have then got the 31st, where she is saying -- she is calling

111, saying, "I'm thinking of jumping in front of a train", I've got here kind of four, five, six, seven, eight calls to various professionals saying exactly what she wants to do.

And, yes, that -- like, how can you not hear all of those things and go this person needs significant intervention immediately. And, yes, it appears that the consultant didn't see that and didn't have that information and neither did I, otherwise I would have -- otherwise I would have been pressing kind of almost far more than I already was, which I already felt was far too much, but it's almost sad to know that if I -- I already felt too involved but, if I had known about these instances, I could have actually, kind of, maybe had a further intervention and been really shining this in his eyes going, like, "Are you seeing this? Like, this is -- this needs something different".

Q. We will turn to the inquest in a moment but I think that was a finding that came out of the inquest, wasn't it?

A. Yes.

Q. Likewise, you state that the consultant psychiatrist failed to consider whether your mother required referral to the Home First team, again, that's something that came out at the inquest, isn't it?

A. Yes. And this just screams to me kind of complacency

and I want to just kind of find my notes. So there was talk of referral to home treatment and then there was talk -- there was a kind of -- it came across very much like a corridor conversation, around the care coordinator having a conversation with the consultant saying "Should we, shouldn't we?" And, from memory, no actual referral happening to even being rejected. So it's not even like -- if the referral was made to home first -- home treatment, and it was rejected, I would have had problems with that. The fact that it wasn't even put in in the first place is an even bigger -- a bigger concern and there's kind of bits that are just really kind of horrible to kind of read in the notes saying that kind of because she was -- I have got the notes here somewhere -- that because she was known to Home First -- here we go, yes, so kind of -- 33(d) on my notes -- 33(d), I think, might be a paragraph out -- it is an ongoing thought about killing herself in front of a train, Amanda is well known, and kind of, because she is well known, Home First treatment team have not accepted a request to make a referral because of her history.

So you have got all of these things and, again, I come back to the question, well, what would have meant a referral to Home First was appropriate. Like, if her

saying she wants to kill herself two nights in front of a train to three or four different professionals and her family, and that all being logged on a medical system and Home First, which is the intermediate level of intervention is not deemed serious enough, again, I keep asking the question, well, what is?

Okay, she has been presenting like this for seven or eight years, so just because that is normal that doesn't mean any further invention is required and she's not done it before, she's visited lots of stations, she's visited stations before, she has not jumped in front of a train, well, unfortunately, like, she did.

Q. Just sticking with that 3 February appointment, you note in your witness statement at paragraph 35(a) that the consultant recorded your mother described her sleep as fine. But three days previously on 31 January, she reported to the Crisis team that she wasn't sleeping, she was getting about two to three hours --

A. Correct.

Q. -- of undisturbed sleep a night and, again, it may be that you aren't able to help us, but can you help us with whether she was still having problems with her sleep --

A. Yes, it was dreadful.

Q. -- on 3 February?

A. Yes, it was dreadful. Again, these are also reports from her partner, that she would be kind of pacing the house at night. She kind of went from sleeping in the bed, sleeping on the sofa. Yes, no, it was absolutely dreadful and, again, this kind of, for me, comes back to kind of the picking and choosing as to what she is kind of describing and how much of a concern she wants to portray herself as and, again, in that meeting as well she -- I mean, I am saying she is picking and choosing. There is also still big red flags in terms of her saying she rates her mood as 0 out of 10 and, prior to that, it was 2 out of 10, and so on.

And, again, you can see in that paragraph she strongly denied any intention to jump in front of a train. She is saying that to the consultant because she knows exactly what the consultant will do if she says something different. He doesn't know because he's not looking at the system or the system failing somewhere, he doesn't know that she has said that to healthcare professionals -- multiple healthcare professionals in multiple different areas.

Q. It is also recorded at paragraph 35(a) that the consultant noted there were no major side-effects with her current medication. So does that go to the point that you were making earlier about the lack of clarity

as to whether the physical symptoms she was suffering were a side-effect of medication or otherwise?

A. Yes, like, just some of it just doesn't make sense. Like, she was hunched over, mouth open, slow moving, and again I come back to kind of there being a general sense of the person that's -- and this comes back to my point about the Linden Centre, the person that's presenting in front of the healthcare teams at that moment is like that person has always been like, that's what it feels like. It feels like there is a lack of understanding of how much of a decline that person's experienced because she did go through different consultant psychiatrists as well, and I can't remember when the physical symptoms started and the consultants psychiatrist changed but it probably was around the same time.

But, yes, there is definitely -- I say it is a ridiculous kind of comment to make that she didn't have, kind of, side-effects or symptoms.

Q. Thank you. And at paragraph 37(a), you state that the care plan after that meeting was that your mother would be reviewed by the consultant again in four months; do you know whether she was happy with that plan?

A. I mean she didn't want to engage with the services, so she -- I mean, ultimately, she wanted to kill herself. So as little involvement with the services as possible

was -- was preferable for her, although, like I said, there were obviously these flashes of cries for help, where she has called the crisis line, or she has called Samaritans, or me, or someone.

But no, I think she was very consigned to "I am either going to be like this for the rest of my life or I am going to kill myself", like that that was it.

Q. Do you know, was she due to have contact with any other clinicians in that four-month interim period, her care coordinator and the --

A. Only --

Q. -- depot injections?

A. Yes, exactly, those routine appointments.

Q. Did you have a view as to the plan at that stage, can you recall?

A. No. It just -- it was, it was just very, very, like, stuck in a rut, just she doesn't seem to be getting any better, no one is really understanding what I am saying and the seriousness of what I am saying or seeing through what she's saying. And it was just doing what we can do, just me and her partner just kind of keeping -- him actually watching her, kind of like making sure he knows where her whereabouts are, me calling, and things like that. It almost felt like we just we had to do the best we could. But we can't watch

her all the time.

Q. No. Very briefly, we know that that was her last consultation with an EPUT clinician and that was 3 February and we know that she died on 12 February.

Would you like to say anything about the nine-day period there before she died, any contact that you had with her, how she seemed?

A. She was just -- I think, a couple of things. She was just clearly like so unwell, like, it was just plainly obvious.

She was doing normal things, she was like -- she would see -- she made a friend on the ward from a previous admission, she saw that friend, and then, as far as I'm concerned, she went to the station on 12 February, like any other time she has been to the station, and this was the right -- she had that 1 per cent extra motivation and effort to do it, which is my problem, in that that could have happened on any of these other previous occasions. It just happened to be on 12 February she had that slight wave of -- or maybe it was that one time where I have now been here 20 times I have now got the confidence to do it.

But no, as far as I am concerned, it was like any other normal visit to the station.

Q. Turning now to the inquest into your mother's death.

You say at paragraph 47 that that took place between 13 and 15 December 2023?

A. Correct.

Q. The coroner recorded a narrative conclusion that your mother died by suicide, however recorded that:

"There were plainly interventions that could have been taken and would have served to protect her from the known risk of suicide and not considering those contributed to her death."

A. Correct.

Q. You have set out those failed interventions very clearly in your witness statement and what I would like to do is just go through those with you now and see if there's anything further that you would like to say in relation to each of them. It may be that you are happy that we have covered that area; of course that's okay.

A. Yes.

Q. So, firstly, and I am at paragraph 48(b), the level of risk that she presented with was not sufficiently appreciated and addressed, they were aware of the risk that she would kill herself by jumping in front of a train, plans were drawn up, there was an increase in risky behaviours but that didn't lead to sufficient changes in the clinical response.

Would you like to say anything further in respect of

risk assessments or failure to properly risk assess?

A. Yes, so I mean just -- it was a -- for me, like a lack of complete information around where -- you know, where this information or where this logging is coming from, from other people. A failure from the consultant -- if the system operates in that way, a failure of the consultant to find it, rather than just kind of relying on, "let's open up her record, okay, nothing immediate pops up right here, I am just going to go ahead". There was, in terms of risk assessment, like actual kind of like risk assessment procedures, the inquest highlighted that they just weren't used and I can't help but think that, having some kind of systematic process of assessing risk there was needed.

And it all sounds fine in the inquest, where they are saying there is an NDT and all kind of professionals around the table evaluating risk, but when you have got six or seven or eight instances two weeks, three weeks before she dies saying she is going to kill herself and exactly how she was going to do it and -- again, I vividly remember in the inquest it saying that she was either still highlighted as green, I think it was green, or possibly amber, ie not kind of a major concern; that's a big worry.

And --

Q. Sorry, just stop you there, but just touching on something that you just raised in terms of the reference to the notes, what you are referring to there is the coroner's finding that --

A. Yes.

Q. -- they didn't appear chronologically for clinicians to review, it was based on team.

A. Yes.

Q. So because it was different teams, those notes weren't necessarily appearing for the consultant --

A. Yes.

Q. -- upfront and centre, if you like?

A. Yes, so the depot nurse would log a concern on her system, the Sanctuary worker would log a concern on their system and, yes, those they were in different, they were filed away in different areas of the system that the consultant couldn't clearly see.

There was also mention around protective factors and what protective factors would stop her doing that. While the protective factors that were listed were me and my brother, and I explicitly asked her on numerous occasions, like, to try and understand the rationale on her level of seriousness, "Would the impact on me and my brother stop you doing it?" Or kind of imagine -- and, again, I have already mentioned my brother's struggles

with his own mental health, what would -- "Would the impact on his mental health after you did this -- have you thought about?" I wanted to actually just understand if she had considered the impact and she very much had considered the impact.

It was her -- it was -- she had such a high level and drive to end her life, she was willing to put -- and this is coming from -- my mum loved us very much very, very, very much, she was willing to put us through that, so she could end her life, like, that's how miserable her life was. So when we're listed as protective factors, I am just not convinced that there was enough, I mean, it wasn't enough.

Q. Adam, just touching on the last two missed interventions that the coroner set out, 48(c), no formal referral to the Home Treatment team, we have touched on that already; and then 48(c) also, the change from your mother merely talking about, in essence, hypothetically ending her life or the specifics or to doing it that day --

A. Yes.

Q. -- and not appreciating that change in risk?

A. Yes.

Q. Did you attend the inquest?

A. I did.

Q. Yes. Were you legally represented?
A. Yes.
Q. Was there a jury or was it just the coroner?
A. No just the coroner.
Q. We know that a Prevention of Future Deaths report was made by the coroner, dated 19 December 2023 and you have helpfully listed that in the documents that you have on page 23 of your witness statement --
A. Yes.
Q. -- is that right?
A. Yes.
Q. I am not going to go through the three findings in that report, simply because, when we turn to your recommendations, they actually follow on from --
A. Sure.
Q. -- those findings and recommendations --
A. Yes.
Q. -- so we will deal with it all together when we come to your recommendations. But, in short, they relate to the fact that, as you have said, the notes don't show continuously, in chronological order, the fact that risk management tools weren't used and the fact that there were occasions where your mother's attendances at the railway station were not passed on by British Transport Police to the care coordinator and treating clinicians;

is that right?
A. Yes, just to add on to that as well, there is a point around -- it all looked well and good the British Transport Police plan with the Trust, it is, "We have got this procedure in place, we have got this system in place to inform everyone". There was no factoring in of it being an unmanned station, and that's something that really came out of this. You see all these things, you are kind of reassured, and then the things that are supposed to be happening aren't happening, which are people relaying to the healthcare professionals that she's attending and you've actually got the point that the station she's regularly going to has no staff.
Q. Yes.
A. So yes --
Q. Understood?
A. -- there is also issues there.
Q. Have you ever received an update from the Trust as to any actions that they have taken in response to that report?
A. I have had responses to the PFD. I can't remember exactly if it said what they had done or what they will do. I can't remember.
Q. Is that the Trust's formal response to the PFD, rather than a separate --

A. Correct.
Q. -- individual response to you as a family?
A. Yes, formal response, yes.
Q. Yes.
Adam, I am finally going to turn to your recommendations for change but I am conscious that we have been going for an hour. Would you prefer to continue now for another 15, 20 minutes and go through those recommendations or would you like a break?
A. No, that's fine, we can continue.
Q. Go through. It's important that we make clear that, obviously, these are your preliminary views, based on the documentation that you do have.
A. Yes.
Q. You may feel that as we go through we have addressed everything on these issues that you would like to and that's absolutely fine but I want to provide you with an opportunity to say everything that you would like to--
A. Yes.
Q. In respect of your recommendations?
A. Mm-hm.
Q. Just to assist. Please can we put up the recommendations on the screen, so page 19, paragraph 51 of Adam's statement, please. Thank you.
So at paragraph 51, at the bottom of the page --

I am grateful, thank you -- we can see there, Adam, you recommend:

"Clinicians [should] work with families to ensure that they understand what is really going on and to take concerns expressed by families seriously."

A. Yes.

Q. Now, I know you have covered this heavily in your evidence --

A. Yes.

Q. -- but is there anything further that you would like to say about how clinicians failed to listen to you or your family in relation to Mandy's care and treatment?

A. Nothing further apart from just to really, I suppose, yes, summarise that I feel that we are the people you need to listen to and we will always treat -- it just felt -- it felt like we had to work extremely hard, like I said, like the kind of gathering, gathering of letters from friends and family. It required that level of documentation and effort to even start to feel listened to and, yes, just really being treated as kind of secondary, secondary opinions.

Q. Do you have any views on engagement with family in terms of the risk assessment process and whether that happened in Mandy's case?

A. I'm still not -- I mean I am really not sure what the

risk assessment process is. All I've got is glimpses, glimpses into it from the -- from the inquest. So, yes, I would -- I really think actually seeing the concrete kind of what are you using to decide this level of risk and then the level of -- a level of intervention is needed.

Q. Thank you. Please can we -- ah, we have it there. Paragraph 52, the next paragraph, your second recommendation is to "Create a better risk assessment tool", as the current risk assessments are "woefully inadequate".

I think the first thing to raise there is that it came out at the inquest, didn't it, that actually those tools that were available were not used?

A. Correct.

Q. Would you like to say anything further about risk assessment tools that you feel should have been used or resources that should have been used in Mandy's case?

A. I just think I'd probably just pool together what I have already said. It's just the how -- how are you getting all the information from various different systems? How are the family's views being treated in this? What's the weighting, kind of like is the family's views just a side comment or is it a real central factor?

Like I said, the protective factors element I think

was, was not enough.

I mean, for me just as a -- whatever risk assessment process has happened in this case is farcical because you just can't -- you just can't, you can't read this case and understand this case and then not appreciate how ill she was and that some serious intervention was needed and didn't happen, and the risk assessment process said she was okay. Like ...

Q. And just to be clear, when you refer to what weighting should be afforded to families' views, in your view, what weighting should families' views be afforded?

A. I don't know. It depends, it depends how you're going to measure it. But I mean, I feel like if my views were taken into account we wouldn't be in this situation.

So I mean it needs to be, it needs to be equal if not more to the -- to the clinicians. Not necessarily with, obviously, management plans but in terms of realising the level of risk.

Q. Yes. Please can we have paragraph 53 on the screen over on page 20. Thank you. Your third recommendation is that appropriate services should be available out of hours and by that you mean qualified staff on duty who can access medical history and make informed decisions about how to manage crisis situations. We have touched briefly on out of hours.

A. Yes.
Q. Is there anything further that you would like to say in respect of --
A. Yes, there is. It was really -- like, I don't know if it was coincidence or what but most, most crises happened out of hours. Like I said, with the call I made to the care coordinator the following day from, like, when Mum's saying night before that she's going to -- whether she is going to run and jump or just jump.

It was really -- it was draining to have to -- even though, even though the Crisis person on the end of the Crisis phone line has the notes there's so much more context to a -- to a case than just reading, the person on the other end of the phone reading through the notes and I felt like I had to re-explain and re-explain and re-explain eight years of history to someone on the end of the phone to get them to realise again -- because all they are going to say is, "The consultant opinion is that she is low risk". Okay, well, then if the consultant is saying she's low risk, then what this guy is saying is kind of, like, fine, but we don't need to act on it urgently. Speak to the care coordinator on Monday. Rather than: Let's do something about this now.

There was a particular -- a particular incident that

I had before this that really kind of summarised it for me, which was mum went into -- she was, she was having a mental health crisis and also a really severe leg infection and I remember the care coordinator kind of saw her, decided she needed to go to A&E for the leg and said she would relay to A&E that once she had kind of got the appropriate physical medication for that that she would then need to be assessed by the Derwent Centre, the mental health part of the hospital.

And the next I know she comes out of her physical, her physical meeting with A&E and there's been no kind of no communication to the Derwent Centre, and this is after hours at this point, and she is standing in a hospital gown in the carpark with me and I am like, she is still in this mental health crisis. She's -- and when she's -- when she can see that I am on the phone to -- to I can't remember who it was, I think it was Crisis or the duty worker or someone, to basically say, "This message that you said was going to be passed to the Derwent Centre has not come through because A&E are saying they're not going to -- they don't know anything", and she can see that I am doing that.

She is then shouting and screaming at me in the carpark and running around the carpark in a hospital gown. I then have to call hospital security and then it

ends up with me having to call the police and trying and get the police to effectively section her. And this was probably three hours of her running round, like, highly, highly distressed.

THE CHAIR: What happened in the end?

A. The police kind of basically were around her near the road, near a busy road basically effectively waiting for her to calm down. She calmed down to the point she then got in my car, went to her partner's, I drove her to her partner's house where she was living and the following day -- I think if I'm not mistaken the following day she was sectioned.

And the care coordinator said that the police should have sectioned. First of all she said, "I don't know why the breakdown in communication happened in the first place". Then, "The police should have sectioned her", and then actually during working hours the next day she was sectioned and, again, I can't remember if it was a section or if it was an admission but she went to hospital.

And it was just another incident, another time where I have said, "This has to happen otherwise we are going to be in real trouble." It didn't, it caused an extreme amount of distress. And then it's always -- the thing I recommend in the first place ends up happening anyway

just two or three days later and in this particular case, on 12 February, they didn't quite catch up in time.

MS LEA: Do you know -- you said she may have been sectioned or she may not. Do you know if that was the 2020 sectioned admission, her last admission?

A. It was -- it was during Covid, so, yes. Highly likely, yes.

Q. Thank you. You can see on the screen in front of you there at paragraph 54 you have set out your fourth recommendation. We have touched heavily on this, but just for completeness it's that there needs to be a change in the way patient records are kept because as came out at the inquest the consultant could not see the reports in chronological order made by NHS professionals outside of the team without actively searching for them in different areas.

Would you like to say anything further on that or are you happy that that's been covered?

A. Nothing really, apart from the fact that I've said the risk assessment process is clearly, clearly flawed and I would just -- I would really love to think that if that information had been available in chronological order and easily accessible to the consultant that the risk assessment process would have a different outcome

and then more intervention would have been put in place.

However, saying that, I am still sceptical as to whether the appropriate level of intervention would have been put in place even with that complete information.

Q. Finally, Adam, there at paragraph 55 your final recommendation is that you are unsure if any concerns raised by you via phone calls or emails were acted upon or logged. So in your view there should be a more formal way of raising concerns about clinical decisions or lack of healthcare professional action and logging the concerns to ensure they are recorded and taken seriously.

Would you like to provide any further examples of concerns that you raise that you fear were not logged?

A. I think it was more just there was -- I had this -- I mean I had concrete experience of there being real problems in -- in the system and trust in the system being eroded. And my job kind of means that I don't often -- well, the time when I had to -- when I was -- when I got those letters from friends and family and so on I don't always have the time to have that level of engagement to really try and get my point across. And sometimes it really was kind of: I am at work, she's told me this thing the night before. I need to call and I need to relay this to the team. I need to trust that

the team are going to deal with it.

There just -- there was a worry with the gaps that I had seen across her care around if I had told this to reception and reception said they are going to pass it on, are they? If I told the care coordinator this, is it being logged on the system? And almost in the back of my head I am thinking I want, I almost -- I can almost see what's going to happen, where this is going to end up, she is going to die and I -- I wanted to know that the concerns I had raised verbally over the phone or via email were kind of being centrally kept and that that information was passed to the right people and acted on in the appropriate way.

But, yes, it felt like there was no closing of the feedback loop there.

Q. Is it fair it say on that point as well, you raised earlier an inaccuracy, for example in the 24 January call, you were very clear that what you were reporting was that your mother was deciding whether to run and jump or just jump --

A. Yes.

Q. -- and which would likely be more successful.

A. Exactly.

Q. And that hasn't been reflected in the notes?

A. Exactly. Exactly that. And on that particular call

like I was worried that that call wouldn't be logged at all.

Q. Yes.

A. But, yes, exactly that kind of thing. Whether there is kind of an online platform that patients and their family can see what official kind of concerns have been logged or what people have referred to, I don't know, but some kind of formal way of seeing what's been raised.

MS LEA: Thank you. Please can we take down the statement. Adam, thank you so much. That concludes my questions for the moment.

Chair, do you have any questions to conclude?

THE CHAIR: No, I haven't got any questions. But I would like if say thank you very much indeed for your time and thoughtfulness in answering these questions.

A. Thank you very much.

THE CHAIR: Thank you to your wife too for coming.

MS LEA: Adam we are going to take a 10-minute break to see if we have any further requests. Before I do, I am going to put on the screen the image of your mother because, if we don't have any questions we can let you go.

A. Sure.

MS LEA: Please can we put up the photograph of Mandy.

Thank you, please can we take the image down.

Chair, we will break for 10 minutes. If we don't have any questions we will resume tomorrow morning at 10.00 am, where we will hear from three further witnesses in relation to the care and treatment received by their family members, those witnesses are Karon Pimm, Janet Carden and Patrick Brennan.

THE CHAIR: So if there are no questions we will reconvene at 10.00 tomorrow.

MS LEA: Yes, Chair. Thank you.

THE CHAIR: Thank you.

(4.31 pm)

(A short break)

(The hearing did not reconvene)

(4.37 pm)

(The Inquiry adjourned until 10.00 am,
on Tuesday, 8 July 2025)

I N D E X